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AS CONFIRMED BY THE NOVA SCOTIA MEDICAL SOCIETY

DEC. 2, 1992

A SCOTIA MEDICAL BULLETIN

International Year of the Disabled!

B. J. S. Grogono, *M.B.,
Halifax, N.S.

OYEZ! OYEZ! HEAR THE MIGHTY VOICE OF THE DISABLED

The old town crier is a familiar sight in Halifax, thanks to the splendid competition of sonority that is held each year on the Historic Properties. Half a dozen of the world's most powerful vocal cords, propelled by their brightly costumed owners, pitch against each other in friendly rivalry. You can imagine these magnificent vocal machines carrying a message across the land as the year ends. Their sounds do not fade into oblivion but persist and reverberate forever gaining strength. Echoing, and amplifying their tones into a crescendo, like the trumpets outside Jericho — **A MIGHTY BLAST OF SOUND**

"This is the voice of the **DISABLED!**
Like the walls of Jericho.
All obstacles shall be overcome!"

On December 16, 1976 a Libyan Arab, Mr. Jamihiriya, introduced resolution 31/123 to the general assembly of the United Nations. This proposal declared 1981 as the year of the disabled, to give full participation and equality to the estimated 450 million people who suffer from some sort of physical mental impairment.

It is fitting that the proposal should come from a North African Country which is spending a vast fortune on armaments but yet whose statesman recognized the enormous problems of poverty, malnutrition, disease and deprivation. They particularly beset the so-called "underdeveloped" countries as well as the industrial — accidental, medical and mental disorders that affect the "developed" nations.

Objects of the International Year of the Disabled Persons (I.Y.D.P.) are:

a. Helping disabled persons in their physical and psychological adjustment;

b. Promoting international efforts to provide disabled persons with proper assistance;

c. Encouraging study and research to facilitate the practical participation of handicapped persons in every day life;

d. Educating and involving the public in the rights of the disabled; and

e. Promoting measures for the prevention of disability and encouraging means of rehabilitation of the disabled.

The response to this Year of the Disabled gradually gained momentum as the year passed. The impact of a global effort is producing changes, not only in material facilities available for the handicapped but also as a profound alteration in the attitude of people everywhere towards those with physical or mental impairment. No longer are the "crippled and maimed", the "lunatics", the "morons", people who are ridiculed, labelled or shunned. Those with impairment are respected as responsible citizens capable of contributing to our society who need opportunities.

*Chief of Orthopaedics, The Halifax Infirmary, Halifax, N.S.

Besides possessing devices to assist their welfare, often many of those with handicaps are better motivated and more persistent than those who have no tragedy or challenge to overcome. The Roosevelts, Miltons, Beethovens, Helen Kellers, Toulouse-Lautrecs, Van Goghs are shining examples of genii beset with severe defects. Milton dictated the whole of *Paradise Lost* undeterred by his blindness. Hawkins is busy exploring new theories to correlate the quantum theory with relativity, whilst his body is supported in an electric chair and the control of his limbs hindered by a amyotrophic lateral sclerosis.

Not all handicapped people are privileged, working in universities, or have advantages of adequate homes and domestic circumstances of these famous people. The Year of the Disabled has begun to provide facilities and opportunities for many who would otherwise be left or unnoticed or denied a fair chance in life.

The Disabled Population

One of the most important contributions of this International Year has been the identification of a vast number and variety of disabilities. Peculiar to each country and clime there is no denying that politics and war play an enormous part in the production of human misery. The potential for further disasters is enormous for even a so-called limited nuclear conflict would lead to casualties and a permanent maiming that would make a Hiroshimma, look like a kindergarten entertainment.

Guerilla war and anti-personnel bombs have also a tremendous potential for producing a new generation of cripples. Countries are spending vast sums on scientific methods of destruction, yet they could equally well deploy this wealth to help the handicapped or prevent disease.

The United Nations Organization has gone some way to define the types of problems that are causing human impoverishment:

Accidents:

Total 20 million per year with 110,000 persons being left with permanent disability.

Road Accidents:

More than 10 million persons per year — paraplegia, amputation, brain damage are common consequences.

Crippling Diseases:

20 million people have leprosy, malnutrition — particularly common in Africa where 250,000 children a year are going blind from vitamin deficiencies.

Mental Illness:

One out of every ten persons are afflicted with some sort of mental illness during a life time. Mental patients occupy one-quarter of all hospital beds.

Blindness:

10 to 15 million people world wide — trachoma, glaucoma, cataracts are treatable conditions.

Epileptics:

There are some 15 million.

Cardiovascular Disease:

This is the commonest cause of disability in the older population of the developed countries. Diabetes is an important risk factor for this disease.

Arthritis:

This is an important cause of long standing disability.

Cancer:

Remains a cause of severe disability, but one which is being vigorously attacked.

War Disabled:

Every war brings its own contingent of disabled.

All Star Baron, driven by Phil Pinkney captures the feature pace at Sackville Downs on July 15th, held in honor of the International Year of Disabled Persons.

From Left are Eric McNutt; Ken MacRae, Chairman of the Nova Scotia Division, Canadian Paraplegic Association; Don Curren, Executive Director, CPA; Mr. Pinkney, and Sackville Downs president Jack Cruickshank.

Organization of the International Year of Disabled Persons

The United Nations plan of action is coordinated by Ms. Zala Lusibon McKenza of Zaïre. She is Director of Social Development and Humanitarian Affairs.

Projects include:

a. A symposium on technical assistance to disabled persons;
b. A long term program of action;
c. Improvement of international transport facilities to provide access for disabled;
d. The preparation of manuals relevant to the year;
e. Issue of commemorative stamps and coins.
f. Promotion of exchange programs for the training of specialties; and
g. Encouragement of participation of the disabled in the I.Y.D.P. projects, and drawing up of long term plans

The United Nations, The World Health Organization, Unicef and Unesco all cooperated in the program for children.

Canadian Contribution

An independent body of Canadian Organizations (C.O.C.) for 1981 was charged by the Federal Government to stimulate and promote programs. This 35-member committee, with Chairman Don Curren from Halifax, has undertaken the enormous project, funded by a million dollar grant.

The C.O.C. also acts as liaison to assist many corporations and associations to emphasize:

a. The profitability of employing disabled people — making a tax dependent into a tax paying person;
b. Integration not segration;
c. Access to community services;
d. Obtaining corporate donations; and
e. Technical aids

FULL PARTICIPATION AND EQUALITY IS THE AIM

Public Information and Publications

The greatest sucess, has been the wide dissemination of knowledge concerning the problems of different handicaps and the means by which individuals adapt. Radio and television programs, newspaper and journal articles have been bombarded — even Canadian Christmas catalogues show children enjoying a party in wheel chairs. Winter sports programs show blind and amputees sporting themselves. Classes for mentally retarded children develop their potential under careful guidance.

Excellent publications include:

1. Obstacles —

Report by a special committee on disabled and the handicapped. The Disabled are not seeking a hand out but a hand up.

Examples from this publication:

Attitude:

We need to change attitudes of culture that are 300 years old. "If only people would stop trying to do everything for us".

Institutions:

"The warehousing of the disabled Canadians in institutions without freedom to chose or attempt. This costly alternative is a denial of basic human freedom — a degredation of humanity and a waste of human reserves".

Government Buildings:

"The public address and the alarm systems in most buildings do not take into account the needs of people with hearing disabilities." "Architectural inaccessibility in one of the most overt barriers to employment of handicapped persons"

2. Action —

A bilingual monthly publication gives all aspects of the C.O.C.'s program.

Conferences:

A world coalition of persons with disabilities was held in Winnipeg in 1980. Four thousand delegates attended with 300 disabled people from all over the globe. A world coalition of people with disabilities was proposed. This conference held in 1980 was good preparation for I.Y.D.P.

Counsellors Conference - Toronto:

This brought new and experienced members of the Canadian Paraplegic Association to exchange ideas and experiences, to include graphic account of the problems of Native Canadians.

Canadian's International Contributions To Disabled:

Dr. Gustave Gingras, pioneer of rehabilitation and Professor Gallan Ocrocher, President of the Montreal Association of Mental Deficiency have carried out work both in South America and in the Caribbean.

Housing:

Canadian architects and builders agree that making a new house accessible costs very little more than a normal construction provided that accessibility is part of the initial design and not an afterthought.

