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THE NOVA SCOTIA MEDICAL BULLETIN

The Hospital Requirements of Nova Scotia

This issue of the Bulletin continues the excellent series of papers from the Dalhousie Department of Preventive Medicine on the hospital requirements of Nova Scotia. The writers are attempting to design accurate statistical tools, or to modify earlier methods, as an aid to future hospital planning.

This effort is to be highly commended. All too often in the past decisions regarding the location or size of hospitals in Nova Scotia and elsewhere have been based on political expediency or an emotional appeal to the public, or both. Physicians have sometimes pressed hard for community hospitals convenient to them and their patients, but too small to warrant the expensive support systems required by modern medicine and surgery. Businessmen have recognized the value of a hospital as a "small industry", contributing to the economic life of the community. How can one find one's way through this maze of conflicting opinion and interests?

Far be it from me to suggest that statistical studies will solve all the problems. Most decidedly, they will *not*, as I am sure the Dalhousie authors would agree. Statistics are only tools to be used with good judgement and discrimination by those who have to make decisions. Hopefully, they will also be used by persons who have some appreciation of the weaknesses as well as the strengths of the statistical approach. The continued refinement of these statistical tools is essential, if the decision-makers are not to be misled. Hence the value of this series of papers by the Department of Preventive Medicine. But the medical profession, government authorities and the public also need to understand something of the complexity of the subject.

One of my interests over the past twenty-five years has been to investigate whether the epidemiological-statistical techniques, that I had learned at Johns Hopkins University, and which had been originally designed to study the effects of various environmental factors on the incidence and prevalence of disease in a population, could be adapted to estimate what health services, facilities and personnel would be required to combat these diseases in a given population.

This experience of twenty-five years, and a rather jaundiced view of a few recent trends, prompted me to accept this invitation to editorialize.

First, I would like to emphasize that statistics can be used for two distinctly different purposes — as propaganda, or as tools to seek out scientific truth. The use for purposes of propaganda is what has given statistics its bad name — "Lies, damned lies and statistics", or "You can prove anything with figures", or "Figures lie and liars figure". The outright propagandist chooses the figures that support his case and purposely suppresses everything else. However, there is also the unconscious propagandist, who misuses statistics without the clear intent to defraud. He may be a clinical investigator who can find seemingly rational explanations for dropping out the cases that do not agree with his preconceived notions. His data always prove what he started out to demonstrate! The scientist, on the other hand, tries to find evidence to disprove his hypothesis.

Frankly, I am afraid that propaganda (conscious or unconscious) is in danger of winning the battle against the scientific method in the health care field. The Hospital Insurance and Medical Care Insurance Plans of Canada have proven to be very costly. The escalation of the cost has become a major concern of governments at all levels, and indeed it should also be the concern of all taxpayers. Instead of confessing that their contract with the people of Canada, to insure necessary hospital and medical services, cannot be

completely fulfilled, governments are pressing hard to reduce standards, while persuading the public and the health professions that present facilities and personnel are more than adequate and that the services are being abused.

Have you noticed how frequently in recent months the newspapers have carried reports of Canadian health authorities pointing out quite categorically that Canada has enough physicians; only a maldistribution creates problems in a few areas. Ask for the source of the data on which the adequacy of the new "standards" are based and you will receive the expert's reassurance, but no scientific facts. I have tried! If the ratio of physicians to population is adequate and there is an excess in the larger population centres, I wonder why there is such a rapidly growing demand on the Emergency Services of the Victoria General Hospital, when Halifax has a much better ratio of general practitioners per 1000 population than any other part of the province.

One expert recently stated, at a meeting which I attended, that the only way to provide good hospital services was not to build any more hospitals. If he had said "cheap hospital services", instead of "good", I might have agreed with him. Obviously one way to keep the cost of health services from escalating is to build fewer hospitals or to train fewer doctors or nurses. The ultimate goal in cheap hospital services would, of course, be to close all such institutions!

But this simply brings us back to the real question. What is meant by "good" or "adequate" hospital services. The physician tends to assume that the only criterion for determining the hospital bed requirements, or other health services, should be the welfare of the patient. If he or she needs a hospital bed, the community should have a sufficient number to ensure that there is little or no delay in admission. Physicians have been trained for generations to place the welfare of the patient first, rather than the cost to the government or to the hospital. On the other hand, politicians and civil servants, who observe the rapidly growing cost of hospital services, think that there should be a method for setting a ceiling on the demand. And to a certain extent they are right. We all know that some patients *are* kept in hospital too long by some doctors. Some are admitted who could get a diagnostic work-up in a doctor's office and hospital laboratory. A rational middle ground has to be sought between those physicians who demand an excess supply of hospital beds and the health care planner who may set an arbitrarily low standard, based primarily on the cost factor.

As a medical scientist, I have been impressed since my student days with the wide variability in response of biological organisms. This applies not only to animals and man but to society as a whole. A range of services is almost certain to be the pattern of a normal functioning society. It seems to be a very odd quirk of reasoning that makes some health planners demand a single figure or ratio as a standard for planning. For example, one method used to estimate hospital bed requirements has been the ratio of hospital beds per thousand of the population served, say, 6 or 7 beds per 1000. Those who designed this measure always regarded it as an average which would only be applicable to a relatively large population group such as a whole province. They recognized that some regions within the province might need more hospital beds than others, because of more people in the older age groups, or an industrial area subject to a higher incidence of serious respiratory disease. A range on either side of the average has always been regarded as essential. Suddenly, however, the health services propagandist has converted this average figure into a "standard" and the standard was then quickly reinterpreted as a ceiling. So instead of a provincial average of hospital beds per 1000 we have a ceiling that says no community may exceed this level. One does not require a knowledge of the newer mathematics to know that if you average the figures 2, 4, 6 and 8, the average of 5 should not be called the ceiling or top of that range. This misinterpretation of an average as a ceiling or top level reminds me of the old story of the Bed of Procrustes. This marvellous bed was always adequate to fit all guests no matter what their height. If they were too short they were stretched to the length of the bed and if they were too long the excess was lopped off.

Finally, one of the fundamental requirements of an epidemiologist is that he will never use a ratio, a percentage, or a fraction, without examining the denominator just as carefully as the numerator. In relating the number of hospital beds to a population it is as important to look at the population served as it is to count the number of beds. For example, if you divide the total number of hospital beds located in Halifax and Dartmouth by the population of these two cities it appears that this Metropolitan area has more hospital beds than any other part of the province. However, these hospitals serve as referral centres for the whole province and a considerable percentage of the patient-days of hospital care is given to residents of the other regions. The correct denominator is therefore the population *served by* the hospitals and not the *population of the geographic area. This ratio reveals that the Halifax Dartmouth Region has the poorest, not the best, bed-ratio in the province.*

My one concern is that statistical and other estimates, which are used as standards or guides, shall be designed on a rational basis, still keeping in sight the main goal, the provision of *adequate* but not excessive medical and surgical services for the insured population. If governments get the help that they need from the medical profession in controlling abuse and in making logical estimates of the future demand, they will behave in a reasonable fashion. If not, arbitrary guides are very likely to be imposed. The epidemiologist with the scientific attitude will then lose the battle to the government propagandist who will try to convince everyone that the new standards are satisfactory. Sound statistical methodology, good common sense, and unbiased judgement may make the combination that will beat the propagandists.

□

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Trends in Hospital Beds in Nova Scotia: Current Supply And Future Needs

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INTRODUCTION

A data base has been developed from the records of the Nova Scotia Health Services Insurance Commission which makes possible annual monitoring of hospital utilization in Nova Scotia (Gordon, Smith and Weldon, 1973[1]). One study of hospital utilization deriving from this data base was concerned with the trends and differences in the regional "demand" for hospital care (Gordon, Weldon, and MacLean, 1973[2]), where demand refers to hospital utilization of patients classified by region of residence.

In this paper we focus our attention on the "supply" of hospital service to the residents of a region. We will consider the supply and pattern of use of beds in the regions and how much use is made of beds from outside the regions. Also, based upon past trends we will provide some alternative predictions of bed requirements in 1980.

The geographic boundaries of the regions employed in this study are shown in Figure 1.

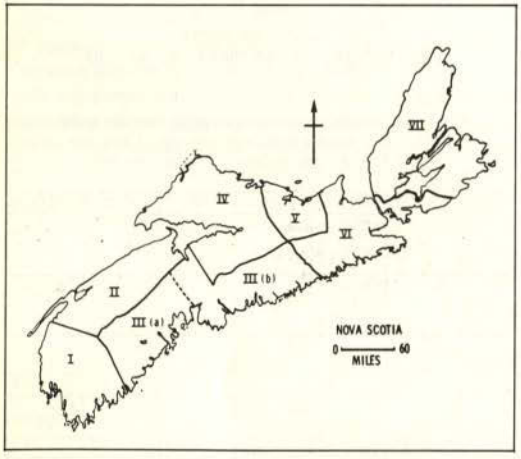

Figure 1

DEFINITIONS

In this section we define the measures which are used to analyze the supply of hospital beds.

1. **Beds/1,000** is equal to $\frac{\text{bed in region}}{\text{population of region}} \times 1{,}000$. If residents of a region only used the beds in their own region then this measure would indicate the best measure of the regional supply of beds.

2. **Occupancy rate** is equal to $\frac{\text{patient days in region}}{\text{beds in region} \times 365} \times 100$. It measures supply in the sense that increasing the occupancy rate has the effect of adding new beds. Furthermore, a high occupancy rate would be expected to result when demand increased relative to supply, so it is a reflection of the demand-supply relationship.

3. **Average length of stay** is equal to $\frac{\text{patient-days used by residents in region.}}{\text{separations by residents in region}}$ A decline in average length of stay would enable a region to handle a greater volume of demand (separations), therefore it is reasonable to view it as a measure of supply, and also a reflection of the demand-supply relationship.

4. **Beds Available/1,000** is equal to $\frac{\text{beds used within region} + \text{beds used in other regions}}{\text{population of region}} \times 1{,}000$. The estimation of beds used in region A by residents of region B is based upon the proportion of the patient days served by hospitals of region A to residents of region B. This adjustment for bed use is necessitated by the fact that residents of a region make considerable use of the beds in other regions, particularly the referral region. To emphasize that our measure indicates the supply of beds, we refer to it as "beds available", though it is calculated as beds used. This proxy measure of supply is justified by the fact that it is impossible for a non-existing bed to be used and unlikely that an existing bed would not be used.

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5. **The Self-Sufficiency Index** is defined to be $\frac{\text{patient-day in hospitals of region}}{\text{patient-days used by residents of region}} \times 100$. (This measure is approximately equal to $\frac{\text{beds}}{\text{beds available}} \times 100$, the difference being an allowance for occupancy rate.) The index measures self-sufficiency in the sense that an index value of more than 100 means that it would be numerically possible for a region to satisfy all the demand for patient days by its residents, i.e. it could be self-sufficient in this numerical sense.

PAST TRENDS AND CURRENT STATUS OF MEASURES OF REGIONAL BED SUPPLY

Having defined the measures of interest, we will now consider what our data base tells us about each of the measures and thereby about the regional supply of beds.

Looking at beds/1,000 in Table I, we see that there has been a trend towards an increasing concentration of beds in Region IIIb, the major provincial referral centre and a slight decline in all other regions except region V. The relative status of the various regions has changed little over 1967 to 1972.

TABLE I

Beds per 1,000 population 1967-72, by region

Region	1967	1968	1969	1970	1971	1972
I	4.5	4.3	4.3	4.3	4.2	4.2
II	6.0	6.0	6.0	5.8	5.7	5.7
III(a)	4.6	4.2	4.1	4.1	4.0	4.0
III(b)	6.7	6.6	7.1	7.6	7.4	7.3
IV	5.1	5.3	5.0	5.0	4.9	4.9
V	5.3	5.9	5.7	5.8	6.2	6.2
VI	6.2	6.1	5.8	5.3	5.2	5.1
VII	7.2	7.2	7.1	6.9	7.1	7.1

TABLE II

Occupancy rates by region, 1967-72

Region	1967	1968	1969	1970	1971	1972
I	70.2	73.8	73.6	79.0	80.5	79.9
II	63.0	64.9	68.1	69.6	68.2	65.8
III(a)	56.9	60.8	63.3	65.3	65.2	64.1
III(b)	78.0	78.6	74.3	72.3	76.3	77.1
IV	67.6	67.6	70.3	73.1	74.3	74.0
V	82.9	77.4	80.6	84.4	80.7	78.5
VI	72.4	72.8	74.4	82.9	77.9	75.1
VII	80.9	78.4	78.9	84.4	84.7	78.1

Turning now to occupancy rates (Table II), we see they vary widely among regions, although the spread has narrowed slightly over time. In 1967 occupancy rates varied from 56.9% to 82.9% while in 1972 this range was 64.1% to 79.9%. The rankings by region for occupancy rates remained virtually the same between 1967 and 1972.

Average length of stay is shown in Table III, and with the exception of regions I and III(b), this measure is gradually declining. The greatest decrease is between 1971 and 1972 so it is difficult to determine what future levels will be reached. Since demand (separation rate) levelled off somewhat between 1971 and 1972, it is probably administrative tightening rather than this demand which brought average length of stay down during this period.

TABLE III

Average length-of-stay 1967-1972 for N.S. and regions

Region	1967	1968	1969	1970	1971	1972
I	9.85	10.16	10.06	9.74	10.19	9.99
II	9.66	9.25	8.57	8.45	8.39	8.10
III(a)	8.43	8.99	8.62	8.14	7.96	7.98
III(b)	10.57	10.69	10.61	10.75	10.93	10.64
IV	10.02	9.82	9.86	9.42	9.26	8.96
V	11.61	11.93	11.91	11.21	10.48	9.71
VI	11.64	10.82	10.26	10.39	9.68	9.17
VII	11.64	11.49	11.03	11.13	10.83	10.28
N. S.	11.14	11.02	10.76	10.67	10.60	10.25

If we consider, in Table IV, the total beds available to a regions population there are two major points of interest. One is that the bed rates are remarkably stable over the years 1967-72 with the exception of complementary trends for region V and VI; the beds available increased by 16.7% in region V and decreased by 16.7% in region VI. The other is that the wide range in the beds available rates was maintained (with the exceptions noted above) during the entire period.

TABLE IV

REGIONAL BED SUPPLY

BEDS AVAILABLE PER 1,000 POPULATION, 1967 - 1972

R. B. - beds available to residents from within their own region
O. B. - beds available to residents from without their own region
T. B. - total beds available to a region's residents

REGION OF RESIDENCE	1967	1968	1969	1970	1971	1972
I	4.4 / 1.3 / 5.7	4.2 / 1.0 / 5.2	4.2 / 1.1 / 5.3	4.2 / 1.1 / 5.3	4.1 / 1.2 / 5.3	4.1 / 1.2 / 5.3
II	5.6 / 1.2 / 6.8	5.7 / 1.2 / 6.8	5.6 / 1.3 / 6.9	5.5 / 1.3 / 6.8	5.4 / 1.5 / 6.9	5.4 / 1.5 / 6.9
III a	4.1 / 2.1 / 6.2	4.1 / 1.9 / 6.0	4.0 / 2.1 / 6.1	4.0 / 2.1 / 6.1	3.9 / 2.1 / 6.0	3.8 / 1.5 / 6.0
III b	4.5 / 0.1 / 4.6	4.6 / 0.1 / 4.7	4.9 / 0.1 / 5.0	5.3 / 0.0 / 5.3	5.0 / 0.1 / 5.1	4.9 / 0.1 / 5.0
IV	4.9 / 1.6 / 6.5	5.1 / 1.5 / 6.6	5.1 / 1.6 / 6.7	4.8 / 1.7 / 6.5	4.7 / 1.7 / 6.4	4.7 / 1.7 / 6.4
V	5.2 / 1.3 / 6.5	5.6 / 1.3 / 6.9	5.6 / 1.3 / 6.9	5.6 / 1.5 / 7.1	6.0 / 1.6 / 7.6	6.0 / 1.6 / 7.6
VI	5.8 / 2.0 / 7.8	5.6 / 2.0 / 7.6	5.4 / 1.9 / 7.3	4.9 / 2.0 / 6.9	4.7 / 1.8 / 6.5	4.6 / 1.9 / 6.5
VII	7.0 / 0.8 / 7.8	7.0 / 0.8 / 7.8	6.9 / 0.8 / 7.7	6.6 / 1.0 / 7.6	6.9 / 1.1 / 8.0	6.9 / 1.2 / 8.1

The number of beds available to residents from within their own region does not show any striking trend, although there is a slight tendency to decrease over the period of study. In examining the beds available from outside the region in Table IV, there appears to have been an increase in this since 1969. A more detailed examination (see (5)) reveals that increased referrals to region IIIb and a general increase in service to out-of-region residents accounts for these trends.

Table V presents the regional patterns in the self-sufficiency index over 1967-72. There is a clear tendency for this index to increase over 1967-69 and to decrease over 1969-72 in all regions except III(b), the referral region. In other words, the introduction of M.S.I. in 1969 is associated with a reversal of a prior trend to increasing regional self-sufficiency. The rates of decrease in the post M.S.I. period are bringing the indicies closer together indicating they might be approaching some common value (with the exception of IIIb).

TABLE V

Self-Sufficiency Index, by region, 1967-72

Region	1967	1968	1969	1970	1971	1972
I	78.8	82.6	81.4	82.3	80.7	80.5
II	84.9	85.0	86.0	84.5	81.5	80.0
III(a)	60.4	64.1	64.1	64.6	63.4	62.3
III(b)	145.1	141.3	142.2	142.1	144.4	146.4
IV	75.8	77.8	77.6	78.0	76.3	76.4
V	83.6	85.5	84.9	84.1	82.9	82.2
VI	78.1	78.8	79.3	79.4	79.5	78.4
VII	92.8	92.7	92.8	91.6	90.4	88.6

Having considered the measures individually, we can look for possible relationships among the measures. In Table VI the ranks (highest to lowest) of the measures by regions for 1972 are presented. There are a number of points we can make. First, the ranks are quite consistent (although region I has perhaps the least stable ranking) with region IIIb highest and IIIa lowest. This suggests there might be another variable effecting all the measures. Also, the regions nearest to IIIb, the referral region, are the ones with lowest ranks (II, IIIa, IV). So although they have less beds/1,000 they also have low occupancy rate and low average length of stay because they refer more to IIIb (i.e. they are also less self-sufficient). Another point is the switch in the rank of IIIb for beds/1,000 and beds available/1,000. Although there are more beds in IIIb, in terms of access the residents of IIIb have the least beds available to them.

TABLE VI

Rank of Measure by Region, 1972

Region	beds/1,000	occupancy rate	average length of stay	self-sufficiency	beds available/1,000
I	7	1	3	4	7
II	4	7	7	5	3
III(a)	8	8	8	8	6
III(b)	1	4	1	1	8
IV	6	6	6	7	5
V	3	2	4	3	2
VI	5	5	5	6	4
VII	2	3	2	2	1

SUPPLY RESPONSE TO INCREASED DEMAND 1967-1972

To better understand the measures of supply being discussed we bring them together and relate them to changes in demand. When population and/or utilization rates increase, the hospital system can respond in one or more of the following ways to accommodate the increased demand.

i) new beds can be built in the region

ii) hospital service supplied from elsewhere may increase

iii) occupancy rates can increase

iv) average length-of-stay can decrease

Table VII shows the percentage change in demand from 1967-72 and in the above measures of response over the same period. We will consider the figures for all of Nova Scotia first (the final column of Table VII). Over 1967-72 the demand (separations) increased by 16.4%, but a decline of 8.0% in average length-of-stay reduced the net increase in total patient-days demanded to 7.1%. This increase in patient-days was balanced by a 6.2% increase in the number of beds and a 0.9% increase in occupancy rate for a 7.1% increase in bed days supplied (bed days supplied ÷ 365

TABLE VII

Percent change in measures 1967-1972 for Nova Scotia and Regions

Measures	REGION I	II	III(a)	III(b)	IV	V	VI	VII	N.S.
Demand:									
Separations	9.0	27.5	17.6	14.4	19.2	31.4	22.8	9.5	16.4
Supply:									
New beds	—3.3	0.0	1.0	17.7	0.2	14.3	—4.0	—3.5	6.2
% Sent Elsewhere	—9.5	—19.8	—2.4	10.0	2.6	9.5	7.4	42.3	—
Occupancy Rate	13.8	4.4	12.7	—1.1	9.5	—5.5	3.7	—4.5	0.9
Average Stay	1.4	—16.2	—5.4	0.6	—10.6	—16.4	—21.2	—11.7	—8.0

beds ^ occupancy rate). The net effect of patient-flows across the Nova Scotia boundary has resulted in a negligible influence on the provincial hospital system.

On a regional basis it is difficult to balance the changes in demand with the changes in supply because of the flows from region to region. It is more appropriate to look at the regional breakdown of the Nova Scotia responses referred to above.

Summarizing the regional responses over 1967-72, displayed in Table VII, Regions I, II and III(a) actually sent a smaller proportion of their residents patient-days to hospitals in other regions, but to accomplish this had to either increase occupancy rates (I and III(a)) or decrease average length-of-stay (II). Regions IV, V, VI and VII increased the proportion of patient-days served elsewhere, while at the same time reduced their length-of-stay by at least 10%. Additional responses by Regions V and VII were that Region V increased its number of beds by 14.3%, Region VI increased its occupancy rate by 9.5%. Region III(b), the major referral centre, experienced a 17.7% increase in beds with only slight changes in the other measures. (The 10.0% increase in the proportion sent elsewhere is an increase from 1.0% to 1.1%).

ALTERNATIVE BED REQUIREMENTS — 1980

We conclude with a modest attempt to project the bed requirements for Nova Scotia and the regions by 1980. To do so we require the following information:

a) population for Nova Scotia and regions — 1980

b) occupancy rates for Nova Scotia and regions — 1980

c) self-sufficiency index for regions — 1980

d) patient-day rates for Nova Scotia and regions — 1980

In working our projections we will consider occupancy rate and self-sufficiency as parameters which we can estimate. In effect we are using these measures as policy variables, occupancy rate being controlled by the administrator and self-sufficiency by the politician.* We will use a value of 75% for occupancy rate and 75 for self-sufficiency for all regions (refer to Figure 2 to see effect of extending self-sufficiency to 1980). These values might be unjustified but they will serve for illustration. The objective is not to find the best or most plausible values but to demonstrate their use.

Our population projections are based upon a report by Dr. Andrew Harvey of the Institute of Public Affairs.

With these fixed values, then, we can determine the bed supply necessary to meet the projected demand in patient-days in 1980. We may predict patient-days by region of residence in several ways, but choose two that we feel are relevant.

(1) Since patient-day rate changes for all regions were close to zero or negative over 1971-72, one may suppose that the average of 1971-72 patient-day rates may be a fair estimate of patient-day rates over the next few years.

(2) Consider the average annual percentage changes over 1970-72, and apply it annually to the period 1970-1980.

*From the Halifax Chronicle-Herald, March 26, 1974. "Premier Regan also told the radio talk show that he was willing to go along with plans for a new referral hospital in Sydney, providing the community takes the necessary first step. "The hospital could have a capacity of up to 500 beds, he said."

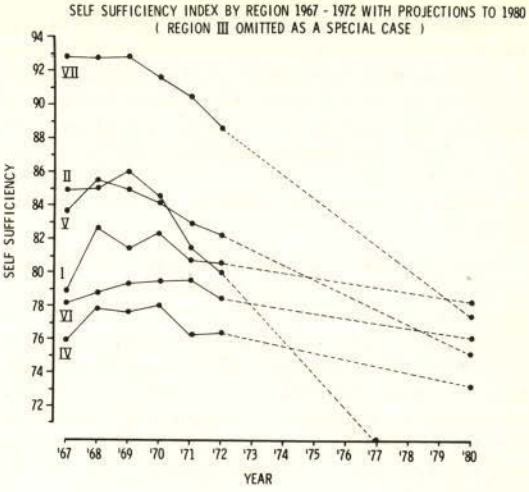

Figure 2

With our values of patient-days, self-sufficiency and occupancy rate we have

$$\text{beds in region } i = \frac{\text{patient-days in } i \times \text{self-sufficiency for } i}{365 \times \text{occupancy rate for } i}$$

The bed requirements in 1980 using the two methods of predicting patient-day rates are shown in Tables VIII and IX.

Both methods suggest that most regions have enough beds in 1972 to serve the predicted demand in 1980. A possible exception is Region VI, which by method (1) may require new beds (but will have a surplus by method (2)). The discrepancy in the two predictions for Region VI is attributable to the use of percentage change in patient-day rates for method (2), since in the past few years patient-day rates in Region VI have declined sharply. Note the marked excess bed supply in Regions VII and II by both methods of prediction assuming all 1972 beds are maintained until 1980. These excesses may, of course, be avoided by implementing policy to increase the target value of the self-sufficiency index above 75% for these regions — if this were done, fewer beds would be required in III(b) than are shown in the table for 1980.

It must be stressed that these projections are *examples* of the kind of projection that follows logically from certain policy decisions in combination with alternative estimates of demand. We obviously are in no position to predict policy. Thus our 1980 "estimates" are to a great extent hypothetical. We would hope the main use of such projections is to form policy aimed at producing desirable deviations from our projections.

One factor that may well affect these projections is the possible provision of new auxiliary facilities and programs to

TABLE VIII

Regional bed requirements, 1980 — Method (1)

	I	II	III(a)	III(b)	IV	V	VI	VII	N.S.
Patient-day rate	1,513.2	1,735.6	1,502.5	1,468.2	1,750.1	2,196.9	1,828.6	2,376.7	1,748.5
Population	52,285	80,942	56,095	315,534	88,302	48,290	62,498	148,503	852,449
Patient-days	79,892	141,857	84,364	448,679	156,048	107,125	115,401	356,397	1,490,507*
Beds — 1980	219	389	233	2,590	427	294	316	977	5,445
Beds — 1972	210	448	206	2,044	422	288	243	1,093	4,954

*not equivalent to regional totals due to rounding error

TABLE IX

Regional bed requirements, 1980 — Method (2)

	I	II	III(a)	III(b)	IV	V	VI	VII	N.S.
Patient-day rate	1,530.3	1,500.0	1,440.1	1,317.9	1,788.5	2,466.6	1,051.2	2,239.2	1,611.0
Population	52,285	80,942	56,095	315,534	88,302	48,290	62,498	148,503	852,449
Patient-days	80,010	121,402	80,780	415,835	157,927	119,114	65,697	332,530	1,373,395
Beds — 1980	219	332	221	2,394	433	326	180	912	5,017
Beds — 1972	210	448	206	2,044	422	288	243	1,093	4,594

care for patients not requiring full hospital level care. A study has been done on the potential for such new facilities and programs [4] in which it was shown that a considerable number of the hospital beds in mainland Nova Scotia are used by patients who could be cared for in non-hospital facilities. The study did not consider this suggestion in enough detail to assess its feasibility, but only established some potential for this.

DISCUSSION AND SUMMARY

The regional supply of beds in Nova Scotia is clearly an important issue in the health care delivery system. In making decisions on the adequacy of supply, the total Nova Scotia picture should be considered. Thus, while looking at beds per 1,000 on a regional basis gives an impression of inequality, consideration of the geographical smallness of Nova Scotia and the corresponding ease of access to beds in one region by residents of another (reflected in beds available per 1,000) presents quite a different picture. In terms of "access" to beds different areas of the province are quite comparable. The principle might be that an adequate supply (in terms of beds per 1,000) for the province implies the regions are adequately supplied, since invariably people are going to get to the beds elsewhere if they are not available locally.

However the location of the beds is important in terms of convenience. In addition the efficiency of the hospitals as measured by occupancy rate is affected by the location. The variation seen in occupancy rates, some being quite low, might partly be a result of location of the beds. The highest occupancy rates are in areas of greatest concentration of population.

A related issue is the ability of a region to handle its own demand for hospitalization, to be self-sufficient. In view of the previous comments, it is probably more efficient for some regions to have low self-sufficiency and some high, depending on the concentration of population. At present in Nova Scotia self-sufficiency is nearly equal for all regions (except the referral region).

Accepting that we have enough beds but that they are not distributed in the best way, we can look at appropriate changes to meet future requirements. If the centres of population are stable, then concentrate in these areas. Most importantly, this requires bolstering the provincial referral center.

In all references to beds, nothing is said of types of beds and supporting facilities. An interesting refinement of the work in this paper would be to classify the hospitals according to their case mix and look at the beds of each case mix type available (medical, surgical, paediatric, etc.) to the various regions. A region might have plenty of beds available over all but not necessarily enough of each type. There are other obvious improvements to be made in the analysis here. However, some guidelines have been established and hopefully food for thought provided. □

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Considerations in General Anaesthesia for Ophthalmic Surgery

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For ophthalmic surgery, the patient must lie down, keep quiet, have a non-moving eye with low intraocular pressure, and wake without coughing or vomiting.

The use of general anaesthesia for ophthalmic surgery is ever increasing, placing greater demands on the anaesthetist and his techniques. In the past, the reasons for not using general anaesthesia were as follows:

1. Risk of coughing and/or vomiting during surgery, especially while the eye was open
2. Risk of post-operative coughing and/or vomiting
3. Prior to the use of endotracheal intubation, the anaesthetist had to be in the surgeon's way or have poor control of the patient's airway
4. Not all anaesthetists want to be involved with ophthalmic surgery, and sometimes junior staff were elected to do the cases.

Improved conditions and techniques of general anaesthesia now provide:

a) Endotracheal intubation which allows the anaesthetist to be more out of the way of the surgeon, and to provide better ventilation and airway control

b) Fewer post operative problems, such as nausea and vomiting

c) Better operating conditions for the surgeon with the patient asleep

d) Since the patient is asleep, his cooperation is not required

e) No movement of the eyeball with adequate anaesthesia

f) New surgical techniques, high magnification microscopes, better sutures all provide better surgical results, with less chance of post operative damange due to coughing or vomiting.

The indications for General Anaesthesia include:

— Operations on babies and young children

— Extensive eye operations

— Patients who object to local anaesthesia

— To expedite surgical schedule.

There are no specific contraindications to general anaesthesia though a number of factors will influence the degree of risk involved and modify the technique used. Some of these factors are:

1. Age of patient
2. Cardiopulmonary status
3. Gastric emptiness
4. Drugs being taken by the patient (such as antihypertensive agents)
5. Drug idiosyncrasies
6. Status of intraocular tension.

LOCAL ANAESTHESIA

When discussing the use of general anaesthesia for ophthalmic surgery, one must not forget the important role local anaesthesia has played, and still continues to play. Local anaesthesia for eye surgery is generally reliable, effective and relatively safe. Also, it is administered by the surgeon and so surgical scheduling may be easier. There tends to be a lower incidence of nausea and vomiting, and a lower incidence of pulmonary embolic complications with the use of local anaesthesia. There is less upset of electrolyte balance and little disturbance of body functions. There are claims of less operative bleeding and that the patients require less postoperative care.

Disadvantages of local anaesthesia include the fact that the patient is awake and eye surgery presents varying degrees of undesirable experiences. Local anaesthesia is often combined with narcotic pre-medication and patients may be difficult to control. The systemic and local complications of local anaesthesia must also be considered.

TECHNIQUES OF GENERAL ANAESTHESIA

As with other types of surgery, patients for ophthalmic operations must be adequately evaluated preoperatively as to their fitness for anaesthesia. In fact, many patients for eye procedures (e.g. cataracts) are older and less fit.

Preoperative assessment of these patients should include an adequate history and physical examination, along with hemoglobin, urinalysis, SMA 12/60 (if available). In the case of patients taking diuretics and antihypertensive drugs, serum electrolytes are desirable. A preoperative chest X-ray and ECG are invaluable, particularly in older patients.

Preoperative medication is worthwhile to:

1. contribute to the patient's comfort by alleviation of apprehension, to produce sedation, amnesia, and prevent postoperative vomiting
2. facilitate induction of anaesthesia
3. reduce the amount of anaesthetic agents required
4. minimize secretions in the respiratory tract
5. reduce the activity of undesirable reflexes — mainly cardiovascular.

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Narcotics and opiates are commonly used, but carry a risk of inducing nausea and vomiting. These drugs may be Combined with antiemetic agents, such as a phenothiazine, but care must be exercised. Doses must be reduced in older patients, since narcotics and opiates combined with phenothiazines may act synergistically to produce profound sedation, hypotension, or loss of airway control.

As premedicants, barbiturates tend to produce a sleepy patient, but one who may become agitated when stimulated, especially if the stimuli are painful.

Neuroleptanalgesia is commonly used for preoperative medication and as an adjunct to either local or general anaesthesia. The most commonly known neuroleptanalgetic goes under the trade name INNOVAR, a combination of droperidol lactate (neuroleptic) plus fentanyl citrate (potent analgesic). The neuroleptic agent has a powerful antiemetic effect, produces sedation, a lack of voluntary muscle movement and detaches the patient from the environment.

Side effects of neuroleptanalgesia may include respiratory depression, bradycardia, nausea and vomiting, extrapyramidal signs (such as chest-wall rigidity and Parkinson-like state) and occasionally psychotic behavioural signs.

Other tranquilizing agents as meprobamate, chlordiazapoxide, and diazepam are as valuable in premedication without the undesirable effects.

Atropine is useful in controlling mucous secretions in the respiratory tract, and where the oculo-cardiac reflex may be a problem. The dryness produced by the drug may be uncomfortable for the patient and some Anaesthetists prefer not to use it. It is felt that when used in the usual therapeutic doses (0.6 mg or less) it is unlikely to cause a problem with regard to the eye.[1] Scopolamine may be used for a greater drying effect, but tends to have less vagal blocking effect.

INDUCTION OF ANAESTHESIA

Sodium thiopental is rarely contraindicated in patients for eye operations. Diazepam may also be useful. Induction using nitrous oxide/oxygen and halothane is advocated in some patients, especially young children.

Endotracheal intubation has the real advantages of providing a secure airway and allowing the anaesthetist to be out of the surgeon's way. The major side effect is that of coughing post-operatively. In short procedures this may be controlled somewhat by the use of local anaesthetic spray to the vocal cords prior to intubation. However, the effect of local anaesthetic spray (xylocaine) to the vocal cord area is minimal after 30-45 minutes. To prevent coughing there is no substitute for gentleness in intubation and extubation and selection of proper endotracheal tube size. Certain patients, such as heavy smokers, have a greater tendency to cough regardless of what you do. The technique of withdrawing the endotracheal tube under deep anaesthesia, respraying the vocal cord area with local anaesthetic, then reinserting the tube and allowing the patient to waken, is not recommended here.

The use of succinylcholine for endotracheal intubation is controversial, since at least the first dose causes a rise in intraocular pressure for a short period (five minutes or less). A rise in intraocular pressure is critical in cases of eye injuries with perforation. Several methods have been suggested for avoiding an increase in intraocular pressure:

1. Deep anaesthesia prior to giving the relaxant, but this may be inconvenient and/or difficult
2. Slow infusion of succinylcholine — it is doubtful if this prevents the increase in intraocular pressure
3. Use of acetazolamide (Diamox), a carbonic anhydrase inhibitor. If given 20-30 minutes prior to the thiopental and succinylcholine, there appears to be a markedly lessened intraocular pressure rise[2]
4. Using a non-depolarizing relaxant, prior to the thiopental and succinylcholine. The use of 10-20 mgm of gallamine triethiodide or 3-6 mg of d-tubocurarine about two minutes prior to the succinylcholine significantly decreases intraocular pressure rise[3]
5. Avoidance of succinylcholine completely with the substitution of gallamine, d-tubocurarine or pancuronium to facilitate endotracheal intubation. Though these drugs can be used, they are generally not as capable of producing the profound relaxation seen with succinylcholine.

MAINTENANCE OF ANAESTHESIA

Many ways exist, but halothane represents a major advance in anaesthesia for ophthalmic operations. It causes little vomiting, is non-irritating to the respiratory tract, can provide smooth anaesthesia with a rapid, quiet awakening. The agent also causes a slight decrease in intraocular pressure.

Methoxyflurane is an equally good inhalational agent, though there is a longer induction period and slower awakening. Renal complications may occur with the prolonged use of methoxyflurane. Methoxyflurane also has little adverse effect on intraocular pressure.