Employment:

Outreach: is an innovative concept that enables groups to develop employmnent potential. "The government should take steps to ensure that all employers with a 100 or more employees develope or implement an Alternative Action Program. This may require technical aid or an attendant".

Indian and Inuit People:

Life expectancy of Indians and Inuit is much less than other Canadians. Sickness, overcrowding, poor water supply, inadequate sewage disposal are all prevelant among some Indian populations. Further assistance is required here.

Recommendations of C.O.C.:

New legislation to replace vocational rehabilitation provisions in The Disabled Persons Act.

A Minister of State for disabled persons be designated, with Cabinet status and a suitable budget.

3. Recreation —

Recreation Canada — Canada's special edition 1981, published by Canadian Parks and Recreation, Ottawa. This provides an imaginitive and comprehensive guide to many aspects of sports and recreation not available to handicapped.

Examples from this publication:

Skiing — Illustration of different ski modifications for amputees and photos of blind skiiers enjoying themselves.

Toboganing — Special adaptions for paraplegics are presented.

Children — Helpful advice is given on how to teach children with motor incoordination.

Volunteers — Information on training and organization.

Sledge Hockey — A description of a team game played by people with spina bifida and muscular dystrophy.

4. Disabled Persons in Canada — Produced by the Department of National Health and Welfare. This publication gives a comprehensive guide to the distribution, history and nature of the major medical and mental disorders that affect Canadians and it lists the major organizations that have combatted them. Human rights, housing services to the disabled, special education, access to public buildings, are all well covered. Rehabilitation aspects emphasises consumer involvement and the need to prevent handicapped persons from stagnating in an isolated environment. More effective sharing of resources and better coordination is presented as the key. "Disabled people are in a new era of self-determination."

***5. British Columbia Medical Journal* — (Vol. 23, No. 9, September, 1981)**

This special issue with guest Editor Duncan Murray (Head of Division of Rehabilitation, British Columbia), gives an excellent review of modern rehabilitation. It includes all aspects of this wide field of disabilities from epiletics to cochlear implants and it should be read by all physicians interested in disabled persons.

Nova Scotia's Contribution to Assist the Disabled

Many major disasters have afflicted our inhabitants over the last two or three centuries. Soon after the original founding of the City of Halifax, two major outbreaks of cholera occurred. The Halifax explosion killed 1700 people and wounded thousands. Two World Wars produced hundreds of disabled veterans who survived the carnage of European conflict. Tuberculosis wreaked appalling havoc on the health of maritimers. Early this century the disease was so rampant, many schools were closed and an anti tuberculosis league formed. Kentville Sanatorium was opened to provide a sanctuary for victims.

The Vast Array of Crippled Children

In 1921, a review of childrens' health was undertaken in Prince Edward Island by a Red Cross Committee under direction of Mrs. McMahon. In 19 schools surveyed, 93% of the children had physical defects and 80% had defects other than teeth problems and 18% of children were underweight — the total number of defects was 455.

Tuberculosis was rampant and it was discovered that the use of the common drinking cup played a major role in the dissemination of this disease. Ignorance and superstition were major obstacles to Red Cross workers who visited afflicted children's homes. So common were skeletal defects that Dr. Tom Acker was invited to come to Halifax, to hold regular orthopaedic clinics and carry out corrective surgery on suitable patients.

Thus began a regular orthopaedic service which was inaugurated in 1926 and continued for three decades or more. At the first clinic children with dislocated hips, tuberculosis, rickets, wrynecks, club feet and victims of poliomyelitis all crowded together in a pathetic collection of untreated deformed humanity. Miss Wilson, a nurse who was present, described this as one of the "most tragic scenes I have ever encountered." Dr. Tom Acker and his brother Jack carried out regular clinics in the Maritimes and practiced orthopaedics for over fifty years. Dr. Tom, who is still alive, recollects vividly how he held clinics in Yarmouth, St. John's in Newfoundland, and Sydney in Cape Breton.

The 29th Annual Reunion Dinner of the Canadian Paraplegic Association, Nova Scotia Division, held on November 14, 1981, at the Lord Nelson Hotel, Halifax, N.S.

Front Row: Cathy Frazee, winner of the Dr. James W. Reid Memorial Award; Kenneth MacRae, Chairman of the Nova Scotia Division: Jamie Webber, winner of the Arthur D. Stairs Award.

Standing: Hon. Laird Stirling, Minister of Social Services, His Honour John Shaffner, Lieutenant Governor of Nova Scotia.

Milestones in the Management of Disabled

The Canadian Rehabilitation Council for the Disabled and the Recreation Council for the Disabled in Nova Scotia have played major roles in the management of children and adults with deformities and crippling disorders.

Rehabilitation

The Rehabilitation centre, under the direction of Dr. A. H. Shears, has recently celebrated its 25th year. Since moving to the new hospital facilities have been greatly expanded, and the prosthetic centre now provides modern orthoses and prostheses for which the cost is subsidised by the Provincial Government. An active recreation program is now organized by Linda Johnson.

Modern Developments

Despite the modern facilities and highly trained personnel now available there are still shortcomings in the care and prevention of disabilities. Technology still cannot replace humanity and our health services reflects some of the incongruities of our society. Indifference, abuse of alcohol, tobacco and drugs, isolation of the elderly, motor vehicle accidents are examples of the casual attitude of some individuals.

This *Bulletin*, however, welcomes some outstanding contributions in the management of disabilities.

Early Detection of Birth Defects

The importance of the early detection and prevention of neural and cerebral defects has become widely recognized. Dr. B. St. J. Brown presents an interesting method of detecting brain lesions by the use of ultrasonic imagery applied through the anterior cranial fontanelle. As this method becomes defined it promises to provide an accurate record of cerebral anatomy, its alteration by trauma, hemorrhage, and congenital defects. This will monitor appropriate treatment and thus limit the brain damage and permanent mental disablement caused by a variety of many conditions.

Early Detection of Hearing Defects

In few other disabilities is early detection so important as deafness. The general practitioner can play a significant role here. Parents are often aware that there is something wrong with their child and are afraid to contact their physician. They find it difficult to make him or her appreciate that there is a real hearing problem. Procrastination may mean the child may miss a vital period of learning and adaptation. Dr. Peter Owsley emphasises the inadequacies of our recent performances.

Although 71% of parents of children with impaired hearing were suspicious between birth and eighteen months, 58% of doctors delayed more than three months before confirming the parents' diagnosis. Only 4% of children enrolled in the Atlantic Provinces Resource Centre for Hearing Handicapped were less than one year old. 86% of the children being sent were more than 2 years old. Doctors should be familiar with the fact that up to 50% of deafness is due to genetic disease and, for a number of children, it is progressive. Common disorders, german measles, Rh incompatibility, upper respiratory illness account for the other 50% of deafness in children.

The World of Silence

The frustrations of impaired communications and the difficulties of growing up with a severe hearing impediment are vividly described by Elibabeth Doull. Technical devices are now of great help to people with hearing impediments and allow them to enjoy television, and the use of a telephone. Flashing signals are now available for them to respond to such devices as door bells and smoke alarms, and to crying babies. Anyone wishing to know more about these inventions or learn about our aspect of assistance from the deaf, should contact:

Metro Area Community Service Board for the Deaf
5185 Prince Street, Halifax, Nova Scotia. B3J 1L6

Overcoming Blindness

To most of us blindness would be a disaster. Yet certain individuals of outstanding spirit and adaptability have somehow made a wonderful adjustment. In Nova Scotia there are many blind people who walk to work and carry out useful lives. Eric Davidson for instance, blinded in the Halifax Explosion, worked as a skilled engineer for 30 years. In this *Bulletin* Mary Wookey tells her story of becoming a physiotherapist assisted by her wonderful seeing eye dog.

Neurological Disease

Paul Gouett gives a lively account of living with an unpredictable disability. Paraplegia, blindness and deafness are difficult enough challenges to live with, but in many instances these conditions are static. In Paul's case it is the erratic and personal variability of the condition which saps his enthusiasm and makes each day a difficult trial. A sense of humour is his most useful ally.

Amnesty International

The role physicians can play in helping alleviate torture and detecting those who have been tortured is presented by Dr. Paul Rosenberg. There are over 5000 members of Amnesty International medical group in thirty different countries. Despite the ferocity, cruelty and intransigence of many political regimes, Amnesty International's persistent efforts have bought considerable alleviation of suffering.