The use of intravenous narcotics, in association with nitrous oxide/oxygen has become a popular means of maintaining general anaesthesia. This is effective providing the depth of anaesthesia is controlled so that the patient is neither too light or so deep that post-operative respiratory and/or circulatory support is necessary.

General anaesthesia may also be maintained by the use of Ketamine or neuroleptanaesthesia.

KETAMINE

The state of anaesthesia produced by Ketamine is known as dissociative anaesthesia and appears to follow interruption of afferent impulses in the diencephalon and associated areas of the cortex, particularly the frontal cortex. A peculiar state of profound analgesia, catelepsy and psychic dissociation accompanied by normal or increased muscle tone is produced. In most cases the retention of muscle tone permits the patient to maintain a clear airway regardless of position. Respiratory depression is usually minimal though may be sufficient to necessitate assistance. Some increase in blood

pressure occurs with mild vasoconstriction. A slight increase in intraocular pressure may be observed, due to the effect on blood pressure and the increased muscle tone. Ketamine should be reserved for use in extraocular surgical procedures.

Ketamine appears particularly useful in children, but does have disadvantages in adults. The results are not too impressive when compared with that produced with well-managed general anaesthesia. Postoperative supervision must be quiet without stimulation or wakening with aggressive behaviour may be seen. Untoward reactions include excessive salivation, tremors, convulsive movements, hallucinations, and even prolonged unpleasant dreams. Pretreatment of patients with a minor tranquilizing agent such as Diazepam tends to modify the degree of unpleasant postoperative sensations in adults. There have been recent reports of transient episodes of blindness following Ketamine anaesthesia.[4]

Neuroleptanaesthesia

Neuroleptanaesthesia really infers neuroleptanalgesia plus nitrous oxide/oxygen, with or without assisted ventilation. There are advantages over other types of general anaesthesia. Neuroleptic action lasts into the postoperative period and the patient has poor recall with a lack of unpleasant memories of the operation. There appears to be a decreased incidence of postoperative nausea and vomiting though the patients may waken rapidly and quietly from anaesthesia.

SPONTANEOUS VERSUS CONTROLLED VENTILATION

The type of ventilation depends more on the patient (e.g., respiratory cripple or neonate) than the ophthalmic procedure. Under physiologic circumstances, changes in venous pressure are much more significant in changing intraocular pressure than are changes in arterial blood pressure. Changes in arterial blood pressure produce significant changes in intraocular pressure only when the intraocular tension is extremely high. Conversely, increase in venous pressure is transmitted directly to the eye, distending the chorio-capillaries and creating additional back pressure on the aqueous veins draining the Canal of Schlemn.

SPECIFIC COMPLICATIONS IN GENERAL ANAESTHESIA FOR OPHTHALMIC SURGERY

Oculo-cardiac Reflex

Traction on the extrinsic muscles of the eye may result in bradycardia, even cardiac standstill. In addition, various arrhythmias have been reported (e.g. nodal rhythm, A-V block, and pulsus bigeminus). The reflex is mediated on the afferent side by ciliary nerves and on the efferent side by cardiac fibers of the vagus.

There are two ways of protecting against the reflex, or treating it:

1. retrobulbar block with local anaesthesia
2. atropine — The dose required to block the vagal efferent fibers in an adult may be larger than standard premedication doses.

DRUGS USED IN OPHTHALMOLOGY

The management of certain eye diseases requires specific drugs, which have their own side effects, plus possible interactions with anaesthetic agents.

Parasympathetic agents (as Pilocarpine)

decreased pupil aperture
pupil-block glaucoma
lens subluxation
peripheral retinal tears
posterior synechia

Anticholinesterase agents (as ecothiophate [phospholine] iodide)

decreased serum cholinesterase — possible succinylcholine apnea
parasympathetic stimulation — sweating
— salivation
— nausea
— diarrhea
— abdominal cramps

Sympathomimetic drugs (as Epinephrine)

raised blood pressure, extrasystoles
reactive hyperemia
allergic conjunctivitis and dermatitis
aphakia — central scotoma possibly due to macular ischemia
angle-closure glaucoma

Carbonic anhydrase inhibitors (as Acetazolamide [Diamox])

nervous system — paresthesia
— depression and mental confusion
gastro-intestinal system — epigastric pain
— decreased appetite
— diarrhea
— constipation

OCULAR COMPLICATIONS OF GENERAL ANAESTHESIA

1. Corneal erosion
   - drying due to open eye (non-operative eye)
   - contamination of eye with anaesthetic agent (was more common with open drop technique)
   - foreign body in eye (e.g., drapes, mask, etc.)
   - secondary infection with permanent scarring
2. Effects of hypoxemia and/or hypotension:
   Retina may be damaged directly producing edema, arterial spasm, hemorrhage, exudate, papilledema, and loss of function.

   Visual pathways, visual cortex and oculomotor pathways and centers may be damaged.

3. Central retinal artery occlusion:
   may be due to inadvertent pressure on the eye during anaesthesia/operation; usually results in loss of vision.
4. Sub-conjunctival hemorrhages
5. Loss of accommodation
6. Acute angle closure glaucoma occasionally follows general anaesthesia/surgery, regardless of the site of operation. □

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After Death What?

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It is in the interests of Medicine that physicians should be more accurately informed concerning the work of the Memorial Societies of Canada and the U.S.A., work represented in Nova Scotia by the Greater Halifax Memorial Society, P.O. Box 291, Armdale, Halifax, N.S.

The Greater Halifax Memorial Society is a voluntary, non-sectarian, non-profit, cooperative association of individuals who want to encourage and assist dignity, simplicity, and economy in funeral arrangements. The Society assists its members to:

(a) Prepare their plans for funeral and memorial services in consultation with their families and others;

(b) Carry out the expressed wishes of deceased members of their families;

(c) Keep informed of all matters related to funeral and memorial laws and practices by providing a consultative service concerning funeral arrangements and costs, cremation, eye banks, and the donation of bodies and parts of bodies to medical schools;

(d) Keep records and instructions concerning members' funeral and memorial plans;

(e) Enlist the cooperation and understanding of funeral directors;

(f) Cooperate with other Memorial Societies with whom they share common purposes; and

(g) Carry out any other activities that may promote the purposes of the Society.

Contrary to a widely-held misconception, the Society does not promote cremation, nor the leaving of bodies and parts of bodies to medical schools, but, in the furtherance of the wishes of a significant number of its members, it has been instrumental in securing cremation facilities in Dartmouth, Nova Scotia, and in facilitating the signing and sending to Dalhousie University Anatomy Department of the official forms required from those who are desirous of leaving their bodies to medical science. The Society has also been active in placing before its members the claims, procedures, and donation forms associated with the voluntary dedication of kidneys, eyes, and other tissues for transplant purposes. At public meetings averaging two a year, it has brought to concerned and intelligent audiences the relevant opinions of doctors, lawyers, morticians, and clergy, and has also contributed to cable television programmes. Its continuous efforts in the education of the public and its own members can justly claim to assist medical science. Physicians and surgeons should consider supporting the Society (as well as helping themselves) by enrolling themselves and their families ($5.00 per adult, minors included free) and commending the Society when it seems appropriate to do so to their patients. □

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"War Amps Offer Help to the Rookie Amputee"

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The "War Amps" of Canada are a group of individuals who lost their limbs during the war service. Some are single amputees, some are bilateral, some are upper, some are lower extremity, some both. Whatever their disability, they have been provided with prostheses and have adapted as far as possible to their disability. Their combined experience and enthusiasm represents an enormous reserve of goodwill and information which can assist anyone facing the prospect of amputation or who has recently succumbed to one.

Figure 1

Two veterans keen to help.

Naturally, the rehabilitation of an amputee is the province of a skilled team of specialists responsible for an amputation clinic and it is not their intention to intrude upon this.

However, like many other aspects of medicine, the advice of the fellow sufferer is sometimes highly valued by the patient. One example is the 'Ostomy Clinic" for those with appliances such as ileostomy and colostomy performed at the Halifax Infirmary. Another is the valuable work the Canadian Paraplegic Association provides in assisting the spinal injury victim. Amps of Canada have therefore formed a Civilian Liason Committee on a national basis which has two functions.

Phase 1 — To assist in the financing of prostheses. A good example is a young boy seven years old who lost both his legs when a train ran over them.

Phase 2 — To assist the physician who has a patient facing the prospects of amputation — not to tell him how, but to provide an example of successful adaptation. Chairman of the Civilian Liason Committee is David Doig, Camp Hill Hospital, who will be pleased to help with any enquiries.

Figure 2

Two veterans with different problems.

*Prosthetics Department, Camp Hill Hospital.

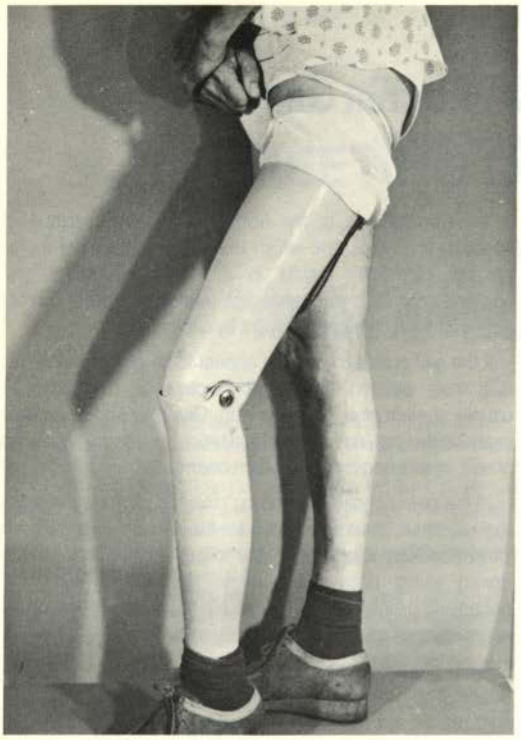

Figure 3

Suction Socket A. K. Prosthesis used without suction device.

Figure 4

Old type B. K. prosthesis on which he can dance.

□

VINTAGE AMPUTEES

The photograph, Figure 1, shows two veterans who became amputees during World War II. Clarence Kelly had his leg blown off by a mine in December, 1944. After an initial debridement, he was fitted with a below knee prosthesis. He has had six prostheses over the years. His is not the latest design, Figure 2, and now-a-days he would probably get a Patella Bearing type which would eliminate a lot of the straps and thigh corset, Figure 4. None the less, he walks well. He can dance, skate, and fish; he has long forgotten the day when he thought he had a disability.

Mr. Kelly has contributed a lot to WAR AMPS. He is a past president and is a member of the National Council. He is largely responsible for this effort to assist amputees in Nova Scotia.

Leon Currie is the other amputee in Figure 1. He lost his leg in Italy and was fitted with a suction socket, Figure 3. He found, however, that he could get along quite well without the suction device and controls his prosthesis by use of his thigh muscles, a trick which is exceptional and very useful. This has allowed him to go into the woods without difficulty.

These two men who have both been amputees for more than thirty years are living examples that you can still enjoy a great life even if you have had an amputation.

Photography — Courtesy Mr. Merriman
— Photography Department, Camp Hill Hospital

"I warn you against all ambitious aspirations outside of your profession. Medicine is the most difficult of sciences and the most laborious of arts. It will task all your powers of body and mind if you are faithful to it. Do not dabble in the muddy sewer of politics, nor linger by the enchanted streams of literature, nor dig in far-off fields for the hidden waters of alien sciences. The great practitioners are generally those who concentrate all their powers on their business. If there are here and there brilliant exceptions, it is only by virtue of extraordinary gifts, and industry to which very few are equal."

Oliver Wendell Holmes

The Problem of Abnormal Gait

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Most physicians have little difficulty in recognizing an abnormal gait. With the aid of an appropriate history and physical examination they are able to discover the reason for the gait abnormality. Some cases, however, do not lend themselves to such easy resolution, and for these a more searching protocol must be used to identify and solve the problem. The intention of this short paper is to suggest an approach to this problem, rather than be an exhaustive study of abnormal gaits.

Normal gait consists of a repeating series of rhythmical alternating movements of the trunk and extremities which result in forward propulsion. Stance phase occupies 60% of the cycle, swing phase 40%, and the period of double support somewhere around 10%.

For purposes of further analysis, the stance phase can be subdivided into heel strike, foot flat and toe off. The swing phase can be examined during acceleration or deceleration of the swinging limb. The period of double support is present in walking, but with increasing cadence this double support period shortens until it is absent and one is then, by definition, running.

In the normal walking pattern the centre of gravity of the body moves through an upward and downward range of about 2 inches, and a medial-lateral shift of the same distance with each gait cycle. Added to this is the rhythmic horizontal dip of the pelvis of 5° in concert with the weight bearing hip joint.

In the examination of an abnormal gait one first tries to determine if the problem is one of complete asynchrony, or whether the problem is more contained, perhaps in a single limb. Complete asynchrony suggests a central nervous system problem, and one looks again to see if there is any pattern in the gait irregularity.

The patient with the cerebellar unsteadiness walks with a broad base and has an irregular, reeling quality to his ambulation. The nice difference between this irregular gait and the drunken stagger is the ability of the latter to correct his balance if he begins to fall. The irregular sinuous movements of the athetoid, due to fluctuating postural tone, involves the appendicular musculature, whereas torsion spasm or dystonia involves the larger axial muscles. These can be differentiated from the irregular, rapid, movements of chorea which tend to be distal, and are not part of a co-ordinated act.

On the other hand, several central nervous system problems resulting in an irregularity of gait have distinct patterns. The rigid, shuffling festinating gait of Parkinsonism is an example, as is the frontal lobe gait consisting of hesitant, tiny steps and which is really a problem of motor apraxia. Spasticity results in a regularly irregular gait characterized by a stiff, adducted, internally rotated, plantar flexed limb which moves forward by circumduction.

If the gait problem does not appear to be global, but rather is a more isolated disturbance of cadence, the patient is usually spoken of as having a limp. One may find it useful to examine the gait, noting both the stance phase and the swing phase, in an effort to localize the abnormality.

In the swing phase, "hip hiking" may be obvious. By using the quadratus lumborum to elevate the hemipelvis on the non weight bearing side, one is able to get additional clearance during swing phase, and avoid scuffing the toe. The underlying problem here may be hip flexor weakness, a stiff hip or knee, or an equinus deformity of the foot.

Most gait abnormalities can be localized to the stance phase. The problem may involve any segment of the lower limb, and it may be an abnormality of sensation or motor power.

It is advantageous to examine the stance phase according to its component parts. In considering heel strike, one may observe the great care with which the foot is placed, and the short period of time during which weight is actually placed on the foot. This antalgic, or painful gait may be due to a local painful condition, or remote hip, knee or low back pathology. It is a protective gait. Another of the same type is the calcaneal gait wherein the patient walks on his heel to avoid weight on a painful fore-foot.

Attention may be drawn to the heel strike because of the unusual sound during this phase. The person may have a pronounced "stamp" or "slap" when his foot strikes the floor. An effort should be made to distinguish between these two. The high-stepping, stamping gait may be due to posterior column disease and loss or impairment of proprioception. The person steps high and hard because he is not too sure where his foot is. Kinesthetic feedback is also disturbed in a peripheral neuropathy.

A "slapping" gait suggests the problem of a footdrop due to dorsiflexor weakness at heel strike. The footdrop may be due to muscle disease involving the anterior tibial muscle group. It may be due to a common peroneal nerve palsy, or secondary to an L5 disc protrusion with nerve root compression. Anterior horn cell disease may explain the weakness, or the footdrop may be the presenting sign of an intracranial parasagittal meningioma.

In the double support phase, one may note pelvic obliquity. Leg length determinations are useful as a short leg often

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THE MEDICAL SOCIETY OF NOVA SCOTIA

PROCEEDINGS OF

10th MEETING OF COUNCIL (1974)

AND

121st ANNUAL MEETING

The 10th Meeting of Council began as the Medical Society Officers, attired in academic gowns and accompanied by Dr. Bette M. Stephenson, President of The Canadian Medical Association, paraded through Council Chambers to the head table. Following call to order by Dr. J. F. Hamm, Chairman, the Officers were introduced to Council and Dr. Stephenson brought greetings from the Canadian Medical Association. Dr. Stephenson wished Council well in its deliberations and indicated she would be available to participate in the meeting as required.

Dr. Hamm welcomed the Exhibitors and recognized their contribution to the Annual Convention. He encouraged Council members to visit the displays and discuss the products and services with the representatives. Dr. Hamm extended the Medical Society's invitation to the representatives to attend the Thursday Luncheon and the Friday Banquet and Ball.

Council business began as Mr. D. D. Peacocke, Executive Secretary, read the names of Society members deceased since November 10, 1973 as follows: Dr. John R. Corbett, Clark's Harbour; Dr. Tha Din, Truro; Dr. Flavien J. Melanson, Yarmouth; Dr. Thomas B. Murphy, Antigonish; Dr. George V. Burton, Yarmouth; and Dr. Miles G. Tompkins, Glace Bay. Council observed a period of silence in tribute to the memory of these members.

The Transactions of the 9th Meeting of Council and the 120th Annual Meeting (1973) as printed in the February 1974 issue of the Nova Scotia Medical Bulletin were approved.

Archives Committee Report — Dr. E. F. Ross reported that the two main items occupying the attention of his committee during the year were collection, cataloguing, and arranging archival material and preparing the design of a Society Mace. He referred to the contribution made by medical students and his recommendation that funds be made available on a continuing annual basis to support the work of a medical student in archives collection was approved. Observing that the Executive Committee had approved the Mace design in principle, Dr. Ross recommended that the Finance Committee should now be directed to proceed with a fund raising project to finance the Mace. The costs and desirability of having a Mace were discussed at length. The consensus of the meeting appeared to be that acquisition of a Mace for ceremonial purposes was desirable but the cost of the proposed design was excessive. It was approved that the Archives Committee pursue the subject of a Mace and come up with a design much less expensive than the one proposed at the 1974 Meeting of Council. In response to questioning, Dr. Ross informed Council that the Committee has been undertaking a project of taping conversations with some of the older members of the Society for retention in the archives collection.

By-Laws Committee Report — Dr. J. H. Quigley informed the meeting that proposals for extensive revision of the Medical Society's By-Laws had been considered by the Executive Committee. Certain of the proposals required policy changes by the Society and because of this the matter had been referred to Branch Societies for review. Dr. Hamm observed that the Branch Society discussions had not yet been organized because of the necessity to discuss more urgent matters but that plans were being made for discussion of the By-Laws to occur during the Spring Branch meetings. Dr. Quigley paid tribute to the contributions of his committee members, namely Drs. H. J. Devereux, G. W. Turner, A. H. Parsons, and J. F. Hamm, noting they had spent many hours on this subject and their experience in Society business had been invaluable. Dr. Quigley asked for expressions of opinion relative to the Committee's proposals, stating that this would be helpful in order to prepare proposals for future discussions at Branches and 1975 Council. Recognizing that little discussion of this matter had taken place at grass roots level, Council elected to refer the subject to Branch Societies.

Cancer Committee Report — Dr. R. M. Cunningham reported that his Committee had been active during the year and was concerned particularly with the availability of extended care beds to permit investigation to be carried out as either outpatient or in minimal accommodation. His Committee's recommendation that no means test be applied to such accommodation was approved with the proviso that possibly various levels of such accommodation could be provided, some of which might have additional charges. The second recommendation that lines of communication between the referring doctor and the Cancer Centre be tightened was approved, as was the proposal that it be mandatory that previous test results and x-rays come with the patient when first referred. Also agreed to was that there be increasing emphasis on the participation of the family doctor and referring doctor in the patient's follow-up care. Council approved a review of the Nova Scotia Tumor Clinic wherein expert advice could be obtained for the best operation of cancer services in Nova Scotia. In response to the question as to who would be responsible for conducting this review, Dr. Cunningham replied that his Committee was placing the problem in the hands of the Medical Society.

Community Health Committee Report — Dr. M. E. Lynk's report covered a wide variety of subjects including health care outside active treatment hospitals, sterilization, venereal disease, abortion, age of consent, peer group help for physicians, family life education, physical fitness, and preventive care. A specific proposal that wallet information cards with the latest dosage and treatment on the various forms of venereal diseases be provided by the Society for members was defeated. Council felt that there were more effective means by which physicians could keep up to date on treatment of venereal disease and that the cost of such a card and maintaining it up to date was too great to be approved. Approved was the recommendation that the appropriate government agency be urged to investigate the transport facilities available for outlying areas to culture particularly the gonococcus, and a uniform method of outlining detection. Dr. Lynk's Committee report referred to the need to provide assistance to physicians experiencing personal problems. The meeting was informed that a joint P.M.B./Society Committee already existed for this purpose and was functioning. The recommendations respecting this subject were defeated.

Discipline Committee Report — Dr. J. A. George reported that no complaints received during the year necessitated action by the Discipline Committee.

Drug & Alcohol Abuse Committee — Dr. C. W. Bugden reported that this Committee was of the belief that alcohol is the drug that is most abused by the greatest number of people and therefore directed its attention to this problem. Dr. Bugden described activities which have taken place in recent times relative to establishment of Detox Centres. He noted that the new approach to treatment of alcoholism is innovative, ongoing, comprehensive, and relatively cheap, operating as it does in the non-hospital setting. He stated that the chief role of the physician with respect to alcoholism lies in the Detox Centres and the community is looking to us to provide the medical

manpower for the three centres now serving the Province. His recommendation that when requested members of the Medical Society of Nova Scotia co-operate to provide medical manpower to the Commission on Drug Dependency and its regional committees in their efforts to detoxify, treat, and rehabilitate alcholics was approved. Also approved was a recommendation that the Society work out with M.S.I. remuneration satisfactory to most physicians involved in the care of alcoholic patients in Detox Centres. The basis for this recommendation was questioned, with Dr. Bugden responding that the problem lay in the area of completion of full physical examinations. Following lengthy discussion on the issue of medical necessity for medical examinations it was agreed that the subject would be discussed further at an appropriate level.

Ethics Committee Report — Dr. R. S. Murphy reported that the major item of concern to his Committee during the year was the subject of physicians' advertising in relation to both frequency and content. Council moved that the Committee further investigate the matter of announcements made by physicians in local newspapers.

Hospital Committee Report — Dr. J. P. Curry reported that the principal activity of his Committee had been development of appropriate prototype by-laws to be used as a guide to hospitals in formulating their own by-laws. He informed Council that a proposal submitted at Keltic in September which was in the main an appropriately amended version of the Ontario Medical Association prototypes, had been forwarded by the Society to the Health Services and Insurance Commission for consideration.

Maternal & Perinatal Health Committee — Dr. P. W. S. Watts informed Council that the Committee has during the past year continued to investigate maternal mortalities, collect perinatal statistics, develop guidelines for obstetrical management of high risk obstetric patients, develop common obstetrical records for hospital and office use, and develop recommendations for Council to lower still further the maternal and perinatal mortality and morbidity in Nova Scotia. He reported that there were no maternal mortalities in Nova Scotia in 1973. He informed Council that during the year there had been some discussion as to the authority of his Committee to investigate maternal mortalities. A review of correspondence indicated the long standing willingness of the Society to carry out this duty in conjunction with the overall program. His motion that the Committee continue to investigate all maternal mortalities in the Province and that its authority to perform this duty be confirmed was approved. Dr. Watts has continued to represent the Society on the Planning and Directing Group of the Reproductive Care Program for Nova Scotia. His recommendation that the Society endorse and the membership support the Reproductive Care Program was approved. Dr. Watts' motion that the Medical Society endorse a common office and hospital obstetrical record form and a Council recommendation that the Committee supply the Executive Committee with a prototype of the office record and hospital obstetrical records were approved. The Executive is to be given an estimate of the numbers of forms required so that this matter may be presented to government with the objective of having the government supply the forms to all physicians and hospitals.

Reproductive Care Program Report — Dr. D. W. Cudmore reported that the Reproductive Care Program, conceived in 1970, was, in 1974 provided funds by the government for execution. He noted that the Society has endorsed the principles of regionalization of obstetrical care at the past four meetings of Council and that the Reproductive Care Program had been an outgrowth of the Maternal and Perinatal Health Committee of the Society. Dr. Cudmore reported that an eight-year (1965-1972) Perinatal Mortality Review had been distributed to the chairmen of medical staffs of each hospital and to the president and corresponding members of each Branch Medical Society. These reviews include comparisons with other hospitals of similar size and location along with the reference hospital. In all such reviews the **only** hospital **identified** is that hospital to which the review is sent. Dr. Cudmore pointed out that the information is as confidential as the medical staff wish to make it and that no other hospital or person has access to the statistics. The arrangement with reference to Branch Societies is similar with emphasis on the confidentiality aspects. He went on to invite discussion on the perinatal mortality reviews. Dr. Cudmore described the techniques used to develop realistic evaluations and comparisons. He reported that the travelling co-ordinator attached to the Reproductive Care Program has been effective in encouraging nurses to enroll in postgraduate obstetrical and neonatal nursing in Halifax. The nurse exchange program is being worked out for four hospitals which have so requested it. Dr. Cudmore referred to the Fetal Risk Project with which the Reproductive Care Group are working very closely and he recognized the immense contribution the Project is making and encouraged participation by all physicians. In conclusion, Dr. Cudmore stated that the Reproductive Care Program is flourishing and is gaining international recognition. He urged all members of the Medical Society to co-operate in the program.

Mediation Committee Report — Dr. J. A. George's report referred to the continuing high volume of complaints requiring mediation during 1974. He noted that the pattern of complaints continues essentially the same — largely physician/patient relationships. Dr. George's report stressed the importance of maintaining doctor/patient relationships at the highest possible level, observing that misconduct by one physician reflects upon the entire profession.

He urged Society members to give this their special attention.

Medical Education Committee Report — Dr. A. Prossin opened discussion of his Committee's report with a comprehensive review of the proposal which had appeared in a recent President's Newsletter. He reminded members of the discussions which had occurred early in the year and resulted in direction to his Committee to provide a report to the Society to enable it to fully appreciate its role in continuing medical education and to establish the nature of Society interest, responsibility and commitment. He reviewed the premises on which the brief was prepared; these being that all physicians licensed in Nova Scotia recognize that maintenance of adequate skill and knowledge is a personal responsibility, that maintenance of competency is a prerequisite to continuing the unrestricted practice of medicine, and that continuing education in its multitudinous forms and variations is required in order to maintain the required skill and knowledge. He went on to suggest that the principle issue at stake was the matter of financing continuing medical education programs. He stated his Committee had reviewed a variety of options such as a deduction from M.S.I. payments but had concluded that the most equitable method would be a levy of equal value against all licensed physicians. He pointed to the necessity for co-operation with Prince Edward Island and New Brunswick in the development of C.M.E. programs. His Committee's resolution that continued liaison between the Education Committees of the Medical Societies of Nova Scotia, Prince Edward Island, and New Brunswick is desirable was approved. There was lengthy debate relative to a universal levy with one speaker suggesting that it was simply an easy method to solve Dalhousie's financial problems. Dr. Reid reported that the Section for General Practice disagreed with a universal levy as Dalhousie's C.M.E. Programs cannot possibly meet the requirements of all physicians and suggested that considerably more thought on financing such programs was required. It was clarified that any such equal levy would not simply be turned over to the Division of C.M.E. but would be managed by the Medical Society as it directed the C.M.E. programs. Dr. Prossin in response to questioning, noted that the overall C.M.E. production is approximately 50 percent specialty — 50 percent general practice. Dr. Miller of New Brunswick and Dr. Dewar of Prince Edward Island informed the meeting that their membership had recently approved an equal levy principle. The Committee's recommendation that a universal method of financing in the three provinces be adopted was defeated. In reaction to the resolution that a per capita assessment be made equal and applicable to all licensed physicians in Nova Scotia, there was extensive expression of disagreement. The motion was criticized for lack of clarity and definition and it left too many questions unanswered. The motion was subsequently defeated. Dr. C. B. Stewart, replied to the suggestion that Dalhousie was contemplating a reduction in financial support for C.M.E., stating that this was not the case but adding that additional funds cannot be made available for the expanded program referred to in the report. Expanded programs would be dependent on the level of grants received from voluntary agencies, the Society and other such sources. He stated that funds for C.M.E. are available from a wide variety of sources and that he felt this avenue should be explored in some detail. Also put at this time was a motion that the Provincial Medical Board be approached to undertake a universal collection method for C.M.E., related to its fee structure. Again, following expressions of disagreement and a suggestion that the best alternative was to search for alternate ways to pay for C.M.E., the motion was defeated.

At this point a motion was introduced that the Medical Society of Nova Scotia withdraw its philosophical and financial support of organized C.M.E. in this Province and recognize that C.M.E. is solely the responsibility of the individual physician. This resolution had the effect of polarizing the issue and, following a number of comments against it, was defeated. This was

followed by a motion that the annual grant of the Medical Society to the C.M.E. Division be considered by an enlarged Medical Education Committee of the Society and be significantly increased to help support the Division of C.M.E. in Nova Scotia while alternative methods of financing are investigated. This motion was defeated in expectation that a similar but more specific resolution would be considered by Council. This motion read that the Medical Society of Nova Scotia endorse the philosophy of C.M.E. and that the Medical Society support the Division of C.M.E. in its search for additional funds, and that the Executive Committee actively research other sources of funds; that it come up with better alternative plans and a positive program of support for the Division of C.M.E., and that a progress report be given at each Executive Committee Meeting of The Medical Society of Nova Scotia. This motion was carried. Relating to earlier debate on the desirability of assessing all licensed physicians through the Provincial Medical Board, it was moved that the Medical Society endorse the policy of the C.M.A. in its negotiations with the Federal Government to allow deductibility of expenses for C.M.E. for income tax purposes. This carried. To conclude discussion of this Committee report, it was moved that in order to provide an interim solution to the financial problems of the C.M.E. Division, a fund be set up into which all concerned physicians in the Maritime Provinces may contribute a sum, this fund to last only one year so that a definitive means of financing can be found in that time period. This related to the direction already provided to the Committee and was therefore referred to the Medical Education Committee.

Membership Services Committee Report — Dr. G. A. Sapp reported on behalf of Dr. C. D. Vair who was absent for health reasons. Dr. Vair's report announced that the membership of the Medical Society is now above 1,000. This report dealt extensively with the Medical Society's insurance plan pointing to steadily increasing participation and improved coverage in the plan. Noted too were efforts to seek increased coverage for full-time geographics whose income exceeds the maximum allowable under their Sun Life Plan. Dr. Vair's report also offered some wise advice relative to investments and participation in the stock market. It was pointed out that details on this type of information are available through the Medical Society office.

Occupational Medicine Committee Report — Dr. D. S. Reid spoke of his personal involvement with the Canadian Council on Occupational Medicine. He expressed the desire that in due course the Medical Society of Nova Scotia would be represented on this Council. He stated that unless the medical profession becomes more actively involved in these matters governments will assume responsibility and determine standards without the influence of the practicing profession. Having served three years he expressed the hope that an active chairman would be appointed to carry on this important work.

Nutrition Committee Report — This report was referred to the Executive Committee.

Pap Smear Committee Report — Dr. R. C. Fraser indicated his Committee had been quite busy during the past year working on the details of the Pap Smear Registry. It is being set up in the Path Lab and will be operating by July 1, 1975. Council approved a proposal that a current pap smear report be present on the hospital chart of all women due to undergo non-emergency major gynecological surgery prior to that patient going in for the operation. Council requested that this resolution be sent to all hospitals with the recommendation that they make appropriate by-law or regulation changes.

Pharmacy Committee Report — Dr. A. D. MacKeen informed Council that the major concern of his Committee during the past year had been in relation to introduction of Pharmacare. He noted that a brief from the Society had been presented to the Law Amendments Committee with the principal consequence being selection of Maritime Medical Care as administrator of the program. He referred to discussions with the Pharmaceutical Society regarding Product Selection and stated that his Committee had authorized earlier in the year that provision for Product Selection be removed from the prescription pads approved by the Society and the Pharmaceutical Society. Council approved his proposal that Product Selection unless expressly authorized by the physician, be unacceptable. His proposal that the Medical Society prescription form be used exclusively by all prescribing physicians was defeated, for a variety of reasons, one of which was the inability to inforce such a proposal.

Presidents' Liaison Committee Report — Dr. George reviewed activities of the President and the Presidents' Liaison Committee with particular reference to government and public relations and the role the Society is playing in influencing important government decisions. Dr. George spoke at some length on Branch Society Meetings and encouraged physicians to take a more active part in their local medical affairs. He indicated the purpose of these meetings was twofold — i.e. to acquaint members with Society activities and to provide members with the opportunity of expressing views in an informal atmosphere to the Officers of the Society. Dr. George informed Council that he strongly recommended that there be two instead of three Society scheduled Branch Meetings per year on the proviso that each Branch schedule not fewer than two and preferably three additional meetings per year to deal with matters germain to local problems and to consider issues placed before the Branch by the Society. There was no disagreement to this proposal.

Public Relations Committee Report — Dr. K. P. Smith presented the Public Relations Committee Report which was a summary of activities that had taken place in this field during the past year.

Traffic Crash Committee Report — Dr. D. P. Petrie reviewed for Council the terrible toll resulting from traffic crashes noting that Nova Scotia's bad record is exceeded only by New Brunswick. He reviewed for Council the eleven recommendations of the Crash Countermeasures Committee which had reported to government in 1974. His recommendation that the Society support these and urge the Provincial Government to study this report seriously and enact suitable legislation in the fields of deterrent measures, education and emergency services was approved. Once again Dr. Petrie pointed to the unco-ordinated and less than optimum ambulance service in the Province. Council approved his recommendation that the Society strongly urge the Ministry of Health to recognize its responsibilities in the field of ambulance services and adopt some programs of training certification and continuing education. A related proposal that all physicians in the Province attempt to increase the basic knowledge of first aid and emergency medical care at the community level was endorsed by Council. Dr. Petrie referred to the recently issued C.M.A. Guide for Physicians in Determining Fitness to Drive a Motor Vehicle. Arising out of this was discussion of periodic retesting of all drivers which was one of the recommendations of the Crash Countermeasures Committee. Following was discussion on the level of emergency medical care. A resolution that the Medical Society review the present level of emergency medical care being even given throughout the Province in an attempt to remedy situations which are felt to be substandard was approved. This approval was followed by some question as to who would assess the situation. Dr. Petrie said that a Federal Study presently being conducted would provide the guidelines or standards against which situations could be readily judged. It was suggested that the Society obtain a copy of the Manitoba report which reviewed emergency departments in that province. The concluding suggestion of the Committee was that the Medical Society encourage public awareness of the tremendous dangers of speeding, drunken driving and inattention.

Workmen's Compensation Board Liaison Committee Report — This report was referred to the Officers for consideration.

Executive Committee Chairman's Report — Dr. J. F. Hamm reported that the Executive Committee had held six meetings during the year. In addition to its role of conducting the business of the Society between Annual Meetings, the Executive Committee has reviewed reports from C.M.A. Council representatives at each of its meetings in an attempt to keep the Society in touch with C.M.A. activities. As well, the Executive Committee at each of its meetings had reviewed the actions of the Officers taken at their bi-monthly meetings. The Minutes of the Executive Committee and Officers' Meetings have been widely circulated and President's Newsletters have been issued to keep members fully informed. Dr. Hamm then reviewed the principal actions taken on behalf of the Society during the year. Council endorsed the actions of the Executive Committee taken during 1974.

Finance Committee Report — Dr. G. C. Pace reviewed the financial statement of the Medical Society's Fiscal Year 1974 prepared by H.R. Doane Limited. Dr. Pace then referred to the Fiscal Year 1975 budget and offered explanations for a number of the changes and increases. The budget was approved.

Dr. Pace pointed out that it was clear from the Society's experience with an expanding operation and general cost escalation that not only must the deficit be made up but provision must be made for continuation of this trend. Dr. Pace had this to say "Doubtless, you will view the recommended membership dues increase with some concern. And so it should be. In explanation I would draw your attention to other reports being presented to

Council. They clearly demonstrate the increased activity within the Society on behalf of the members. Of special significance is the developing expertise in the field of negotiations on your behalf. As well, the insurance program is developing according to our expectation of some five years ago when we began the process of assuming responsibility for a plan designed for our membership. Membership in the Society continues to rise as more and more practicing physicians recognize and appreciate the multitude of services available through the office."