Workers' Compensation - A changing Scene

Dr. Ian Cappon brings his fresh and invigorating insight into the present and future roles of the Worker's Compensation Board. He points out that the vast catalogue of industrial diseases, whose onset is insidious but whose effects are crippling, may be the result of the employees' toxic environment. The Nova Scotia Board has 100 employees and processes some 32,000 claims each year.

He says that it is only because firm associations have not yet been established between occupation and disease that the present system works so well. 95% of recipients of total disability are disabled by disease not by accidents. The role that physicians could play and the likely astronomical increase in claims for occupational disease, brings a prospect which the medical profession and medical schools will have to face boldly.

Conclusion

The Year of the Disabled, originating as a proposal from the United Nations, will continue to have a profound effect on our attitude and behavior but will require persistent efforts of social workers, physicians, legislators and the disabled, to ensure that the **VOICE OF THE DISABLED** shall never fade. □

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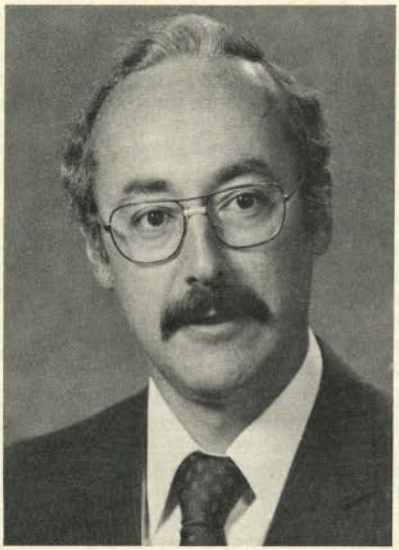
Dr. Murdock Smith

PRESIDENT

The Medical Society of Nova Scotia

1981-1982



Dr. Murdock Smith was born in Sydney in 1940 — a city he has called home ever since.

Although his formal education took him away from Cape Breton — Halifax's University of King's College and Wolfville's Acadia University with final graduation as a physician from Dalhousie University in 1969 — Sydney has remained just that from the day he entered general practice.

He is an active staff member of the Sydney City and St. Rita's Hospitals, serves as medical director of the city's Spring Garden Villa and is also staff physician at the Children's Training Center.

He has represented the Cape Breton Medical Society on the Executive of the Medical Society of Nova Scotia; has twice served as Executive Committee vice chairman and has also contributed a three-year term as chairman — all demanding jobs in the provincial Society's policy formulation and implementation sector.

Closer to home, he is a past president of the Cape Breton Metro Branch of the V.O.N., a past member of the board of directors of the Sydney Co-Operative Society, a director of the YMCA, a session member of St. Andrew's United Church, and a member of the Ashby Bridge Club.

Dr. Smith is married to the former Frances Johnson of Upper Stewiacke. He and Frances have four children — Helen, Kathleen, Murdock and Robert.

His favourite pastimes include his time with his family, playing bridge, reading and walking.

He also admits to a secret wish: "To find time to get back to playing the trumpet." □

Living With My Disability

Mary Wookey,* M.C.S.P.,
Bridgewater, N.S.

I was born in wartime Britain. My disability was realised when I was a baby; the diagnosis, bilateral chorioreninitis, with secondary optic nerve damage. This meant I had very little sight. The term used was light perception. It was realised after six months at the local village school, that I would have to attend schools for the visually handicapped, which I did until I was eighteen. We were all taught to read and write Braille, and further instructed through this medium. Other special aids were introduced as they became necessary. Our education followed the normal curriculum throughout junior and senior schools. There was a bias towards the arts subjects history, English and languages, as special aids for science and math subjects were not available then. Being away from my family at boarding schools from the age of five to eighteen made me fiercely independent, as I grew away from the family environment. I was determined to get a secure job.

One of the chief problems of the visually handicapped person is lack of easy mobility in unfamiliar and busy surroundings. From the age of five I have always made a point of becoming familiar with my everyday surroundings. I do it quickly and with as little fuss as possible. It makes life much easier. Often people have been unaware, or have found it hard to believe that I have so little sight. Once out on the street, it becomes very obvious. I have now overcome that problem with my Seeing Eye Dog, Nikki. She is a very special friend and companion. She has greatly increased my confidence and independence.

I learnt from my early days that if I wanted to know about objects and my surroundings, I had to use my hands to examine everything very closely. A blind person, who is curious, develops their sense of touch to a very high degree. Along side this, goes a good memory. A good memory and a skilled sense of touch are two great assets to the blind. This is particularly so in my chosen profession, physiotherapy.

The fact that I have a secure, professional job, am able to run my own apartment, which includes cooking, cleaning etc, and am able to do some of my necessary shopping, makes me feel I have come to terms with my handicap to a great degree. One continues to strive to overcome one's disability, continually.

When I left school I had gained eight subjects at ordinary level (O levels) and two at advanced level (A levels), History and English Literature. My first choice of career was to teach History, but I realised in my last year at school that the chances of achieving this ambition was very remote. I knew about the Royal National Institute for the Blind School of Physiotherapy, as some of my school friends had started their training there.

I requested to have a look around the school to see if this would help me sort out my thoughts. The school staff felt I would do well, and I was encouraged to go ahead with the training. The first year, I found that I did not really see the point of the course. I had no difficulty with the academic work, but found practical work boring. It seemed pointless carrying out treatments on my colleagues who were normal, healthy individuals. The big change came when we started hospital work, and were let loose on real patients. My first patients were a class of ladies with Colles' fractures. After three weeks of treatment, one of the ladies showed me a sweater she had knitted since her cast had been removed. I remembered how stiff and painful her hand had been. These first few weeks at the hospital changed the whole scene. I have always enjoyed my work since, and no longer had doubts about the course. My enthusiasm and interest at that time dispelled any doubts the school staff may have had about my suitability to be a future physiotherapist. I passed the Chartered Society of Physiotherapists final exam in November of 1963.

The Royal National Institute for the Blind School of Physiotherapy sets out to train blind students to become successful physiotherapists. The classes are small, six to eight students. There is no difficulty with the academic work. Students take their notes in Braille, or handwriting if preferred. Subjects like anatomy must be very exact. The practical work is done on a more or less individual basis. I used Braille for my lecture notes, and also made use of voluntary readers, who were readily available. Many of the students used tape recorders for recording their information.

I feel that one of the chief barriers for a blind person is the inability to read print. A big area of communication is cut off. The visually handicapped depends greatly on the spoken word. I sometimes find I have not heard about something important, because I could not read the notice board. My colleagues are very good about reading circulars, etc. One has to be fully informed to be successful. To succeed in one's work, a blind person has to work that much harder at it; and sometimes, if you are tired, etc, it is difficult to maintain the high standard you have set for yourself. I have found that several ways of being successful are; to be trusted to carry out my work with the minimal supervision; to be responsible, and to have a commonsense approach to new tasks given one. I always like to be punctual at work and appointments. Perhaps one of the most important ways to succeed is to show that you enjoy and care about your work. This has made a great difference to me.

There is always room for improvements, to make one's life easier. Most handicapped people would feel that easy access to public buildings would be very helpful. Ramps, which are appearing now, instead of steps, are both helpful to the wheelchair-bound and the visually handicapped, or those who have difficulty walking. Wider aisles in shops would make for much easier passage for all individuals.

I experience my greatest difficulties when I move to a new area. People do not know how to offer help. My disability becomes more of a frustration to me then, and often I am embarassed to ask for assistance. Often the general public

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feel they may upset you by proffering their assistance. On most occasions, I will accept help when it is offered, unless I am very sure of myself, and then I try to refuse it politely. The general public sees a lot of films and hear talks, but the best way to help the disabled is to allow them to integrate into normal society, and to be ready with assistance when it is requested, or when it is very obvious that it would be appreciated. I feel I have proved my ability to survive. Living in a small community has definite advantages. Government regulations, as far as I know, are fairly satisfactory, but I make one plea. The visually handicapped person has great difficulty with the paper money system in this country, and probably in others. I found in Britain I never had difficulty sorting my paper money, as each value is of a different size.

I know very little about research of eye conditions. It no doubt would be a wonderful thing if I could gain an increased amount of vision. At the same time, I would have a great deal of adjusting to do, and it would require a considerable amount of patience. There might be things I would be frightened of, the busy life of the city, with the constant flow of traffic. At present, I only hear it. It would be wonderful to get out into the country and see nature all around. □

My Silent World

Elizabeth Doull,
Halifax, N.S.