Dr. Pace informed Council that in the not too distant future it would be necessary for the Medical Society to move to other premises. He said that the Officers had been considering this problem and had struck a committee to search out a possible place of relocation. He informed Council that the committee was considering the purchase and renovation of a specific building of which one third would be used by the Society and two thirds leased to other tenants. In any case he stated there would be additional costs of approximately $11,000-12,000 per year, in a sense, rental charges.

With all these factors in mind, Dr. Pace moved that the membership dues for regular members be increased by $45.00 per year commencing fiscal year 1976. This was approved unanimously.

Reports of Nova Scotia Representatives to C.M.A. Offices

C.M.A. Board of Directors — Dr. W. F. Mason's report contained no recommendations, it being a comprehensive summation of important business conducted on behalf of the membership at C.M.A. level. Topics discussed included drug quality assessment program review, population policy, education grants for divisions, and assessment of Council functions.

Council on Community Health — Dr. A. C. Walkes reported on the activities of his Council which had dealt with a wide range of subjects such as school health, family life, non-medical use of drugs, alcohol and tobacco, emergency medicine, population policy, the definition of death and abortion.

Council on Medical Education — Dr. Byron L. Reid reported that his Council had spent a great deal of time on the subject of compulsory relicensure. He noted that as a result of C.M.A. General Council in June, policy had changed somewhat resulting in redirection to his Council. It will now concern itself with assessment and evaluation of continuing medical education and its relationship to quality of care. He noted, too, that the Council will be expanding its role in assessing preregistration programs for physician training and assessment of programs for paramedics.

Council on Medical Economics — Dr. G. C. Pace reviewed for Council the nature of activities of concern to his Council with particular reference to the developing Department of Research and Development. On Dr. Pace's recommendation Council considered and endorsed resolutions approved at C.M.A. General Council (1974). These read as follows: "BE IT RESOLVED THAT CMA through its divisions, urge all provincial health care insurance plans to adopt a common policy that would allow direct payment to out-of-province physicians for insured services rendered to out-of-province residents." "WHEREAS there is the necessity of finding a reasonable compromise between the education and service components of the remuneration of internes and residents, and WHEREAS input from educators, interns and residents should be solicited in attempting to reach a solution to the problem. BE IT RESOLVED THAT the CMA in consultation with the association of Canadian Medical Colleges, the Canadian Association of Internes and Residents, and the Canadian Hospital Association consider and report on the remuneration of Internes and Residents." "BE IT RESOLVED THAT CMA contact the association of Canadian Medical Colleges and the Association of Canadian teaching hospitals, and recommend to them that all physicians involved in the teaching process in teaching units receive a periodic financial statement from the unit indicating both receipts and expenditures and the allocation of the funds within the unit." "WHEREAS THE parameters of the available physician income studies have not been designed by practicing physicians to accurately reflect the effects of fee-for-service, BE IT RESOLVED THAT (a) the CMA Department of R & D carry out an independent study of physicians incomes, (b) that a subcommittee of the Council on Economics be appointed to work with the Department of R & D to delineate the current methodological and data source parameters necessary for such a study, and (c) That this be considered as an item of highest priority by the Department of R & D."

Council of Medical Services — Dr. H. J. Bland informed Council that one of the principal activities of his Council was exploration of the role of the primary care physicians. Also considered were such topics as accreditation of office practice, the role of practitioners working in isolated and remote areas, reporting of adverse drug reactions, emergency care physician training, and Pharmacotherapy.

Report of Representative to M.D. Management Ltd. — Dr. G. A. Sapp reviewed for Council the nature of activities which concerned M.D. Management Limited. These include the vexatious matter of tax legislation, development of advisory economic services for physicians, improvement of the loans plan for physicians entering practice, as well as continuing interest in the C.M.A. Investment and Retirement Programs. A request from the floor that periodic information on performance of C.M.A. funds be disseminated to members was agreed to. Dr. Sapp stated that he would make appropriate arrangements.

Reports of Representatives to Other Organizations

Canadian Cancer Society — Nova Scotia Division — Dr. R. C. Fraser spoke of the increasing activity being undertaken by the Canadian Cancer Society and the Nova Scotia Division. His report described the nature of the liaison between the Society and the profession, noting that this has enabled the organization to grow and develop major programs of education, services to patients, public information, and research. He stated that the importance of the Society in the public health picture is increasing year by year and under good guidance has restricted itself to a field outside the actual treatment of the patient. Dr. Fraser's report went on to describe in some detail the nature of the services provided.

Maritime Medical Care Inc. — Dr. R. A. Burden submitted his report for information, referring to the wide range of activities of the Corporation in both its private and public side operations. His report referred to the close co-operation of the Society and the Corporation that had been typical of the past years operation. He looked forward to a continuation of this relationship as the very complex problems relating to Fee Schedule development take place in the forthcoming year.

Medical Advisory Board — N.S. T.B. & R.D. Association — Dr. F. J. Misener's report presented on his behalf by Dr. J. J. Quinlan described activities of the Association during the past year and included an expression of appreciation to the Medical Society for its continued support.

Nova Scotia Health Council — Dr. J. F. L. Woodbury made specific reference to the new Minister of Public Health noting that this is his only portfolio, thus he is spending a great deal of time on health matters. In response to questioning, Dr. Woodbury confirmed that the Minister works very closely with the Health Council and depends extensively on it for advice, particularly in the absence of a Deputy Minister of Public Health. There was some discussion regarding establishment of health care centres and what would be the nature of their staffing; how would the Society be involved; how soon would such facilities be set up. Dr. Woodbury explained that the Medical Society is already involved by virtue of its association with the Commission and participation in the activities of the Research Advisory Committee which monitors projects promoted by the Health Council. With respect to monitoring, he explained that the process is one whereby a body is established to overview a project to reduce waste, eliminate misuse of facilities, etc. With respect to research, Dr. Woodbury explained that the Health Council Research is related to day to day operational type research as opposed to long term scientific studies.

Nova Scotia Rehabilitation Council — Dr. A. H. Shears report was referred to the Officers for consideration.

Provincial Medical Board — Dr. G. W. Turner presented a very comprehensive report outlining the wide range of activities of the Board during the past year noting that this increasing activity by the Board will require additional funds. As well he referred to the possibility of the Board having to move to other premises and this too would require additional funds; this would likely be reflected in higher licensing fees in the future. There was lengthy discussion on Board policy relative to registration in Nova Scotia by physicians trained outside Canada. Dr. Turner explained in clear, concise terms that the bases for the regulations were entirely the Board's concern for the quality of medical services being provided to the residents of Nova Scotia. Responding to a suggestion that there might be racial discrimination, Dr. Turner confirmed that failure to fulfill its statutory responsibility to ensure quality and competency would be discrimination against all Nova Scotians. Dr. Turner referred to the continuing excellent relations with the Medical Society and pointed to the example of co-operation whereby a joint committee has been established to concern itself with physician rehabilitation.

RH Committee Director's Report — Dr. R. S. Grant's report to Council on his committee's consideration of fetal maternal incompatibility described the three phase program of service, prevention, and education. In his

absence the three recommendations (1) That physicians do RH testing at the patient's first prenatal visit, (2) That physicians endorse the practice of placental localization prior to initial amniocentesis, and (3) That physicians endorse the practice of RH testing before requesting therapeutic abortion, were referred to the Executive for consideration.

V.O.N. Home Care Program — Dr. W. F. Verge's report contained three recommendations which were approved, these being (1) That the Society continue to support the V.O.N. in their request to government for financing, (2) That the Society support the V.O.N. in their pilot project relative to V.O.N. preparing patients for O.P.D. surgery, and care for patients released from hospital earlier than normal, and (3) That the Society continue to support the V.O.N. in their co-ordinated Home Care Program for the Province of Nova Scotia as previously presented to the Minister of Health. In addition, following discussion of payment mechanisms for the V.O.N. Council directed the Executive Committee to pursue further with government ways to increase home care programs through the V.O.N. and other suitable agencies.

Medical Advisory Committee on Driver Licensing — Dr. C. C. Giffin's report was referred to the Executive Committee.

Nova Scotia Highways Safety Council — Dr. G. A. Lawrence elaborated on the comments of Dr. Petrie and described for Council the nature of the driver education programs. He impressed upon Council the increasing necessity for Medical Society support of the Highways Safety Council programs.

Uterine Cancer Control Project — Dr. S. C. Robinson's report provided Council with a detailed rundown on statistics relating to this Project. It was reported that no significant reduction in the incidence of invasive carcinoma of the cervix had occurred during 1973 and that deaths from malignancy of other parts of the uterus remain few. Dr. Robinson reported that almost without exception the new cases of carcinoma of the cervix have not previously had cytology recently. His report included the strong suggestion that cytology screening does bring out the potential cases of carcinoma of the cervix and this points to the need for continuing screening programs to ensure that the hard-to-get-at group are seen. Dr. Robinson encouraged physicians to promote the pap smear program.

Section Reports

Dr. Hamm noted that this was the first year that the By-Laws specified that Sections shall report to the Annual Meeting. He expressed his appreciation to all the Sections with respect to their response in this regard.

Section For General Practice Report — Dr. D. S. Reid reporting on behalf of his Section, provided Council with a concise resume of activities over the past year. His first recommendation that in future tariff considerations, fee anomalies be corrected before the across-the-board increase be granted triggered lively debate. He expressed the view that, generally, life time earnings by Section should be roughly equal and that across-the-board increases only add to disparity of incomes. Several speakers stated that the Society does support this concept and that the record clearly shows a degree of achievement in this respect. Some concern was also expressed that passage of such a recommendation would have serious consequences because of its resulting restraint on the Society's Negotiating Committee. As well, the point was made that passage of this motion would represent nonconfidence in the Officers. Dr. Reid responded that this certainly was not intended and that the purpose of the resolution was to bring the matter to the fore and ensure consideration of the economic position of general practitioners and low income physicians. The motion was defeated and a reworded motion that in future tariff considerations, the Medical Society continue to correct anomalies as well as granting any across-the-board increases was approved. Debate on tariff continued with Council approving a resolution that the Medical Society discourage government from using an increase in doctor/population to our detriment in fee negotiations.

Dr. Reid reported that his Section had dealt with the subject of family life education expressing the view that all physicians should participate at local level in community projects and programs of this nature. His Section's resolution to this effect was approved. Noting that his Section had also considered the matter of contraception and sterilization in relation to family planning, he introduced a resolution that the Society remind its members of their obligation to make readily available to all who seek it, information in regard to contraception and sterilization; if for personal reasons the physician cannot provide or prescribe accordingly he should refer the patient to a colleague who can, as recommended in the C.M.A. Code of Ethics. This was approved.

Dr. Reid informed Council that the Section's Standards Committee had been active in the past year as it undertook inquiries on behalf of the Society. He observed that there is cause for concern regarding the quality of medical records maintained by some physicians. To this end he introduced a resolution that all doctors in private practice keep a medical record to conform to the following: "Clinical records on every patient should be kept, giving or including the name and address of the patient, date seen and adequate patient's history, and particulars of physical examination. investigations ordered and their results, diagnoses made (if any) and the treatment required." This was approved by Council.

Dr. M. A. Smith addressed Council on a subject that had been of long time concern to general practitioners, namely the provision of measles vaccine to physicians in their offices at no charge for use in immunization programs. He stated an awareness that government had been approached repeatedly on this subject and steadfastly refused to comply. However, he expressed the wish that Council would support his Section's position. His resolution was approved by Council.

Section for Internal Medicine — Dr. A. J. MacLeod's report provided Council with a comprehensive review of the Section's activities during the past year. To a major extent these concerned Fee Schedule matters as well as other items referred to the Section by the Society. The Section noted with pleasure the appointment of Dr. R. N. Henderson to the Health Services and Insurance Commission's Special Committee drawing up guidelines for the establishment of Internal Medicine Departments and specialty units in hospitals.

Section for Pathology — Dr. V. W. Krause reported to Council describing the activities of his Section during the past year. This included consideration of quality control programs and availability of technologists. As well, the Section had done extensive work on Fee Schedule matters and is co-operating with the Society through its membership on the Society's Salaried Physicians Committee. Council passed a resolution reading; "THAT WHEREAS a greater fraction of the effort by general pathologists is now spent with clinical laboratory matters, and whereas several clinical pathologists in Nova Scotia are now devoting all of their efforts to these matters and whereas the present Fee Schedule does not adequately compensate for this activity, it is moved that in future Fee Schedules, provision be made for adequate professional remuneration for practicing clinical pathologists."

Section for Psychiatry — Dr. E. A. Smith, newly appointed Chairman, informed Council that the major effort of his Section had been devoted to Fee Schedule problems during the past year. He addressed Council on the problem regarding shortage of psychiatrists in the Province of Nova Scotia. He suggested urgent action was required to reverse the flow of psychiatrists. He noted that the Society's Salaried Physicians Committee was working on the problem but it would require the full co-operation of the Society to resolve it.

Section for Radiology — Dr. W. F. Mason reported for this Section and expressed to the Society sincere appreciation of Nova Scotia radiologists for effecting the smooth transition to the new method of payment for radiologists. He informed Council that the Section was working extensively on development of the case for private radiology facilities in Nova Scotia and again expressed appreciation to the Society for its co-operation and assistance. Noting that the radiology fee agreement is scheduled to terminate soon, Dr. Mason gained endorsation of Council for the following resolution: "WHEREAS the Society in 1973/74 recognized the need for an upward adjustment in the tariff and successfully negotiated same, BE IT RESOLVED THAT the Society commence discussions at the earliest possible date to ensure that a similar adjustment occurs in the tariff for radiology services at the termination of the present agreement."

Section for Surgery — Dr. J. J. Quinlan briefed Council on his Section's activities over the past year. Of particular interest was the Section's effort toward improving quality and availability of continuing medical education programs. The Section also dealt extensively with Fee Schedule matters. Dr. Quinlan reported that there is increasing co-operation between the Nova Scotia and New Brunswick Section for Surgery and he anticipates that the future will see increasing development of co-operative programs to the mutual benefit of both Sections.

Section for Internes and Residents — Dr. John Clark reported to the Society on behalf of the Chairman, Dr. Bruce Pretty. He stated that the Internes and Residents through its association had successfully gained the Society's agreement to represent them for all purposes. On behalf of the

Internes and Residents he expressed their satisfaction with developing arrangements and all those involved look forward to increasing involvement with the Medical Society of Nova Scotia.

Annual Meeting — On four occasions during Council the Society was called to order in Session of the Annual Meeting to ratify the actions of Council and to hear the President's valedictory address. Dr. J. A. George's address appears in this issue of the Bulletin.

The Society considered the report of the Nominating Committee and approved appointment of Branch Representatives and alternates to the Executive Committee as shown below: Antigonish-Guysborough — Dr. J. E. Howard; Alt. —; Cape Breton — Dr. A. C. Walkes, Alt. Dr. M. R. Rajani; Dr. P. D. Jackson, Alt. Dr. D. S. Robb; Colchester East Hants — T.B.A.; Cumberland — Dr. M. P. Quigley, Alt. Dr. V. M. Hayes; Dartmouth — Dr. R. W. Beazley, Alt. Dr. D. M. Andrews; Eastern Shore — Dr. J. C. Acres, Alt. —; Halifax — Dr. D. K. Murray, Alt. Dr. B. L. Reid; Dr. A. J. MacLeod, Alt. Dr. J. A. Delahunt; Dr. A. H. Parsons, Alt. Dr. R. W. Napier; Lunenburg-Queens — Dr. W. G. Dixon, Alt. —; Pictou — Dr. W. A. MacQuarrie, Alt. Dr. R. H. T. MacGregor; Shelburne — Dr. J. U. MacWilliam, Alt. Dr. W. H. Jeffrey; Valley — Dr. D. L. Davison, Alt. Dr. R. D. Stuart; Western — Dr. C. R. Wyman, Alt. Dr. T. B. Murphy.

The 1975 Nominating Committee approved is as follows: Antigonish-Guysborough — Dr. T. W. Gorman, Alt. Dr. R. Sers; Cape Breton — Dr. H. J. Devereux, Alt. Dr. P. D. Jackson; Colchester East Hants — Dr. A. J. James, Alt. Dr. S. G. MacKenzie; Cumberland — G. A. Lawrence, Alt. Dr. J. P. Donachie; Dartmouth — Dr. J. F. O'Connor, Alt. Dr. D. M. Andrews; Eastern Shore — Dr. P. B. Jardine Alt. —; Halifax — Dr. A. J. MacLeod; Alt. Dr. D. K. Murray; Lunenburg-Queens — Dr. F. G. Bell, Alt. Dr. A. Steeves; Pictou — Dr. R. G. Munroe, Alt. Dr. H. A. Locke; Shelburne — Dr. N. K. Sinha; Alt. Dr. F. Markus; Valley — Dr. H. R. Roby, Alt. Dr. E. G. Vaughan; Western — Dr. C. R. Wyman, Alt. Dr. T. B. Murphy.

The following nominations were approved. President-Elect — Dr. T. J. McKeough; Chairman, Executive Committee — Dr. J. F. Hamm; Vice-Chairman, Executive Committee — Dr. D. A. MacFadyen; Honorary Secretary — Dr. C. C. Giffin; Treasurer — Dr. G. C. Pace.

Responding to a call for new business, Dr. C. B. Stewart rose to express his concern regarding the Graham Commission Report, particularly as it relates to health services. He expressed grave concern and reservations with many of the proposals and expressed the view that their implementation would have serious consequences in the future. He felt that special action should be taken within the Society to involve all the Branches and Sections. Dr. George informed the meeting that the Society had established a task force to prepare a brief to the Select Committee holding hearings on the Graham Commission Report.

The 121st Annual Meeting of The Medical Society of Nova Scotia adjourned at 5:00 p.m. November 22, 1974.

ANNUAL MEETING EXHIBITS

The Medical Society of Nova Scotia wishes to express its sincere appreciation to those firms which exhibited at our Annual Meeting in November 1974 at the Hotel Nova Scotian.

LIST OF EXHIBITORS

Atlantic Trust Company
Bank of Nova Scotia
Boehringer Ingelheim
Burroughs Wellcome
Calmic Limited
Cooper Laboratories
Commission on Professional & Hospital Activities
Cyanamid of Canada
Department of Highways
Fisons (Canada) Limited
Charles E. Frosst & Company
J. F. Hartz Limited
Dr. A. M. O. Hebb
Hoffman-LaRoche Limited
International Medication Systems
Maritime Medical Care Inc.
McNeil Laboratories
Nova Scotia Commission on Drug Dependency
Parke Davis & Company, Ltd.
Pfizer Pharmaceutical Division
Pharmacia (Canada) Limited
Phillips Electronics Industries
A. H. Robins Company
Royal Bank of Canada
Royal Trust Company
Smith Kline & French
Upjohn Company
Warner-Chilcott Laboratories
White Cross Surgical Medical Supplies
Wyeth Limited

Medical Society members appreciate the extensive financial contributions that exhibitors make toward defraying the costs of conducting an Annual Meeting. As well, the additional expense of preparing exhibits and arranging for the displays are also recognized. Most important, however, is the opportunity the exhibitors have given to members of the profession to meet with representatives of the various firms for discussion of new products and services available to them.

Members of the Society are encouraged to convey their gratutide by giving the exhibitors' representatives an extra expression of appreciation on the occasion of their next encounter. □

D.D.P.

Presidential Valedictory Address, 1974

Dr. J. A. George, M.D.,
Antigonish, N.S.

Society members, guests, ladies and gentlemen . . .

Just about a year ago, your current past president Dr. Al Myrden delivered a farewell address in which he touched upon the duties and responsibilities of Society office holders and of the office of the president himself.

Perhaps if I had been just a little more attentive or, possibly, if Dr. Myrden had been a trifle more explicit I would have been forewarned to a greater degree of the tasks which then faced me.

It has been a strenuous year . . . an extremely strenuous year . . . and I think it essential that I hand out a few verbal bouquets to some of the people who have made a very demanding job a little bit easier.

First and foremost, we are extremely fortunate in having a society staff with the strength, character and diligence of our Executive Secretary, Doug Peacocke and the hard working Doc Schellinck. Without these able and interested people and an excellent office staff it would be impossible for any physician — considering practice obligations — to do anywhere near an acceptable job as your President.

Quite frankly, it would be impossible to cope with the vast amount of correspondence, arrangements for and the recording of meetings, or with the vital day to day operations of your society.

This organization is also fortunate in having in the back-up role men like Drs. Brian O'Brien, Tom McKeough, Graham Pace, John Hamm and Murdock Smith. I would like as well to say a special thank you to Dr. Al Myrden whose knowledge, ability and advice contributed much to the successes we enjoyed over the past year.

Unfortunately, I simply don't have the time to list all those others whose dedication and hard work on behalf of the society deserves recognition . . . but I think most of you know who they are. To them I say a general but heartfelt thank you.

The office of president of The Medical Society of Nova Scotia deserves comment . . . no, it *demands* comment.

Many of you may not recognize the responsibilities and the time consuming demands that go with the job. It has been my experience that the office demands at least 100 days a year in order that its obligations should at least be adequately served. And these aren't simply weekdays I'm talking about. Saturdays, Sundays, late nights and early mornings play an important part, too. The practice suffers, the travel miles pile up and considerable financial loss can be expected.

This is not a complaint; it's simply a fact of life.

But I think the time has come when the society must recognize that the burgeoning responsibilities of the president will in the very near future require some form of just compensation. Your president, today, tomorrow and in the years to come, plays a vitally important role not only on behalf of medical professionals but also on behalf of the entire health care system and, by extension, on behalf of all Nova Scotians. He — and someday, no doubt, it will be she — assumes enormous responsibilities and attendant financial and family hardships.

I think the time to consider compensation for the job is now . . . and I would like to recommend at this moment that the society form a committee to investigate the nature of the job and to decide and report on the nature of the compensation required.

I for one would like to see that committee's report at the next annual meeting.

Of course, the rewards of the job cannot be measured solely in financial terms. It does engender wonderful associations both within and outside the medical profession. It broadens one's appreciation of the problems we face today and the challenges ahead for us tomorrow. It gives one a better understanding of the individual physician's real needs as opposed to — if you'll forgive me saying so — his occasionally extravagant requests.

It has been my experience that many of the problems encountered in the job at first seem impossibly complex but, in fact, they do yield to the co-operative efforts of the officers, the executive and involved members of the society.

As Dr. Bette Stephenson mentioned yesterday, this is the age of complaints about medicine. Doctors are prime targets. Sometimes we deserve it, but more often than not these complaints can be pinned down to relatively simple misunderstandings between doctors and their patients and misunderstandings by both parties as to their specific role in the health delivery system. At the individual level, these misunderstandings are quickly cleared up when both parties have had a chance to express their views.

There are some areas of misunderstanding between the profession, the public, and often government which require more patience, tact and hard work than what might be termed local problems. We pledge to devote our attention to problem areas of health delivery.

Perhaps as a case in point I might touch on one area that has recently come to my attention. I have heard it said that we don't have enough hospital facilities in Nova Scotia or that government is not moving fast enough in new hospital construction or improvements.

It is in situations like this that the Medical Society has an enormous task ahead of it. Creating a broad understanding of both the problems and the potential of our health care system is not something which can be done overnight. It's a long, slow, tedious job. But it's a job worth doing, and it's a job worth doing well.

It's a job which we must share with government and with all those involved in the system . . . including the consumers.

It is absolutely imperative that we continue to deliver better and better care to the people of Nova Scotia through the rational expansion of personnel and facilities as well as the development of greater levels of skill. We must continue to upgrade our knowledge. We must guarantee to Nova Scotians that their physicians are in the front ranks of medical advances and are ready to provide the best care available anywhere.

That is our responsibility. We cannot shirk it.

And yes, we must do so co-operatively with government . . *but* we must always stand firm against proposals for the extension of services which because of their costs as compared to their benefits may be less than reasonable additions to the delivery system and, in some instances, may hinder our ability to provide quality care.

I for one also believe that we must at all costs avoid the erosion of the physician's responsibility in hospital matters through the surreptitious transfer of recognized medical procedures to unskilled or semi-trained personnel whose functions are cost related rather than related to the well-being of the patient.

In some instances, promotion of the inclusion of this type of person in direct care delivery comes from well-meaning, concerned sections of society who see it as an improvement in the system. But in many cases, recommendations along these lines are being made by

groups and individuals who want to play at being health care experts and systems professionals without ever having experienced the realities of patient care.

I think, too, we should be particularly concerned with the proliferation of surveys which are being carried out at considerable expense to the taxpayer and which seem to be ends in themselves. Certainly, no one can complain about the acquisition of knowledge, data, and general information if some beneficial purpose can be served. But today we seem to be suffering a "survey for the sake of it" syndrome.

One particular concern of mine is that current surveys and recommendations seem to be geared solely to increase the bureaucratic element in the health care system to the exclusion of physician in-put and with very little real appreciation of the patient as anything other than a unit to be manipulated.

There is a distinct trend today to forget the physician as the prime deliverer of care and to encourage greater bureaucratic authority among a few appointed — not elected — individuals who will, in effect, be making decisions as to the type of care a patient shall receive.

This is the very antithesis of good medicine . . . and it could spell real trouble for Nova Scotians requiring physicians services.

For instance, the Graham Commission Report recommends a beautiful hierarchy of appointed individuals in regional distribution who will eventually be established as an additional level of hospital care administration. Hospital boards will lose their autonomy and even their purpose for being if this recommendation is ever carried out.

The attempt to exclude physician in-put from any policy making body is also seen in hospital by-laws currently under consideration which categorically state that physicians should not be members of a hospital board.

It seems to me that we have reached a point in time when we must stand up and be counted before we are relegated to a form of health care team so engrossed in paperwork and restrictive covenants that the primary care physician will end up as a sorting clerk rather than the backbone of the health care system.

If this happens, what levels of dedication to patient care and to the ethics and ideals of medicine can we expect of the doctors of tomorrow?

Having got that off my chest, I do have some positive things to say about our relations with the people we serve.

The Medical Society of Nova Scotia has been extremely fortunate in having to deal with two sympathetic, interested and dedicated Ministers of Health over the past few years.

But it has been a two-way street. We went to those ministers and said we are ready and willing to help Nova Scotians. They responded positively, and it is largely through the co-operative efforts of those men and the society, that we have avoided many of the pitfalls other jurisidictions have experienced.

I'd like to see this co-operation continue. I'd like to see it expanded. I'd like to see this happen because it's important to Nova Scotians. We are the people with direct experience in the health care system. We have a lot to offer those who make policy in this area. We have an obligation to proffer strong, positive advice . . . advice based on experience and concern.

We have been bombarded with propaganda on physical fitness for many years and the recent books from the Federal Minister of Health Mark Lalonde has again stimulated our thoughts in this direction. I feel as do the other members of the executive that we as physicians must take a more active part in P.F. programs.

It is unfortunate that in periods of financial difficulty the school boards of many areas of the province make economies by cutting down on what is considered non essential items such as Physical Education, and music.

In all fairness to the local boards, this is due in part to the reduction in grants to them thereby decreasing funds available for such "non-educational" activities as Physical Education.

It is time to feel concern for the general well being of children, particularly those in rural areas who are bussed to school and home again with practically no opportunity for healthy exercise. The economies in the past few years have resulted in a decrease in the number of teachers of Physical Education in many schools.

In many schools in Europe Physical Fitness is a large part of the curriculum to the extent that 30-50 percent of time allotted to school is taken up with Physical Fitness. Investigation of the effect of this on learning has shown it to be beneficial in making the student more alert and responsive to teaching in the class room.

I feel the Medical Society should recommend to Government that a very close look be taken at the present Physical Fitness program for the schools, and that funds be made available to upgrade and improve facilities and increase personell, so that the physical and mental health of all young people will benefit. A particular look at the availability of outdoor fitness on Physical Education areas for schools should be of prime concern.

I would also like to recommend that increased availability of school gymnasiums be made throughout the province. This would enable local groups to develop positive programs of Fitness for adults in evenings and on weekends when these facilities are unused.

By improving our programs of Physical Fitness in the schools and in the community we will be doing a service to the individual and the country. The individual will be healthier and will enjoy a happier life because of his physical well being.

Fellow members, it is with mixed feelings that I say goodbye to the presidency today. First there is regret that I may not be able to contribute as much to the society in the coming years and, secondly, there is a certain amount of relief that some of the problems the job involves will be passed on to the strong shoulders of Dr. O'Brien.

I wish him well. I pledge my continued co-operation and assistance to him and to you and I thank you for the support you have offered me over the past twelve months. □

explains the problem. Other reasons for pelvic obliquity may be found in lumbar spine abnormalities.

In the foot flat phase, a hyperextended knee suggests hamstring weakness and this may be either upper or lower motor neuron in origin. Weight bearing on one leg may reveal gluteus medius weakness and a Trendelenberg sign. If this is present bilaterally the patient will have a "duck waddle" gait.

At toe off the patient may not push off, rather move the foot forward "en bloc". This can be due to local causes such as reduced forefoot mobility, or loss of pushoff from an Achilles tendon rupture and subsequent elongation. Impaired pushoff may be due to plantar flexor weakness secondary to a problem with the posterior tibial nerve or the pathology may originate at the S1 root level.

One may well go through all this careful observation and still be left with an undiagnosed bizarre gait. Hysteria should then be considered. It is also useful to keep in mind that a child may mimic an abnormal gait that catches his fancy, and thus confound the most thorough clinician. □

References

MacConaill, M. A. Muscles and Movements: a basis for human kinesiology, Baltimore, The Williams and Wilkins Company, 1969.

Rasch, P. J. and Burke, R. K., Kinesiology and Applied Anatomy: the science of human movement, 3d ed., Philadelphia, Lea and Febiger, 1967.

Wintrobe, M. M. *et al.* (eds). Harrison's Principles of Internal Medicine, 6th ed. New York, McGraw-Hill, 1970, pp. 131-134.

Physician Self - Assessment

Lea C. Steeves, M.D.,

Halifax, N.S.

The following questions have been submitted by the Division of Continuing Medical Education, Dalhousie University, and are reprinted from The American College of Physicians **Medical Knowledge Self-Assessment Test No. 1** with the permission of Dr. E. C. Rosenow, Executive Vice-President.

It is our hope that stimulated by these small samplings of self-assessment presented you will wish to purchase a full programme.

DIRECTIONS: Each of the questions or incomplete statements below is followed by five suggested answers or completions. Select the ONE that is BEST in each case.

1. In a 56-year-old man who has dyspnea, pulmonary function studies show a residual volume of 140 per cent of normal, and a total lung capacity of 119 per cent of normal.

   Which of the following is the most likely diagnosis?
   (a) Atopic Asthma
   (b) Emphysema
   (c) Fibrosis
   (d) Bronchitis
   (e) Bronchiectasis

(Please turn to page 209 for answers) □

The doctor and his "leisure"

Scouting as a Hobby

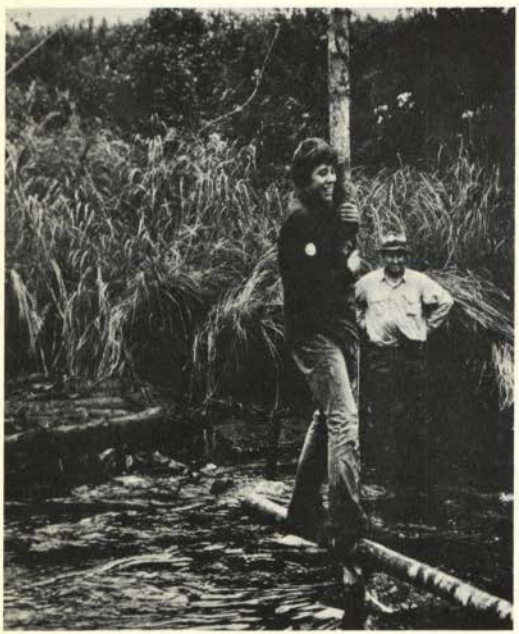
Paul Cudmore,* M.D.,

Halifax, N.S.

For almost 35 years, I have been associated in some way with scouting. As a leisure time activity, it presents many opportunities, some requiring a regular expenditure of time and others very sporadic. Three friends come quickly to mind. Doctor A — is an Akela — a wolf cub pack leader. He finds it a refreshing change to work with this highly enthusiastic age group. Enthusiasm in boys can be measured in many ways but the easiest is simply to observe the noise level at a pack meeting. Pack meetings are held once a week. In addition, there are frequent outings for small groups (a "six") which take the form of nature walks, visits to historic sites and other interesting places. The Akela and assistants share the load.

Dr. B is a Scoutmaster with an award winning troop strong on outdoor skills. They have frequent weekend camps when pioneering projects may be the theme. Orienteering, the sport involving map and compass and some knowhow, is popular too. His canoe camping and winter camping events provide real challenges to leaders and boys alike.

Dr. C. was in turn a cub, a scout, and a scoutmaster. He is now a member of the Provincial Council where he enjoys the committee work which facilitates the financing, organization and administration of the scout program throughout the entire province.



Several weeks ago, four Halifax doctors participated in the 1974 Boy Scout Operation Alert. This is a weekend wide game with over 25 projects staffed by 150 adults. Some projects emphasized skills such as artificial respiration, fire by friction and how to safely change a tire. Climbing a ladder and descending on the aerial runway required little skill but lots of courage. Four hundred and fifty boys from all over the province attended. Two of the boys sustained fractures during this year's game. Both occurred on an apparatus which had had over 1000 users with no previous injuries. Reviewing the cases revealed that both boys were obese and in very poor physical condition. All projects are safety inspected by the medical team before boys are allowed to use them. Of our four physicians, two served as medical officers and two on the administration staff.

Many physicians, and especially physician fathers, serve on group committees and other organizations which sponsor scout groups.

As most everyone knows, Scouting was begun in Great Britain in 1908 by Lord Baden-Powell of Gilwell. He had seen boys playing a most important and adventuresome role in the South African War. On his return to Britain, he began writing a weekly column in the newspaper entitled *Scouting for Boys*. This proved immensely popular wherever the paper was read. Soon groups began to form and Scouting, as we know it today was born.

*Associate Dean, Department of Medicine, Dalhousie University.

Scouting appeals to me today every bit as much as it has to scouts and leaders since the time of Baden-Powell. I can think of few ways of spending some leisure time which are as inviting.

Scouting has spread throughout the world and during 1975, boys from all over the world will congregate in Norway for another World Jamboree. Jamborees have been held since the early days of scouting and have brought millions of boys together in a manner fostering international good will and understanding.

In Nova Scotia, Wolf Cubs have the largest membership, 7,000 boys. Cubs are between the ages of eight and eleven. Scouts, ages eleven — fourteen are next. There is a growing interest in Ventures, ages 15 — 18. Rover Scouts, over eighteen are few in number. A new program designed for boys between the ages of five — eight was introduced 18 months ago and is proving most popular. The boys are called Beavers and the groups, Colonies.

Scouting was seen by Baden-Powell as a program of high adventure for boys in the great out of doors. Scouts are challenged to excellence in personal development and skills, religion, citizenship and more. Adults who devote some leisure time to providing leadership for this program are richly rewarded in satisfaction. For those who have never enjoyed Scouting as a boy, and for all new leaders, excellent training programs are available.

One scout leader was recently overheard saying — "Now I can do all those things I wanted to do as a boy." □

GUIDELINES FOR AUTHORS

Reference to these guidelines and recent issues of the Bulletin will help authors in preparation of their papers. Send the original typed copy to the Editor and keep a carbon copy.

The entire manuscript (including references and tables) should be typed double-spaced, with a generous margin on the left, on only one side of the pages. Do not underline unless the type is to be set in italics. Standard abbreviations (**e.g.**, hr, mg, ml) are acceptable without definition; less-common abbreviations should be written in full the first time they are used. Give generic as well as proprietary names and the manufacturer's name for drugs.

References. Identify references by numbers within the text, and list them in numerical order on a separate sheet [see (f)].

Figures. Provide an unmounted glossy print of each, clearly marked on the back with a SOFT marker, indicating top, figure no., and author's name. Show scale when relevant. Do not write legends on them [see (h)].

The usual framework of a paper is as given in (a) to (h) below, starting each section on a new page and numbering pages consecutively to the end of (h).

a) Front page, showing title, author(s) and degrees, whether the author is in family practice or the institution where the work was done, and address for correspondence.

b) Brief summary.

c) Introduction.

d) Materials and methods, then Results; **or** Case report.

e) Discussion.

f) References.