I am a deaf woman but I regard myself as an ordinary individual who strives hard to improve my skills and knowledge in order to cope well in the challenging hearing world. Maybe it is a different perspective in the eyes of the hearing world. There are things I will, of course, never achieve such as: obtaining full hearing, perfect flawless speech or the ability to follow every word spoken. Yet, I have mastered skills in the last two areas which allow me to function well in society.

I was born with profound sensori-neural deafness in both ears, for which the cause was unknown. There was no evidence of inherited deafness in our family except for my maternal grandmother who had problems in one ear since her early adulthood. At birth I had some residual hearing which enabled me to hear extremely loud sounds without the assistance of an hearing aid and also to hear voices with the help of amplification, even though I was not able to understand the words. Thus, vision naturally became the most important sense.

Now I do not use a hearing aid for a number of reasons. One was the inability to get used to it. Another reason was that a hearing aid is now of very limited use to me since I lost most of the residual hearing due to an ototoxic drug some years ago. In the end, I find that I prefer the quietness to the world of indistinguishable noises.

Deafness, for many people, means communication problems of varying degrees depending on each individual's background and factors imposed on him. It also means being cut off by the world which heavily relies on sounds for knowledge, exchange of ideas and feelings, enjoyment and relaxation. It means missing out on plays, music of many sorts, whims of weather, sounds of nature, radio, interviews on TV programs and of course ugly sounds of the traffic, factories and offices (that is where we are blessed for not having our hearing). One big advantage of deafness is that we deaf people can sleep soundly or concentrate on a good book. We do not have to listen to nagging people or arguments! But this is a very small part of one's life.

Deafness, for me personally, means unclear speech and the difficulty to be understood and to understand what is spoken. It is like being in a glass tube not being able to communicate with people effectively as I would wish. I believe my speech would have been clearer and more understandable if it were not for my teenage stubbornesses. I was sent to a nearby speech therapist but her Victorian matronly attutide turned me off and I screamed to be taken off the hook. I might have felt differently if I had a different therapist, one with a youthful and bubbly personality. My speech was very sorely neglected until I took some more therapy in Halifax and then continued on in Washington, D.C. Today my speech, at my best moments, is fairly clear especially to people who are accustomed to me. Strangers who have no experience with a foreigner, a person with speech impairment or a deaf person, however, have a great deal of trouble deciphering my speech.

Lipreading (also known as speechreading) helps a lot; and is a way of life for me in the hearing world. But I still have trouble following people who talk too fast, mumble or move their mouths unnaturally. Also the hardest people to understand are the ones who have teeth obstructions, or untrimmed moustaches or who chew gum. Lipreading is sometimes tiring or erratic when one is not alert. Only very few people master it excellently. The people I am best able to understand are those who take the trouble to speak clearly and a bit slower.

Just like a hearing person, I like to be understood as well as to understand what is said to me. When I have trouble making myself understood or understand what is said, then I prefer to resort to writing rather than to discard the idea of going on. After all, either the person I am talking to or I had something to say in the first place! Still, unless I know a person very well, I like important information or lengthy explanations or directions in written form to be really sure to avoid any misunderstanding. I really appreciate people who are willing to resort to writing or who take trouble to talk slowly.

Unlike most deaf people, I did not learn sign language till I was an adult. Once I gained these skills, I, of course, did not abandon my oral skills; I needed them to keep in touch with hearing people. I now mingle in both worlds: deaf and hearing.

In the hearing world, I prefer to talk on a one-to-one (or two) basis with hearing people while shying away from groups in which I miss a great deal of what is spoken. Trying to follow a conversation with more than one person is like following a ping pong ball bouncing back and forth.

But when I attend meetings, I use an interpreter for the deaf who signs and mouths words. I depend mainly on lipreading with signs as a secondary support; thus, reducing any vision fatigue. Lipreading alone is not an easy task; and being able to lipread and sign helps to insure that I have accurate information. But I do not use an interpreter in any one-to-one basis in any of my business or personal matters. I prefer to handle them on my own. I of course resort to writing when oral skills do not work.

Besides oral and signing skills, I depend on facial and body language to compensate for what is spoken in varying tones even though facial language sometimes does not tell you the truth. Some people cleverly put on a mask while giving sweet and flowery words. I also depend on vibrations for cues. For example, I feel the vibrations of a person coming in the office. The best of all, fortunately, is the printed word which compensates in some ways for a person's inability to hear. However, some sounds such as sounds of nature cannot be recorded or described on a piece of paper.

There are three important technical devices which help to compensate for my disability. The first one, a TV decoder makes captions (subtitles) visible on the TV screen. The captions are invisible without the device thus avoiding any

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distraction for a regular TV viewer. It is great being able to follow TV after twenty five years of merely looking at the moving pictures and making erratic or educated guesses about what is actually happening.

The second device is the Telecommunication Device for the Deaf (TDD) which enables me to use the telephone provided that the other party has a similar device. The TDD is connected to a boxlike coupler on which the receiver is placed to transmit and pick up what is typed on either side. Since the late seventies several portable devices which look like small typewriters or calculators have been developed. I still resort to asking hearing people to make calls to those who do not have a TDD.

The Kiwanis Club of Halifax donated a Vuphone to the Metro Area Community Service Board for the Deaf (MACSBD). The Vuphone is a portable Telecommunication Device for the Deaf (TDD) and provides a vital two-way link between the MACSBD and the deaf community. The Vuphone uses the regular telephone to transmit typed messages to and from people who cannot hear or speak.

The Vuphone will be used by the MACSBD to contact deaf persons with the information about job openings, appointment times and meeting dates. Deaf people will also be able to contact the MACSBD for telephone assistance in reaching hearing people.

Shown from left, are Elizabeth Doull, Information Officer MACSBD: Frank Nicks, Secretary, Halifax Kiwanis; John Moore, Eve Tupper chairman of the MACSBD, and Ken Dairymple, Treasurer, Halifax Kiwanis. (Wamboldt-Waterfield)

The third aid is something we deaf people cannot live without because it helps us to see sounds like the door bell, the phone ringing, the baby crying, the smoke detector, etc. It is a device with a bulb which flashes on and off in response to sound. There is even a flashing clock to help us go to work on time!

I began my education in schools and classes where sign language was discouraged or forbidden. There, I learned the art of lipreading, the skills of speech itself and of course the basics of reading, writing, science and other subjects. At the beginning I did not learn anything through lipreading and I was never able to learn by hearing with the amplifiers alone. I did absorb, like a sponge, anything which was printed. It was the only way I could learn and it remains my major source of information even today.

My best experience in the educational area was when I attended regular school for seven years. There, I discovered my English was far behind that of my fellow students because I had been in a deaf class and had only deaf students' English to compare with my own. We had been isolated from the hearing world; and we were content with the way we were. I learned quite a lot in my courses in regular school; and I enjoyed the other students. The drawback I faced especially in high school was the social life. It was not easy mingling with hearing students although I had quite a few good friends who understood my problems and had more patience. I found that sports helped me to make friends.

My social life improved by leaps and bounds when I went to Gallaudet College in Washington, D.C., where I received my B.A. degree. This college is designed for deaf students to study for the bachelor or masters' degrees in arts or science. There, the degree of accessibility is very high. Professors simultaneously moved their lips, used sign language and used their voices for the benefit of students of all backgrounds, making less work for us to decipher every word and a chance to digest what was spoken or discussed. The staff in the cafeteria, in offices and in the library were able to sign, too. Movies were captioned. The best aspect of all was the social life. There were thousands of students my type and my age whom I was able to communicate with freely. I learned sign language very quickly and soon spoke it fluently. I loved the social life. I found that I did not have to study my courses hard in Gallaudet as I did in my high school, probably because I was able to follow my professors and because the educational standards there were not probably as high as that in regular universities. I concluded however that I could not have both the social life and good education.

Still, it was not my choice not to hear and if I could wish for anything I would choose to hear! I would have selected a professional field probably in the legal, medical or educational area. I would not certainly be in the field of deafness which is about the only area many deaf people can choose if they wish to pursue a professional career. I am a 'people' person who likes to work with people, not with my hands or with routine paperwork. At present I am working in the field of deafness as an Information Officer. Working in this field is risky and uncertain, the duration of employment is precarious or temporary — a matter of months or a few years. Despite these hard facts I love my work.

There is a need of improvement of accessibility to overcome this disability. The TDDS should be placed in government offices, hospitals, and other vital areas so that we deaf people can call them directly just like the way hearing people do. The other need is to place flashing lights to help us see the alarm.

The other area which requires time, effort and public awareness is to help people become aware about the truth about deafness because we do not have room for pity. We want them to understand our problems and accept us for what we are. The worst part which we are trying to eliminate is the labelling of "deaf-mutism" and "deaf and dumb", regardless of the type of background we have. These words are degrading. Some years ago in the hospital one doctor-resident labelled me as a deaf-mute, not knowing about my background. I gave him a little lecture about this tendency to label us. I expect he has learned his lesson well today. . . Many deaf people can speak some words clearly; and most can even scream! □

For further information regarding technical devices contact Metro Community Service Board for the Deaf, 5185 Prince St., Halifax, B3J 1L6.

What? No Leg Bag!

Paul Gouett,*
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Indeed, the title of this piece is highly irregular but then, so is the disease!

I am referring to Multiple Sclerosis, the disease with which I am afflicted. It is "irregular" in that no two people with it exhibit the same characteristics at the same time. It is a degenerative illness that has no regard for set patterns of digression. Each case appears to march to a different drummer. It can effect one limb or all four. It can effect speech or eyesight, both together or neither. Bladder and bowel malfunctions can be caused or not. Sometimes it remits; other cases, never. It can be a slow progression of symptoms or one of immediate ravage. If anything can be said to be standard about it, it is that MS causes anxiety through its unknown pattern of development. You never really know at what stage you'll be tomorrow.

With that kind of prognosis for the future, multiple sclerosis develops a strange outlook in the individual. I really should only speak for myself but I do have a consensus opinion of fellow "afflictees" upon which to base my observation: for us, as is the case in most debilitating situations, there is no past. The memories of occurrences in our lives before our accidents, contractions or whatever are too painful. They are over and done with and cannot be relived in the same style. There is an added dimension to MS, however. In view of the extremely uncertain path of the disease, the future is clouded, as well. I, myself, only plan in terms of weeks or even days.

My reluctance to dwell on the past or to make long range plans for the future has, from time to time, created a certain amount of misunderstanding both in my wife and my friends. Fortunately, I no longer have to explain my sentiments in that area. It is an insular, somewhat selfish attitude, but I need it to get by. "Any port in a storm!" is the proper phrase for it.

There is nothing that adequately prepares you for the development of MS. Due to its unpredictable nature, "filling in" patients completely on the havoc may only serve to terrify them over something that may never occur in their case. It is certainly a difficult dilemma for the physician to face — whether to be brutally honest or somewhat superficial. It really depends on the doctor's assessment of that particular patient's ability to cope with the information.

One thing is definite, however: the medical people involved must make it perfectly clear that should any changes occur, the patient can contact them. Be supportive. Don't make the diagnosis sound as if, "This is the way it is. Now you must learn to live with it yourself." That is rather like a Pontius Pilot approach to medicine. In my own case, that is what occured. I was not made to feel that should anything happen with the possible progression of the MS, I was to contact someone in particular about it. I had it and that was that. As a matter of fact, I don't even recall the name of that neurologist. Such an important moment in my life and the man left so little impression that I recall nothing about him!

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People who have been most helpful to me over the past years are the physiotherapists and, in particular, the occupational therapists of the Nova Scotia Rehabilitation Center. They have provided me with a wealth of ideas for support techniques to make my life that much easier. They have taught me to adapt my manner of doing things by employing some aids and methods. It has paid off and, at this point in time, I am reasonably comfortable with my life.

I have found over the years that doctors in general do not advise you to contact other with similar afflictions. This may not be the rule in other areas of medicine, but it does seem to apply to MS. There is good reason for it, I think. I have personally never met anyone in my 10 years with multiple sclerosis who exhibits the same symptoms as myself. They are either in better shape or worse. This creates an amount of stress in me knowing that I can't climb back to an easier plateau, but I can slip down to a more severe one. Some people find it reassuring to see someone in worse straits than themselves. It gives them a chance to feel that things are not so bad after all. I personally can't buy that. "There but for the grace of God. . ."

I spoke of my friends earlier. That is an area which merits some discussion: many of my long time friends are very upset with the prospect of seeing me in my degenerated condition. At first, it was difficult to come to terms with, not seeing them and not understanding why. Now, however, it is much easier. I understand and feel no malice. I miss them but accept their feelings. It's also easy for me to cultivate new friends.

I was originally diagnosed as having MS in January 1972. At the time I was teaching high school in Ontario. The neurologist with whom I spoke told me that I had a mild case and that it would likely never progress. As I sit here in my electric wheelchair, typing with a stick, I realize that he was only partially correct — I do, in fact, have MS.

And how do I cope with this multilettered curse? Simply by maintaining a sense of humour. I don't mean to imply that the whole thing is a joke. It's just that often times situations arise that are difficult for one reason or another. To approach them seriously, with an indented furrow in one's brow, is psychological suicide. Avoiding stressful encounters is also helpful. Don't go to places where you know you're going to have access problems. Why create the hassle? Go to that dining room or theatre once, bring the problem to the attention of the owner or manager then, if there is no response, level both barrels.

There are several aspects to my invalid status which are extremely difficult to get around. One of them is the "Second Look Syndrome". Don't rush to your medical dictionaries to isolate the definition because one doesn't exist. The phrase is one of my own creation and refers to that momentary glimmer of interest shown by the opposite sex. I am not speaking of any great head snapping stare but just a casual glance. When you are in a wheelchair, whatever the reason may be, you are immediately written off as an object of any

sexual aspirations. It seems that if you are somehow in need of support in one way, you are dead in the others. That, of course, is not true. I am tired of being cancelled out. I am filled with as many needs and desires as the next person. Part of me, however, might as well be a bookend!

I am deviating further and further from some sort of serious treatise of my disease. The things which I mention, though, are serious concerns of mine. They are all side effects of my MS and as such must be dealt with along side it. People often say to me how easily I seem to accept my disease and get on with the business of living. That makes me feel very good even though it is not true. I may be able to smile but I've never truly "accepted" the multiple sclerosis. To do that would be like welcoming a killer brandishing his gun into my house. MS makes you do some pretty strange things but it doesn't make you stupid! □

The Canadian Medical Group and Its Efforts to Alleviate Torture*

Paul Rosenberg, M.D.,
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INTRODUCTION

The widespread use of torture as a tool of political repression in many parts of the world is alarming.[1] These gross violations of human rights are almost all contrary to the laws of the country concerned and international agreements. Amnesty International opposes torture in all cases and without reservation, and works for the release of men and women imprisoned anywhere for their beliefs, colour, language, ethnic origin or religion, provided they have neither used nor advocated violence.

The United Nations Commission on Human Rights has defined torture as the intentional inflicting of severe pain or suffering, physical or mental, by or at the instigation of a public official, on a person in order to obtain from him or a third party information or confession, punishing him for an act he has committed or is suspected of having committed, or intimidating him or other persons. Their definition excludes pain or suffering inflicted under lawful sanctions. This is contrary to Amnesty International's assertion that human rights are not subject to national laws, and that there must be a broader view of what constitutes torture. Torture is also dependent on the extent of its effect on the personality of the victim, not solely the suffering, and the use of psychotropic drugs should be regarded as included in the broad definition of torture.

Evidence of physicians abusing the healing role of medicine for the purpose of inflicting pain and suffering has emerged across the world, from the prisons of South America to the psychiatric wards of Eastern Europe.[2] Physicians are providing their services to facilitate the practice of torture, allegedly resuscitating victims to permit continued torture, administering harmful medicines, and incarcerating people under the guise of psychiatric commitment.

THE CANADIAN MEDICAL GROUP (C.M.G.)

The C.M.G. was formed in June 1978 by physicians from the Toronto area involved in medical examinations of refugee applicants. There are now about two hundred members throughout Canada involved in various activities. Members are largely physicians, but there are also nurses, dentists, and non-health care workers. The co-ordinator and executive committee are based in Toronto.

There are Amnesty International medical groups in thirty countries, with over 5,000 members. Originally advisors to Amnesty International and involved in travelling medical investigation teams, physicians realized that they had a broader role to play and organized into professional groups. Perhaps the most active is the Danish Medical Group, formed in 1974, with close liaison with their national medical association and their government. The C.M.G., due to Canadian immigration laws, the deterioration of human rights in this hemisphere, and the pattern of air routes that bring refugees from South America to our major cities, has had the opportunity to document many refugee claims of torture, in numbers second only to the Danish Medical Group.