Examples: **Journal papers** – EBBERT, A., Jr. Two-way radio in medical education. J. Med. Educ. 38:319-28, 1963. **Books** – MAJOR, R. H., and OELP, M.H. Physical Diagnosis, 6th ed. Philadelphia, Saunders, 1962, p. 51. **Contributions in books** – Voheer, H. Disorders of uterine function during pregnancy, labor, and puerperium. **In:** Pathophysiology of Gestation, ed. by N.S. Assali. New York, Academic Press, 1972, vol. 1, pp. 145-268.

g) Tables (each, including heading and footnotes, on a separate page).

h) Figure legends (all listed on one page); state magnification of photomicrographs.

Of Things Remembered

J. W. Reid, M.D.,

Halifax, N.S.

Childhood memories are spotty with rare episodes standing out in remarkable clarity against a background of complete blackness.

One such goes back to the high-chair and the dining room at home. My father and I were the only ones at the breakfast table and I was sitting opposite him under the big moose head that hung over the fireplace. I have no idea how it got there.

It must have been a quiet time in practise for he was leaning back in his chair waiting for his breakfast to be brought in no doubt contemplating the monster over the fireplace and the monster in the high-chair considering, perhaps ruefully, that he had been responsible for the destruction of the one and the conception of the other. Several years later I remember him mostly in the mornings as being on the jog trot about the office, mixing medicine and making papers of powders to take on his rounds.

The maid brought in his breakfast and for me a boiled egg sitting upright in an old fashioned egg cup. The moment she cut the top off that egg there rose the most dreadful stench that instantly permeated every cell in my body causing overwhelming nausea and immediate vomiting. It had that instantaneous effect which in later years one observed when treating syphilis with arsenic. The patient would smell and taste the drug the moment the needle entered the vein, before the injection was begun.

This brought a quick end to my father's tranquil breakfast for he grabbed chair and all and rushed me down the back hall to the kitchen and out onto the back verandah where the egg was disposed of and I was cleaned up.

Off and on in later years I had other occasions related to that episode when I would experience nausea on opening a boiled egg which was perhaps not quite fresh but certainly not bad. Maybe it came in times of fatigue, stress or general ill health for I recall occasions when as a student sitting in class I would be suddenly taken with nausea and the memory of that stench (no connection with the quality of the lecture I'm sure) or perhaps walking on the street one would suddenly be overcome with the memory of that smell and a nausea felt simultaneously in the head and the stomach. Fortunately these attacks were momentary and never accompanied by vomiting, and no doubt of neurotic origin.

Later, as a student, when we developed symptoms of every new disease we studied, we suffered from tuberculosis, nephritis, hyperthyroidism, rheumatic heart disease, mitral stenosis, aortic regurgitation and heart failure. Never from coronary occlusion or myocardial infarction. Patients who died of those conditions succumbed to acute indigestion, for they had not yet been defined as myocardial infarction. We didn't worry about cancer. We were too young.

The origins of neurotic symptoms are obscure and often multiple. They may be hidden deep in that clone of cells from which the human develops into what he is to be. They may be the result of toxic episodes during the pregnancy or be caused by minute birth injuries which leave no demonstrable exterior signs. They may be related to the chemistry of allergy or develop in susceptibles from toxins or traumas in early life.

I recall a woman who had a carton (small) of sermons in shorthand which she had collected over many years of church attendance. She explained that she took down most of the service except the hymns. This she did because just to sit listening she felt uneasy and vaguely afraid.

With that delightfully inadequate knowledge and experience from which the young derive such confidence and authority, I undertook to delve into her history to see if one might come up with an explanation for her trouble. Sure enough there came to light an episode in her girlhood when she became ill in church, vomited in the pew and was taken out by her mother with vomitus on her Sunday dress and her hands pressed tightly over her mouth to defend against the recurring waves of nausea.

This I thought was the answer and explained to her with profound wisdom that her uneasiness in church was the result of this early experience which she had managed to put out of conscious memory and that now, knowing that it was only the memory of this painful episode that made her uneasy, she could enjoy the church service without the shorthand.

It was several months before I saw her again and I enquired how she was getting on. Fine. Could she enjoy the church service? She didn't know. She hadn't been to church since being made aware of the cause of her discomfort. Being more thorough than I she believed in complete prophylaxis and so avoided the noxious situation altogether. In those days this was hardly considered an acceptable outcome of therapy.

The lot of the neurotic, like that of the policeman, has never been a happy one. They all have or eventually develop organic disease and die like everybody else. Often, for many years, perhaps most of their lives, they have no demonstrable signs, and repeated expensive investigations fail to turn up any cause for their symptoms. They could never be convinced however and remained a part of the doctors office decor for years.

In the early days of the psychiatric thrust into community medicine the general practitioner was overjoyed at their avowed intention of dealing with this menace to the financial well being of the prepaid medical insurance plans of the day. They however very quickly developed remarkable expertise in the positive diagnosis of neurosis and the certain determination that they could do nothing about it. Soon, all too soon, the family doctor found the same old upholstery back on his waiting room chair.

Wise doctors, in those more leisurely days were very short, gruff and it seemed to me almost cruel to their neurotics. They

had good reason. The neurotic loses all sense of time when he enters the doctor's consulting room and will devour it ravenously if he has any encouragement. Worse than that, like the lover of the indiscreet maiden, he tells. Thus if you allow your sympathy to show too often you will find your office full of these unfortunate people and your time diverted from those whom you could really help.

In the years just after the first world war the medical school was full of old soldiers, and believe me they were tough hombres with very little respect for God or man and none whatever for kids out of high school. They were an awesome crowd to move among and there was always a group of them in any of the handy boarding houses. I shared a room with one.

This chap had gone through the war as a private soldier and came out of it with little or no feeling against the Germans but with a bitter and abiding hatred of the Canadian army and particularly it's sergeants. So deep was that feeling that I have seen him politely accost a stranger on the street to confirm his recognition of a sergeant in civies.

We were sharing a garret room, sleeping on cots against the wall. It was my first experience of sleeping on a cot and the first night I struck my head a terrific blow against the wall and nearly knocked myself out. The next night, from an excess of caution I fell out of bed with a great thump. The third night I found the centre and had no more trouble.

He was in engineering at N.S. Tech. and a dreadfully hard course it seemed to be. He had hours of homework to do every night. Problems and precise drawings of machine parts that would take hours. Medicine seemed a breeze by comparison. We had drawings to do too but nobody seemed to mind if a sleek looking dog fish developed racing wheels, a steering column and stabilizing fins before taking it's place in the starting line, or that a covered metal waterbath on a tripod should have a ladder, a door, windows and chimney to become a forest fire watch tower.

The Tech. in those days had the cruel habit of holding their Xmas exams not before but immediately after the students returned from the Christmas holiday. One or more of his instructors may have been ex-sergeants for as the day of departure for the holidays came near my room-mate quickly resolved never to come back. He didn't.

In this instance I witnessed the only benefaction ever to come to a student from college athletics. He was a good goaltender and when he didn't return his captain and others called him, coaxed him, begged him. No use he wasn't coming back. A group of his team mates went to his hometown by train (winter roads were impassable to cars in those days) forcibly took charge of his person, brought him to Halifax, lodged him in a boarding house with a number of teammates, made him sit his examinations and took him to hockey practise. He did well in his exams, in goal, in the rest of his course and graduated to an eminently successful career in his field. He even joined the reserve army. So much for the power of games!

In those days after the first world war the medical school as has already been noted was full of old soldiers and airmen but no ex-naval personnel. It was unkindly said that having been on sea duty for several years they had no desire to spend so many additional years in training only to find themselves largely at sea for the rest of their lives. We decided in the interest of higher education to form a navy of our own to be modelled in miniature after the R.G.N. of the day.

This navy was to consist of an Admiral, a Vice Admiral, an Able Seaman, a Cook and a Cook's Bitch. The only fellow who was known to have any naval contact whatever was a chap who had reputedly travelled on a troop train with the White Russian Admiral Kolchek during the Bolshevik war in Russia in 1919. With this preeminent qualification he was made the first Admiral.

It was an unenviable appointment without secure tenure and though in the mind's eye gorgeously uniformed in blue with yards of heavy gold braid and epaulets of tasseled gold wide enough to rival the wing span of a Handley Page bomber, he was liable to sudden and terrible demotion at the whim of the rest of the Force. His only security lay in being always clever and always right. If in class he asked the wrong question or gave the wrong answer or goofed in any way, it was the single duty of the Cook's Bitch to advance on him wherever he might be in class or clinic and vigorously, with ostentation tear off his massive epaulets. He was immediately demoted to Cook's Bitch and the rest advanced a notch in rank.

It is to the total credit of our teachers (schooled as they were in the Equanimitas of Osler) that they never once paused, peevishly complained or otherwise noticed this bizarre classroom behaviour. Our classmates had long suspected that we were crazy.

Most of these old soldiers had vivid memories of their war experiences, though they rarely spoke of them except to complain of the long periods of dreadful food they endured. They brought to the boarding house tables of Halifax a delicacy of taste and a discrimination of flavour and freshness which became the bane of many boarding house keepers in the vicinity of the medical school. Added to their epicurian taste was a complete disregard for hurt feelings and a remarkable indifference to the condition of walls and ceilings.

Eggs were not often served in the boarding houses then and were never quite fresh or definitely bad. They were served fried with their almost colorless yolks broken, covered with shiny grease and resembling nothing so much as a white pancake with a porcelain glaze. Sometimes we would get a boiled egg for breakfast. It was usually sticky.

I recall one fellow who would cut the top off his egg and if it wasn't quite fresh, would balance the top neatly on his knife and flick it up to the ceiling where it would sometimes stick on contact. The same mild protest was made against poor butter, of which there was an abundance just then, and sticky boiled rice on occasion. Stronger protest might see the contents of the butter dish or other food scraped into a corner of the room like the discharge of a large, untrained domestic animal with poor digestion.

Not surprisingly we moved about frequently from house to house as rumors spread about food being actually edible at this place or that. Our departures were never mourned. There

were no fraternities, no student residences except Pine Hill where a few well connected medical students were accepted and no restaurants nearer than down town.

Many men went all the way downtown to their meals. A weekly ticket could be bought for five dollars and the card was punched for each meal. One very well to do fellow lived at the old Halifax Hotel and came to and from classes by taxi. Needless to say he was not a medical but a law student and his affluence derived from the gaming tables in the law school cellar. We eventually found a delightful place where the meals were different and delightful and the table was set with Ainsley china and sterling silver. Our manners improved.

About this time the American medical schools went to a six year course and served notice on Dalhousie to do the same or forfeit their 'A' rating. This set off a chain reaction which included altering the curriculum, changing admission practises and admitting American students in numbers.

Up to that time Dalhousie was a school training medical students for the local area. It had no illusions of grandeur and it's admitting practise reflected it's practical regional nature. If you wanted to study medicine you could enter from grade eleven. If you lacked a couple of subjects for full matriculation it was of no moment. Those could be carried over the full course as long as they were completed before graduation. The reasoning behind this was that if you were fool enough to want to study medicine you deserved all the encouragement it was possible to offer.

The train moved warily into the station at Halifax on a golden October morning an hour or so before noon. I left the train hurriedly as it was the last day of registration and I didn't dare be late. As I passed the engine it was hissing steam and huffing and puffing with such gasping respirations that you could see it's black barreled chest heaving dramatically as though it had fought it's way through miles of wild beasts, landslides and flood to get you here safely. They were proper hams those old steam engines and their drivers knew how to make them put on a real act in the station.

The registrar that day was Prof. Nicol, Head of the Classics department, a quiet man with an endearingly dry sense of humor. He also had some loss of visual acuity for as I entered the room he looked up and asked, as though I were a human being, "What can I do for you?" He had not even noticed the great locomotive huffing and puffing at the other side of the counter. "I have come to register" I said hopefully. "What course" he asked patiently, Here the mighty engine turned crafty. "What have you got without mathematics?" it hissed in a conspiratorial tone as though making a deal for some bootleg liquor. "Medicine is the only course without math." he said promptly, giving me a sharp look. He turned a page or two in a book on the counter and turned to me with a twinkle "and so far as I can see there isn't much of anything else in it either".

Years later the sad truth dawned on me that we were indeed the most rigidly trained, the most poorly educated and the most narrowly confined profession in the world. True there are many cells in our prison and we are free to move about and look in many cell doors but as time goes on new specialties, sub-specialties and para-medical techniques grow with the uncontrolled and undisciplined violence of cancer, until within and between the cells there is no common understanding, no comprehension — and no patient. Jailor where's your key?

The trouble may have originated with the incompatible marriage of art and science in medicine. Science has become the dominant and domineering partner in this unnatural union whose children are more and more schooled in the precise technique of chemistry and physics the results of which, because they are reproducable must therefore be infallible and unquestionable. Whole schools of thought bow down and the mind checks it's free flight at the frown of this scientific monster who has given over the care of the sick to the research laboratory in whose great lottery thousands of lives and millions of dollars may be ground to pulp before a single winning ticket is produced.

Most great advances are made in the great minds of brilliant men. Not in the big laboratories of big institutions, which are often filled with little men with smaller minds hoping for an inspiration.

Research has become the sacred cow of the western world just as the missionary effort has been the rallying call of the Church for a hundred years. To question the usefulness, the validity and indifferent success of these endeavors is like denying abortion at a meeting of 'women's lib.' The results have been less than ideal for either organization.

Medicine is now being taught at test tube level from last month's Journal. The physiological, anatomical, pathological and psychological platforms on which medical teaching and practise have been erected over the past century or two have been submerged in a flood of novelty so rapid, so roiled and so turbulently uncontrolled as to make it almost impossible to say what constitutes good medical teaching or sound practise.

The Universities, finding their medical students graduating as passable scientists but poor physicians, afraid or unwilling to take up the responsibilities of the care of the sick, have reacted not by removing the volumes of specialist esoteria from the undergraduate years and exposing the student to more practical, confidence building courses but by adding another year to his internship.

The medical societies and the departments of continuing medical education knowing that they should try to rescue the unfortunate doctor drowning in that dreadful flood of novelty most of which passes over or around him to be lost in the great swamp of insignificant banalities at the river's end, have offered no practical help. Their only suggestion is that he work harder, study longer and learn forever. As if useful learning could only be found in next month's journal.

No one has dared to suggest that the universities and the august learned societies have a responsibility to take steps to reduce the torrent of writing which is drowning the competent and conscientious family doctor. So much of this writing is self agrandizing trash that does nothing to enhance the care of the sick and only raises the level of the flood.

Surely, in the face of this ever increasing deluge of medical publications our societies and universities can organize a

medical publications council and secretariat on an international base to review, limit and hopefully reduce the number of journals. Such an effort, through better organization and placement of material might greatly improve the quality of medical reading while reducing it's quantity.

Recruitment to the medical profession will not long continue at the required level if our family doctors are so walled about with study sessions, learning laboratories and electronic teaching machines, that they are unable to find time or strength to demonstrate their competence in the care of the sick.

In spite of some current opinions, a soundly based medical education does not depreciate to nothing in five or ten years. To say that it does is to denigrate the course and it's teachers. It also exposes a very shallow philosophy of healing. The medical student during his years of training develops a knowledge of the human body and mind, it's structure, function and pathology. He develops skills in observation, interrogation and examination that never leave him. He learns, or should learn the basic principles that govern the care of the sick human body that last forever.

Of all the children of the hapless marriage of art and science in medicine the psychiatrists alone have retained their intellectual freedom. Untrapped as yet in the implacable net of phony scientific truth they are still able to see the sick man in the context of the world and have brought forth from the murky depths of insanity, treatment techniques, evolved from intellectual activity and profound thought, that are as dramatically life saving as insulin and penicillin.

Many of the world's great tragedies have resulted from the ruthless pursuit of the disordered thought of diseased minds. Toward the prevention of such cataclysms must be directed a continuing and world wide prophylaxis. Only men of great faith and vision can perceive it's eventual success.

There is so much brevity in the world. Good intentions, good will, good works, life, memory and man. All are so short lived and so soon forgotten.

To these thoughtful and tireless workers the following unsolemn lines:

The Psychiatrist

Conceived in casual conference,
Fertilized by Freud,
He probes the guilty conscience
Within the vaulted void.
He drugs to isomeric motes
What normal cells remain
And unconcerned with antidotes
Dissolves the morbid brain.
Or shocks the wretch of sense bereft
Until the spasms tell,
That cosmic dust is all that's left
Within the rotund shell.

And lo, his eyes with pity fill,
His heart with grief's o'er lain-
Tis not the patient who is ill,
The bloody world's insane! □

ANNOUNCEMENT

In April, 1973, the Canadian Public Health Association officially constituted a new division named the Tropical Medicine and International Health Division. The purpose of the Division is to support and uphold the interests of tropical medicine and international health in Canada. Membership is open to anyone interested in promoting the aims and objectives of the Division.

Further information and/or application forms may be obtained by contacting:

Edward Ragan, M.D., Barbara Copley, R.N.
Chairpersons, Membership Committee,
Tropical Medicine and International Health Division,
Canadian Public Health Association,
55 Parkdale Avenue,
Ottawa, Canada K1Y 1E5.

Physician Self-Assessment

Question No. 1 Correct Answer E

Correspondence

To the Editor:

Re: Cervical Screening

I would like to indicate some agreement with Dr. G. H. Anderson in his defence of cervical cytology in your October number, but take issue with one of the points he has raised. Exfoliative cytology may provide a test of value in gynaecological diagnosis and this may indeed warrant the appropriate laboratory resources. Furthermore this could imply some potential reduction in mortality. However there is no adequate evidence to date that this is a test of value in screening apparently healthy women.

Anderson's quotation from the symposium of the International Union Against Cancer held in 1972 has been accurately transposed, namely, "There was unanimous agreement that exfoliative cytology of the cervix provides a test of value . . . in screening apparently healthy women".[1] The difficulty however lies in understanding how this conclusion was reached when in the same report, the authors acknowledged that "In cancer of the cervix . . . cytological examinations reveal the presence of carconoma in situ, but the duration of this lesion and the frequency with which it becomes inavasive are not reliably established; without this information it is impossible to predict the value of excision in the pre-symptomatic state". The two statements are frankly contradictory.