GOALS OF THE C.M.G.

The original goals of the C.M.G. were to support imprisoned colleagues, sponsor resolutions condemning torture and sponsor formulation of specific codes of ethics for health care personnel, to increase our colleagues' awareness by publications, seminars, and conferences, to participate in Amnesty International medical missions and research, and to complete medical assessments for legal purposes, and provide ongoing treatment and rehabilitation programs for the victims of torture.

SPONSORING RESOLUTIONS

The work of the C.M.G. falls into five interrelated areas. The first is sponsoring resolutions concerning torture and codes of ethics. The ultimate protection against torture is human integrity and individual autonomy. The Declaration of Tokyo 1975, of the World Medical Association, was an initial step in asserting the physician's duty to act ethically and independently of political pressures. The Declaration of Tokyo reaffirms the physician's duty to act in the interest of his patient alone by not condoning or participating in torture, not providing premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment, that the physician not be present during any such procedure, and that he have complete clinical independence in care. It calls for support and encouragement of medical colleagues in the face of threats or reprisals.

Efforts are being made through the United Nations and the World Medical Association to extend the Declaration of Tokyo to provide mechanisms for implementation and enforcement of these stated norms of conduct. What is required is an affirmative obligation to make publicly known deviations from the standards, and provision of a mechanism for hearing appeals for those covered by the code.

Members of the C.M.G. have attended international conferences and seminars including those in Athens, March 1978, in Copenhagen, December 1979, and at the World Medical Association meeting, January 1980.

MISSIONS TO OTHER COUNTRIES

The second area of work is as participants in missions to other countries, to investigate or publicize problems there. C.M.G. members have attended a discipline hearing in Brazil

*As presented at the Ronald St. John MacDonald Symposium of the John E. Read International Law Society, Dalhousie Law School, Halifax, N.S., March 25, 1981.

in February, 1980, respecting a physician accused of falsifying reports of maltreated prisoners and falsifying a death certificate, and participated in missions to Chile and to Columbia.[3] The information gathered on these visits is important for the work of Amnesty International and is used to focus international attention on human rights violations in these countries.

EDUCATION AND RESEARCH

Efforts to foster awareness amongst the medical community are an initial step in shaping public opinion and combatting torture. Articles have been published in prominent medical journals,[4] and grand rounds at hospitals have been presented on torture related subjects. My own involvement with the C.M.G. began when I attended the October 1979 workshop on the Medical Aspects of Torture, and was encouraged to start doing medical examinations of refugee applicants.

Research into the physical and psychological sequelae of torture on epidemiological and pathological bases is ongoing. The Anti-Torture Research group was founded in November 1978 as an independent supplement to the Amnesty International medical groups and is responsible for the research efforts. It is hoped to have a "torture syndrome" recognized, analogous to the "child abuse" syndrome, as this would greatly aid victims not only in their claim for asylum, but also in rehabilitation, as evidence that fits into known patterns of torture would be more readily accepted when definite causation is impossible to prove.

LETTER WRITING CAMPAIGNS

The fourth area of activity is in letter writing campaigns, mostly through the Amnesty International urgent action network. C.M.G. members are enlisted to write on behalf of other health care workers and prisoners of conscience with urgent problems, usually related to their health. There are also campaigns of a more general nature, as those protesting deaths in the Uruguayan prisons and against Pakistan's reintroduction of the Islamic punishment of Sharia (amputation of limbs as punishment, performed by surgeons). A member might write a letter each month in the urgent action network.

REFUGEE WORK

The final area of involvement is in refugee work. A refugee by the United Nations Convention and by our Immigration Act is a person outside the country of his nationality who has a well-founded fear of persecution from the authorities of that country, due to his race, religion, nationality, membership in a particular social group, or his political opinion. The onus is on the refugee claimant to prove this, and he often has difficulty with his credibility being questioned, and with a lack of extrinsic evidence to substantiate his claim. Medical reports are useful at the initial examination under oath or during further appeal, to corroborate the refugee claim. Protocols for examinations have been devised, about three hundred systematic medical examinations have been completed, and a series of case histories published.[5] In a number of cases claims of torture have been substantiated through physical and psychological evidence, and the applicants granted refugee status.

Voluntary medical services for torture victims also provide the first therapeutic outlet in many cases, as the victims are able to recount their experiences. Further treatment is limited in some provinces by the victim's ineligibility for medicare, deferred until refugee status is obtained, often after one half to two years have gone by. Debilitating neurological and orthopedic problems are not treated, and other problems, such as peptic ulcer disease, are not investigated.

EFFECTIVENESS OF THE C.M.G.'S EFFORTS

Progress is being made in the areas of C.M.G. activity. Letter writing is believed to be an effective method for alleviating torture. Although direct confirmation is difficult to obtain, the urgent action network finds that about one fifth of prisoners for whom they campaign eventually are released, and the conditions of another fifth are improved. Anecdotal reports by many prisoners credit letter writing as an essential factor in their survival. Medical missions have led to documentation of human rights violations and focussed international attention on offending governments. Work continues to formulate codes of conduct for the medical profession. Medical and dental services have been provided for over three hundred refugee applicants in Canada, and those claims corroborated by medical evidence have been considerably more successful in gaining refugee status than unsubstantiated claims. Research into the physical and psychological sequelae of torture is being carried on internationally, and the C.M.G. is analyzing the systematic medical examinations made. Through publications and seminars the Canadian medical community has been presented documentation of torture, protocols for medical examinations, and discussions of the sequelae of torture.

I hope that if the work of Amnesty International interests you, you will become involved by contacting your local Amnesty International group. Those health care workers who wish to participate in any of the activities of the C.M.G. that I have described are welcome to join in our efforts to alleviate torture. The mailing address for the C.M.G. is as follows:

Amnesty International
10 Trinity Square
Toronto, Ontario

The newly formed Canadian Legal Group can also be contacted at this address. □

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Early Diagnosis of Hearing Loss in Children

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It is extremely important that a hearing impaired child be diagnosed early. During the first few years of life the physical, intellectual, emotional development of a child is characterized by its malleability or adaptability and openness. Research in the field of psychology of learning has shown that opportunities for the early improvement of a handicapped child are greater the sooner the handicap is detected and educational intervention is started. Measures taken in this respect offer an opportunity of preventing impending handicaps as well as counteracting handicaps which are in process of development in good time, so that their long term effects can be reduced. Detection and improvement during the first year or even during the first few months of life are of paramount importance.

The provision of hearing aids and auditory education offered in early childhood to hearing impaired infants has demonstrated that early intervention with amplification can contribute to a more normal development of speech and language.

The main pre-requisite for a multi-disciplinary diagnosis is the early detection of high risk infants as well as of handicapped infants. Löwe[3] stated in 1978 that Ciwa Griffiths and Judith Ebbin reported their research on the effectiveness of early detection at the HEAR Center at Pasadena indicating that, "The most significant outcome was the demonstration that early intervention with amplification revealed a critical period of hearing under eight months age level. This indicates the prime importance of early indentification and intervention, since hearing levels change to normal response with 67% of those under 8 months of age and 0% changed with intervention beginning after eight months of age."

According to new human genetic research studies, about half of all hearing impaired children are suffering from hereditary disease deafness. This means that the ratio between genetic deafness and acquired deafness is about 1:1. Among approximately 50% of hearing impairments caused by genetic factors there are a considerable number of cases of progressive deafness. Many of these children only suffer during their first and second years of life from a slight or mild hearing loss before they lose most of their hearing. It should be possible during preschool years to offer them a far reaching speech and language development if we could only succeed in identifying them in time as hearing impaired, and if we provided an early emergency education program for them.

Löwe[3] suggested that the exploitation of two important biological factors is at stake in the early education of hearing impaired children. These factors are the phase specificity of the sensory development and the great malleability of the infantile brain. Phase specificity of the sensory development means that the different sensory systems can only fully unfold or, in the case of a hearing impairment, gain their possible functional proficiency if they are intensely stimulated at the time of their maturation, during which the period of stimulation is limited. The term malleability on the other hand means that the compensatory potential of the brain is essentially greater in early infancy than in later periods.