Doubts concerning the value of cervical screening are grave indeed, and I would like to quote the following from a recent review by Lambourne and Lederer (1973).[2] "Ahluwalia and Doll in 1968 pointed out that a comparable fall in incidence and mortality had occurred in parts of Canada not affected by the British Columbia screening programme. The conclusion of Macgregor, Fraser and Mann (1971) that a fall in incidence of invasive carcinoma in Aberdeen was attributable to the local screening programme has been criticized by Wilson, Chamberlain, Cochrane (1971) and similar criticisms seem valid for the report by Dickinson, Mussey, Soule, and Keeland (1972) from Rochester. Pedersen, Hoeg, and Kolstad (1971) in a detailed analysis of the experimental programme carried out by the Norwegion Cancer Society in the county of Østfold show that although the programme achieved a more favourable stage distribution of invasive carcinomas there was no reduction in incidence of invasive carcinoma although hundreds of cases of dysplasia and carcinoma in situ had been eliminated".

Closer to home again, Sellers (1973),[3] in an analysis of trends in mortality from cervical cancer in Ontario and British Columbia from 1959-71 concluded that "evaluation of the effects of cytological screening on mortality from cancer of the cervix continues to be complex and elusive, but there seems to be little evidence of the reduction in mortality which was anticipated by many observers". Kinlen and Doll (1973)[4] compared the trends for British Columbia, Ontario, the rest of Canada and England and Wales. They noted that "the mortality from cervix cancer has declined materially in the last 10 years, particularly under 45 years of age, but there is very little difference between the experience in British Columbia, Ontario and the rest of Canada". While they do observe a somewhat faster decline in the 45-64 age group in B.C. and note that the higher rates of hysterectomy in that province are not sufficient to account for all of this difference, none the less the difference is small and they are not able to define the impact of other basic epidemiological variables such as migration and socioeconomic differentials.

I would also like to point out the view expressed by Miller[5] who came to similar conclusions in a review of the evidence in 1973, namely, "Let us insist that proper procedures for evaluation be incorporated in every new programme so that we avoid the dilemma we now find ourselves in for screening for carcinoma of the "cervix". Furthermore, a more basic contention is that such evaluation should have taken place on a trial basis before more general programmes were instituted.

Submitted with respect and some concern,

Yours sincerely,

F. M. M. White, M.D., C.M., M.Sc.,
Bureau of Epidemiology,
Laboratory Centre for Disease Control.
Department of Health and Welfare
Ottawa, Ontario.

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To the Editor:

Re: Anaesthetic Care in Nova Scotia

I read Dr. Feindel's article on "Maintaining Standards of Anaesthetic Care in Nova Scotia" in the November issue of your Bulletin with mixed feelings. The author deserves praise for presenting causes underlying inadequate anaesthesia care, among them shortage of manpower in the speciality of anaesthesia.

His opening statements leave me puzzled as to their intended meaning. Does the author take pride and satisfac-

tion from the fact that "Canada shares a unique position with few countries in the world, in that anaesthesia care is not yet delegated to a nurse-practitioner (a strange term) or anaesthetic technician"? By saying "not yet" does the author envisage a change in this state of affairs?

In the second sentence of the opening paragraph Dr. Feindel writes: "to allow unsupervised technicians to administer anaesthesia would be a retrograde step and must be avoided". The message contained in this statement is so obvious that, I am sure the author does not expect anybody to question it. Again, I must seek clarification as to the author's real intent. Is he allowing for the possibility that *trained* technicians may enter the ranks of anaesthesia manpower? In this he would not be alone. The Health Services Commission in Quebec in collaboration with anaesthetists of that province, have launched a pilot project last year to train and evaluate anaesthesia technicians and their future role in patient care.

Among the steps suggested by Dr. Feindel to be taken in anticipation of future needs of this province in anaesthesia manpower, one finds no plan to train purse-anaesthetists or anaesthesia technicians. I consider it a grave omission!

While countries with standards of health care at least equal to that of our own, make good use of these young, highly motivated people, Dr. Feindel, and I am sorry to admit, many other anaesthetists would have us wait for awakening of interest in anaesthesia among the undergraduates and busy general practitioners, and this at a time, when waiting lists for surgery grow longer every day.

At the recent European Congress of Anaesthesiology in Madrid, a half-day symposium dealt with the matter of training and staffing in anaesthesiology. I had an opportunity to listen, and later discuss the role of nurse-anaesthetists with colleagues from across Europe. Most of them rely heavily on help of non-medical personnel in operating rooms, intensive care units, emergency teams, apparently at no loss of their professional status or income.

In my opinion, anaesthetists, nursing associations and governmental bodies responsible for health care in the Atlantic provinces, should make a close study of methods of training and conditions of employment of nurse-anaesthetists or technicians in the United States and Europe.

I hope that this letter in response to Dr. Feindel's fine article will attract further expression of opinion on the matter of nurse-anaesthetists from other people concerned about anaesthesia practice in the Maritimes.

Yours very truly,

S. B. Donigiewicz, L.R.C.P., M.R.C.S., F.A.C.A., F.R.C.P.(C)
Halifax, N.S. □

CALL FOR HOCKEY EYE INJURY REPORTS

Physicians are reminded of the hockey eye injury survey being conducted by the Canadian Ophthalmological Society this year. Progressive reporting forms were sent to all COS members last September. Other physicians are urged to contribute any pertinent data, and may obtain reporting forms by writing:

Dr. T. J. Pashby, Chairman
COS Hockey Eye Injury Committee
20 Wynford Drive, Suite 112
Don Mills, Ontario M3C 1J4

Even a partially-filled reporting form may be sent in at any time. As soon as the Committee receives it, they will mail you a new one. The Committee is working closely with hockey authorities and manufacturers to develop protective equipment and, if ecessary, rule changes to drastically reduce the number of serious eye injuries revealed by last year's preliminary COS survey.

YOUR REPORTS ARE URGENTLY NEEDED.

IT IS NOT TOO LATE TO BEGIN!

THIRD ANNUAL MEDICAL MOOT

The annual medical moot sponsored by the Nova Scotia Medical-Legal Society in cooperation with the Faculty of Law and the Medical School of Dalhousie University, will be held on February 6, 1975 at 7:00 p.m. in the Weldon Law Building, Faculty of Law, Dalhousie University.

The case will deal with a possible medical malpractice situation arising from the adverse complications which followed the prescribing of the birth control pill for a fifteen year old girl. The issues to be argued and decided are the standard of care to be expected from the defendant doctor in prescribing the pill and the validity of the consent of the fifteen year old plaintiff.

"The final test of a leader is that he leaves behind him in other men the conviction and the will to carry on. . . . . The genius of a good leader is to leave behind him a situation which common sense, without the grace of genius, can deal with successfully."

Franklin D. Roosevelt

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SECTIONS

Anaesthesia	W. A. P. Thompson	D. K. Rushton
General Practice	D. S. Reid	A. H. Murray
Internal Medicine	A. J. MacLeod	L. K. Harris
Obstetrics and Gynaecology	C. Maley	R. H. Lea
Ophthalmology and Otolaryngology	T. C. Fort	G. J. Whiston
Paediatrics	B. D. Grover	R. S. Grant
Pathology	V. W. Krause	T. Hindmarsh
Psychiatry	E. A. Smith	C. Taylor
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Salaried Physicians		
Surgery	J. J. Quinlan	S. Anand
Urology	F. G. Mack	W. A. Ernst

THE WAKE

"Waking," or watching around a corpse before burial, is a custom little practised today, except in Ireland. The custom seems to pre-date Christianity and to have been at first essentially Celtic. The corpse, with a plate of salt on its breast, was placed under a table on which was placed copious quantities of liquor. The latter item soon became the cause for the wake, as an institution, getting a bad reputation. The wake probably has its origin in the superstitious fear that evil spirits might steal or harm the remains of the dear departed. With the advent of Christianity, prayers were added to the proceedings.

With this priceless information out of the way, I shall recount what was to me one of my most interesting house calls. This took place in one of the suburbs of Glace Bay more than 20 years ago. It was late at night, near midnight, when I received a call from a hysterical female. This, in itself, was hardly an unusual experience. The caller seemed to have an emergency but I could barely make out what she was saying for the noise in the background. Obviously, a great drunken party was in progress with what seemed to me, at the time, to be an inordinate amount of screaming. I couldn't make sense out of what she was saying but I did manage to hear the name of a street in New Aberdeen and a last name. I drove at once to the area and having found the street, it was obvious that knowing a street number would have been superfluous. My destination shone like a beacon, a veritable Star in the East, to show the way. Added to this was a cacaphony of sound that left no doubt as to the site of the party.

I parked my car and walked into the house.

It was a typical Dominion Coal Company house. New Aberdeen was made up, for the most part, of row upon row of these company houses. Every house was identical on the outside and structurally the same on the inside. They all needed a coat of paint, all the time, and were well ingrained with coal dust. The front door opened directly into the living room and was called a "parlour." And it was into this room that I strode, almost bumping into a large box in the middle of the room. I realized at once that it was a coffin, open, set up on wooden horses, and containing the remains of the newly departed, the latter quite oblivious to the racket around him.

About a dozen men and women, thoroughly corned, were crying and screaming and surrounding a man who was being supported against the wall. This was obviously my patient and as I got near him I realized that he was screaming something. I could not make out his words at first and then, through the noise I heard, "I'm blind, I'm blind!" After considerable questioning, the story of his blindness emerged. Apparently this man, about 50, a cousin of the deceased, was well into his cups when he leaned over the coffin to kiss the corpse, slipped and fell on top of the body. When he was lifted off, he was blind, and as no amount of encouragement from his fellow wakers was restoring his sight, they called the doctor.

The examination revealed a thoroughly inebriated middle-aged man, staring straight ahead, crying and screaming. Both eyes reacted to light but he would not follow a moving finger because he "couldn't see it." It was fairly obvious that this was an acute case of hysterical blindness and fast treatment was called for. Having about six months of practice in Glace Bay under my belt, I was well qualified to handle the case. I decided that a well directed back of the hand across the chops would do the trick, and did just that. Suddenly there was dead silence in the room, broken in about five seconds by the patient's, "I CAN SEE, I can see!" Archimedes' "Eureka, Eureka!" couldn't have sounded any better.

And, as far as I know, the cure has been permanent. □

M.E.B.

Some Pictorial Highlights of the 121st. Annual Meeting

Outgoing Society President Dr. J. A. George, (left), Antigonish, congratulates in-coming President, Dr. D. B. O'Brien during 121st Annual Meeting closing festivities.

Dr. R. L. Denton (left), Digby, is honored as the first Society member to bring the rolls up to 1,000. Making the presentation is his father, Dr. G. D. Denton, Wolfville. Out-going President Dr. J. A. George, (center) looks on.

Ladies' program highlights include a sherry party at the St. Mary's University Art Gallery. Host was curator Robert Dietz. Looking on, from left to right, are: Mrs. D. B. O'Brien, Halifax; Mrs. J. A. George, Antigonish, and Mrs. C. L. Gosse, Halifax.

Dr. D. B. O'Brien, Halifax, is installed as President of The Medical Society of Nova Scotia by C. M. A. President, Dr. Bette Stephenson, Willowdale, Ontario.

Personal Interest Notes

CITATIONS FOR SENIOR MEMBERSHIP IN THE MEDICAL SOCIETY OF NOVA SCOTIA

Dr. Herbert R. Corbett

Dr. Herbert R. Corbett, Sydney, receives Society Senior Membership from Dr. J. A. George (right). Reading the citation was Dr. L. A. Skinner, (center) North Sydney.

Honourable Lieutenant Governor, Honourable Minister of Public Health, President of The Medical Society of Nova Scotia, head table guests, fellow members and wives.

The Medical Society of Nova Scotia has honoured Dr. Herbert Redmond Corbett, by electing him to Senior Membership in the Society.

Dr. Corbett was born in Mulgrave, Nova Scotia, at the turn of the century and later lived in Halifax. He attended St. Mary's College and graduated from Dalhousie University in 1923. Following graduation, he was appointed to the Medical Staff of the Nova Scotia Sanatorium. He took post-graduate training in Diagnostic Radiology at the University of Michigan and returned to the Nova Scotia Sanatorium as Radiologist.

In 1938 he moved to Cape Breton, where he was appointed radiologist at St. Joseph's Hospital, Glace Bay and in Sydney at St. Rita's Hospital and at the City of Sydney Hospital. Later he restricted his services to St. Rita's Hospital and acted as Consultant Radiological Services to the N.S.H.I.C. from 1959 — 1962.

He served with the Royal Canadian Army Medical Corps (Reserve) retiring with the rank of Major.

The Cape Breton Medical Society members will recall the many years Bert served as Secretary, where his voice was heard in most discussions.

He is a past president of the Nova Scotia Radiological Society and he was made a life member of the Association of Radiologists, a Senior member of The Canadian Medical Association, and an honorary senior member of the Nova Scotia Association of Radiologists. He is a Fellow of the Royal College of Physicians and Surgeons of Canada in Diagnostic Radiology.

His hobbies include gardening and he is an expert in the culinary art.

Mr. President, it is a pleasure for me to present to you, Dr. Herbert Redmond Corbett, for acceptance of the honour bestowed upon him by the Medical Society.

L. A. Skinner, M.D.

Dr. Herbert B. Whitman

Dr. Herbert B. Whitman, Westville, Nova Scotia, receives his Senior Membership from out-going Society President Dr. J. A. George.

Honourable Lieutenant Governor, Honourable Minister of Public Health, President of The Medical Society of Nova Scotia, Executive, Head Table Guests, Ladies and Gentlemen.

Wise, indeed, was the decision of The Medical Society of Nova Scotia this year to elect Dr. Herbert Whitman to Senior Membership in the Society.

Herb, as he is better known by his medical colleagues, was born in Halifax County but moved at an early age to Louisburg where he received his early education. Grade 12 was obtained at Sydney Academy from where he graduated in 1921.

He entered Dalhousie Medical School in 1922, graduating in Medicine in 1928. This was followed by a year of internship in Cleveland, Ohio and then a Residency in San Francisco.

He began Family Practice in Westville, Nova Scotia in 1931 and he has continued his practice until the present time.

In 1937, Dr. Whitman married Molly Harrison, a School Teacher and their marriage produced a son and daughter. His son Dr. George Whitman is associated with him in Family Practice in Westville.

Dr. Whitman has always had a large busy practice but managed to find time to do some curling and to engage in his chief Pastime — Fishing. He is a Charter Member of the Rotary Club and has been active in this Club through the years.

He has served terms as President of the Pictou County Medical Society and Aberdeen Hospital Medical Staff. He has also served as President of Maritime Medical Care and as a Director.

In the past few years Dr. Whitman has been made a Fellow of the College of Family Practice as well as a Fellow of the International College of Surgeons.

Dr. Whitman is a capable Physician, who is held in high regard by his patients, by his community and by his medical colleagues.

Dr. Whitman — it is both a pleasure and a privilege to have made this introduction on your acceptance of the honour bestowed upon you by the Medical Society.

E. E. Henderson, M.D.

Dr. Robert N. Hetherington, Anaesthestist for the Fishermen's Memorial Hospital and the Dawson Memorial Hospital retired recently. He was honored at a dinner in Liverpool by the Medical staff on his retirement where a presentation was made. At this time he was appointed an honorary member of the medical staff of the Fishermen's Memorial Hospital. Best wishes are extended to Dr. Hetherington on his retirement.

On Monday, 18 November 1974, a well-attended Faculty of Medicine dinner honoured the retired Head of the Department of Medicine, Dalhousie University **Dr. R. C. Dickson.** Well-deserved tributes were given by the Dean of the Faculty, Dr. L. B. Macpherson, by Vice-President C. B. Stewart and by the President Henry D. Hicks.

Dr. Dickson was presented with a silver tray appropriately inscribed and Mrs. Dickson a Royal Dalton figurine as a memento of the occasion.

Dr. R. O. Jones, Professor and Head of Dalhousie University's Department of Psychiatry, was recently honoured by the alumni of his residency training program with the gift of a lectureship bearing his name.

The occasion was the 25th anniversary of the Dalhousie Department of Psychiatry Residency Training Program. This was held in conjunction with the Atlantic Provinces Psychiatric Association meeting 18-21 September, and attended by 60 alumni of the program.

This program, initiated by Dr. Jones, was the first university sponsored residency training scheme in Dalhousie, and indeed in Canada, and was a model for the development of similar programs, not only in Psychiatry but in other specialties.

The Lectureship will be used to assist the sponsorship of a guest teacher in the Department of Psychiatry each year at a time when the lecturer will be able to attend and participate in the program of the A.P.P.A.

OBITUARIES

Dr. M. G. Tompkins, Sr., 87 physician and community worker, died on November 17, 1974. Dr. Tompkins graduated from Dalhousie Medical College in 1914 and spent his entire medical career devoted to the care of the mining families and other residents of Glace Bay, New Waterford, Dominion and area. He was a past president of The Medical Society of Nova Scotia as well as holding other major posts in organizations associated with his profession. Dr. Tompkins had been made Senior Member by both The Canadian Medical Association and The Medical Society of Nova Scotia. Our sympathy is extended to his sons, daughters and their families.

Dr. John R. Corbett, 85, of Clark's Harbour died November 13, 1974. Born in Granville, P.E.I., he received his education at Alberta University and McGill School of Medicine. He also did Postgraduate work at the New York Poly Clinic and at the Royal Victoria Hospital, Montreal. He practiced in Shelburne during War World Two and after the war at Clark's Harbour until his death. The Bulletin extends sincere sympathy to his widow and daughter.

Dr. Jean (MacDonald) Lawson, Kitchener, Ontario, died on November 4, 1974. Dr. Lawson was born in Moncton, N.B. Following her undergraduate study in Moncton, she graduated from Dalhousie in 1944. She later attended Women's College in Toronto where she obtained her degree in Obstetrics and Gynecology in 1950. Dr. Lawson practised in Halifax and was a member of The Medical Society of Nova Scotia between 1957 and 1967. Dr. Lawson was highly respected by all who knew her and will be greatly missed by her husband, three children and friends. □

GENERAL INDEX

VOLUME 53, 1974

ABBREVIATIONS:

Ed. — Editorial; DL — The doctor and his leisure; BN — Brief Note; AWT — Around the Willow Tree; 1000 — Thousand Word Series; C — Correspondence.

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