Most children who are normal, intellectually and emotionally and physically, will usually learn speech and language by the age of two years, if they are constantly exposed to meaningful speech and language from the time of their birth by their parents. Unfortunately, the child with a hearing loss impairment will not develop speech and language. Unless the child's hearing loss is detected by six months to one year of age and a program of parent education and home training initiated to help the child develop speech and language, such a child may never develop understandable speech and language.

How well are we doing in Atlantic Canada in terms of the early detection of hearing loss in children? Statistics based on enrolment in parent education and home training programs at the Atlantic Provinces Resource Centre for the Hearing Handicapped strongly suggest we are not doing well. The following table demonstrates this graphically:

CHILDREN ENROLLED IN PARENT EDUCATION PROGRAMS OPERATED BY A.P.R.C.H.H.: 1980-81

Province	Age Range	Number of Children
New Brunswick	0-1 yr.	0
	1-2 yrs.	3
	2-5 yrs.	17
	Total:	20
Nova Scotia	0-1 yr.	2
	1-2 yrs.	2
	2-5 yrs.	25
	Total:	29

Only two children or 4% of the total number of children enrolled in the parent education program are less than one year of age. Five children or 10% are between one and two years of age. Forty-two or 86% of the children being served are more than two years of age.

In a study by Canning[1] in Atlantic Canada of the interaction of parents of hearing impaired children with the medical profession during the diagnostic process, 71% of the parents reported they were suspicious of a hearing loss in their child between birth and eighteen months of age. Although 58.2% of the doctors delayed up to three months before confirming the parents diagnosis, other physicians delayed up to a year (20%) and 21.8% did not make the diagnosis until from one to six years later.

*Director, Atlantic Provinces Resource Centre for the Hearing Handicapped, P.O. Box 308, Amherst, N.S. B4H 3Z6

Canning's study also revealed that parents were critical of medical care during the diagnostic process in terms of (1) what they were told, examples: "Don't worry", "He's a late developer"; and (2) how they were told their child was hearing impaired, example: Inadequate explanation. Not encouraged to ask questions. Never saw a report.

It has been the writer's experience that parents of hearing impaired children are probably the best diagnosticians of the hearing loss of their children because they are with the child more than anyone else and can observe him on a day-to-day basis over a long period of time. Time and time again parents have told the writer that they discovered their child's hearing loss at somewhere between birth and one year and then spent the next two or three years trying to convince the family doctor that their child indeed did have a hearing loss.

Interested and observant parents will discover very early in their child's life that he does not hear normally if they find that they cannot answer the following questions affirmatively during the first three months of life, according to Duffy[2].

1. Do loud sounds and strange sounds startle, frighten or amuse him?
2. Does he respond to his mother's voice before he sees her during the months from four through six?
3. Does he respond to the sound of footsteps approaching his crib?
4. Does he turn his head to localize the sound, especially his mother's voice?
5. Does he respond to familiar sounds in his environment such as the ringing of the telephone or the doorbell, the barking of a dog, or the voices of his sibling?
6. Does he repeat any sounds that he hears other people in his environment making?

During the months from seven through twelve:

1. Does he show understanding of language, made important to him through experiences such as the names of foods, pets, toys, family members?
2. Does the child follow simple commands?

During the year from one to two:

1. Does the child have a jargon or gibberish which sounds like he is trying to imitiate the sounds and infectional patterns of the speech he hears around him?
2. Does his voice quality sound normal?

During the year from two to three:

1. Has the child's understanding of language increased, and does he follow more complex commands than he previously did?
2. Has he started to speak, and has his vocabularly increased?

From the health history of the parents and the baby and an examination of the child's ears, nose and throat, the doctor may discover that a child has a hearing impairment. If the doctor is alert to some of the causes of hearing loss in infants such as: German measles during the first three months of pregnancy; Rh incompatability; birth injuries; the toxemia of childhood diseases like measles, influenza, mumps; upper respiratory and subsequent middle ear infection; closure of the Eustachian tube by enlarged adenoids; the toxic affects of certain drugs and inherited deafness, he will be suspect of the child having a hearing loss. If the doctor shares the fears with the parents about the child's hearing, knowing how vitally important hearing is to a child, he will not take these suspicions lightly.

If there is any question at all of a hearing loss, the doctor can refer the child to a hearing and speech clinic or to the Atlantic Provinces Resource Centre for the Hearing Handicapped, Amherst, Nova Scotia, for an in-depth evaluation of the child's hearing by audiologists/educators of the deaf. It is imperative that hearing handicapped children be detected prior to age two so that an educational program can be implemented and speech and language developed. □

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THE MEDICAL SOCIETY OF NOVA SCOTIA

PROCEEDINGS OF

17th MEETING OF COUNCIL

and

128th ANNUAL MEETING

November 20-21, 1981

INTRODUCTION

These Transactions are a summary of the decisions made by the Medical Society at its Annual Meeting. They are not a reprint of the Reports to Council. Should additional information and detail be required, the Reports are available through the Society office (453-0205).

The 17th Meeting of Council began as the Medical Society Officers accompanied by Dr. G.C. Jollymore, Nova Scotia Representative to the C.M.A. Board of Directors, representing Dr. Leon Richard, President of The Canadian Medical Association, paraded through Council Chambers to the head table. Following call to order by Dr. G.H. Ross, Chairman of the Executive Committee and General Council, the Officers were introduced and Dr. Jollymore extended greetings from The Canadian Medical Association. Dr. Jollymore, on behalf of Dr. Richard, wished Council well in its deliberations and noted that Dr. Richard would be available to participate in the meeting upon his arrival later in the morning.

Dr. Ross welcomed the Exhibitors and recognized their contribution to the Annual Meeting. He encouraged Council Members to visit the displays and discuss the products and services with the representatives. Dr. Ross extended the Medical Society's invitation to the representatives to attend the Banquet and Ball on Friday evening.

Council began as Mr. D.D. Peacocke, Executive Secretary, read the names of Society members deceased since October 1, 1980 as follows: Dr. James T. Balmanno of Yarmouth; Dr. J. Bruce Crowe of New Glasgow; Dr. H. Kenneth Hall of Halifax; Dr. Alan McD. Lawley of Digby; Dr. Wilfred MacIsaac of Margaree Forks; Dr. Seymour G. (Bud) MacKenzie of Truro; Dr. Roy A. Moreash of Halifax; Dr. Jeptha S. Munro of North Sydney; Dr. J. Arnold Noble of Tantallon; Dr. Willard C. O'Brien of Wedgeport; Dr. Harold A. Ratchford of Scarborough, Ontario; Dr. Louis R.G. Rustige of Mahone Bay; Dr. H. Leslie Stewart of Halifax; and Dr. Russell C. Zinck of Lunenburg.

The Transactions of the 16th Meeting of Council and the 127th Annual Meeting (1980) as printed in the December 1980 issue of The Nova Scotia Medical Bulletin were approved.

ALLIED HEALTH DISCIPLINES COMMITTEE REPORT: Dr. A.H. Shears reported that his Committee, struck to support C.M.A. activities relating to monitoring the development and emergence of allied health professions' activities as they relate to the practice of medicine, had only recently become organized and active. The importance of this Committee, particularly in relation to protection of the public as well as the practice of medicine itself was stressed.

ARCHIVES COMMITTEE REPORT: Dr. W.A. Ernst provided Council with a detailed resume of the activities of his Committee. He encouraged members to contribute to the collection and preservation of medical records and memorabilia.

Pointing to the earlier contribution by the Society of $11,250.00 for archival activities, Dr. Ernst raised the matter of increasing costs of this program. Council approved his recommendation *"THAT The Medical Society of Nova Scotia contribute an additional $500.00 for the purpose of maintaining and cataloguing medical historical material for the year 1981."*

BY-LAWS COMMITTEE REPORT: Dr. C.H. Reardon's report that his Committee had not examined any By-Law issues during the year was received for information.

CHILD HEALTH COMMITTEE REPORT: Dr. R.F. Gunn reported on the studies his Committee had conducted during the past year relative to inclusion of first-aid training for teachers and adequacy of first-aid facilities and equipment.

Council approved the following resolutions: (1) *"THAT The Medical Society of Nova Scotia bring to the attention of the Nova Scotia Department of Education that there are severe discrepancies in Nova Scotia universities which are producing teachers, in regard to preparing the prospective teacher with basic training in first-aid to assist the sick or injured child."* (2) *"THAT The Medical Society of Nova Scotia recommend to the Department of Education and School Boards in Nova Scotia that regular refresher courses in first-aid be provided for teachers."* WHEREAS in many Nova Scotia schools first-aid equipment and facilities are inadequate, (3) BE IT RESOLVED *"THAT the Medical Society recommend that School Boards be required to provide back boards and first-aid kits, and if labs are present, also fire blankets, drench showers and eye washes."*

Discussion relative to these resolutions was extensive and the suggestions raised by Council members will be recognized as the submissions to appropriate authorities are prepared.

COMMUNITY HEALTH COMMITTEE REPORT: Dr. D.C. Brown reported that his Committee had met several times to discuss the subject of Health Hazards of Uranium Mining. One meeting was with Mr. David Nantes from the Government Select Committee on Uranium Mining, and Dr. Wm. H. Thurlow who has been active in this issue for some time. The British Columbia Medical Association Environmental Health Committee publication "The Health Danger of Uranium Mining and Jurisdictional Questions" was the basic document utilized by the Committee in its examination of the problem. Council examined the background of the issue as set out in the following:

> "WHEREAS preliminary exploration for uranium has started in Nova Scotia and survey teams are working on claims near agricultural lands and populated areas and,
>
> "WHEREAS mining and milling of uranium involves production of hundreds of tons of radioactive waste or 'tailings' for every marketable ton of uranium oxide and,
>
> "WHEREAS no technology exists to prevent the radioactive waste from the tailings ponds from contaminating the water supply — e.g. the most hazardous of the many radioactive

elements in such water is radium — 226, which is readily absorbed by algae, fish, and other aquatic life, and

"WHEREAS the radioactivity associated with these tailings remain dangerous for over 100,000 years, and

"WHEREAS a study of air quality of houses in mining communities in Elliott Lake and Bancroft, Ontario and in Uranium City, Saskatchewan, showed that 15-30% of the houses had higher than permissible levels of radioactive radon daughter products, and

"WHEREAS uranium miners are at a much greater risk (ten fold) of developing lung cancer, and

"WHEREAS Preliminary drillings contaminate water tables and the biosphere and no technology presently exists to contain the radioactive wastes,

"BE IT RESOLVED *THAT The Medical Society of Nova Scotia inform the Government of Nova Scotia of its concerns for the health of Nova Scotians with respect to proposed Uranium Mining and exploratory drilling,*

"THAT nothing shall be done which would endanger the future health of Nova Scotians,

"THAT no mining or exploratory drilling proceed until technology has been developed to adequately and acceptably contain this contamination, and

"THAT the Society offers its assistance and co-operation in studying further this potential health hazard for the purpose of protecting the future health of all Nova Scotians."

PHYSICAL FITNESS SUBCOMMITTEE REPORT: Following Dr. B.R. Wheeler's report on the activities of the Physical Fitness Subcommittee Council approved three recommendations reading: (1) *"THAT Grants ($500.00 each) to the sports of cross-country skiing and orienteering be continued for at least another year."* (2) *"THAT The Medical Society of Nova Scotia sponsor an award for non-smoking areas in restaurants in co-operation with the appropriate Branch of the Nova Scotia Government, The Nova Scotia Lung Association, and the Nova Scotia Cancer Society."* and (3) *"THAT The Medical Society of Nova Scotia recommend to the Federal and Provincial Governments that advertising for cigarettes be prohibited."* Additionally, Council endorsed the Subcommittee's Report on Physical Education in Schools which included the following recommendations to be presented to the Provincial Government and to individual school boards: (1) *"THAT physical education in schools be compulsory,* (2) *"THAT physical education in schools be on a daily basis,* (3) *"THAT physical education be sufficiently intense and last for long enough to produce a training effect,* (4) *"THAT physical education classes be sufficiently enjoyable and variable as to encourage students to continue some kind of physical activity after leaving school,* (5) *"THAT public schools, School Boards, and the Department of Education should be encouraged in the idea that physical education is not a frill but an essential part of education."*

CANCER SUBCOMMITTEE: Dr. Allan Pyesmany's report noted that his Subcommittee had been involved in ongoing liaison with the Cancer Society in discussions relating to establishment of non-smoking areas in restaurants and Uranium Mining.

NUTRITION SUBCOMMITTEE: Dr. C. Noel Williams' report made reference to the investigations during the past year into the operation of the Permanent Weight Control Clinic. Decisions relative to this issue were reported elsewhere by the Executive Committee Chairman.

EDITORIAL BOARD COMMITTEE REPORT: Dr. B.J.S. Grogono's report was presented to Council by Mr. Peacocke because of Dr. Grogno's absence at a national conference of medical journal editors in Toronto.

The report noted that the Bulletin faced an increased charge for publication but vigorous efforts were being made to offset fees increases by economies in the printing and publication process. Council approved his recommendation *"THAT financaial support continue for the following year on the understanding that every effort will be made to keep costs down to acceptable levels."*

Mr. Peacocke reported on plans for future issues of the Bulletin. He extended on Dr. Grogono's behalf a request that more physicians involve themselves in the Bulletin by contributing articles or in any way which suited their experience and expertise.

ETHICS COMMITTEE REPORT: Dr. R.T. Michael reported a quiet year for his Committee with no recommendations to present to Council

EXECUTIVE COMMITTEE REPORT: Dr. Gerald H. Ross' report presented a concise, comprehensive summary of the actions and decisions of the Executive Committee during the past year. Dr. Ross highlighted some of the events which he felt might be of particular interest — for example, Dr. G.R. Forbes of Kentville, and Dr. J.C. Wickwire of Liverpool were named Senior Members of The Canadian Medical Association; the Executive Committee supported the widely held stand against elimination of the practice eligibility route to Certification in the C.F.P.C., and formation of the Sydney Medical Society. Council approved the Executive Committee's recommendation: *"THAT The Medical Society of Nova Scotia endorse and authorize the formation of a new Branch Society to be known as the Sydney Medical Society, and THAT this Sydney Medical Society have the rights and privileges and powers of Branch Societies as outlined in the By-Laws of The Medical Society of Nova Scotia."*

Continuing, Dr. Ross noted that the Executive Committee had reactivated the Public Relations Committee which would be comprised of a representative from each of the Branch Societies.

Dr. Ross reported that the Executive Committee had approved a proposal that the composition of the Nominating Committee be altered to provide for one member from each Branch Society. Dr. Ross presented as a motion the following notice which had appeared, as required by the By-Laws, in the Nova Scotia Medical Bulletin — *"THAT Sections 12.3.1.1 and 12.3.1.2 be deleted from the By-Laws of The Medical Society of Nova Scotia and a new Section 12.3.1.1 be inserted which would read: 'The Society shall at its Annual Meeting elect from its members a Nominating Committee for the ensuing year which shall be made up of one member from each Branch in the Society. The President of the Society if present shall be the Chairman thereof. Each Branch in the Society is entitled to nominate from its members who are in good standing in the Society one member as an alternate to the Nominating Committee. These nominations shall be made in writing to the Executive Secretary six weeks prior to the date of the Annual Meeting of the Medical Society.'"* This proposal was subjected to vigorous debate as to the pros and cons of changing the representation from the various Branches which is currently based on, to a degree, population. Responding to a query as to whether or not the By-Laws Committee had presented a recommendation relative to this proposal, Mr. Peacocke informed Council that the Committee had been kept informed and had had every opportunity to comment but in reporting to Council the By-Laws Committee had made no reference to the subject. The recommendation was *"REFERRED to the By-Laws Committee for consideration and report to Council 1982."*

Concern was expressed regarding the appointment of members to the Nominating Committee with the view being expressed that in many instances it was the most junior physician in the Branch. It was the general concensus that there should be criteria established relative to this point to ensure that those representing the Branches and selecting future Officers of the Society should be experienced members. The By-Laws Committee is to be asked to consider this aspect as well.

Dr. Ross indicated he believed it was an appropriate time for the Medical Society to review the subject of Rules of Procedure. Council approved the following resolutions: *"THAT the By-Laws Committee*

review "Bourinot's Rules of Order" third revised edition as a basis for procedure and rules of order for meetings of The Medical Society of Nova Scotia," and *"THAT the recommendations of the By-Laws Committee be brought forth to the Executive Committee and then to the 1982 Annual Meeting, with a suitable Notice of Motion of By-Laws change to appear in the Nova Scotia Medical Bulletin if necessry."*

EXECUTIVE SECRETARY'S REPORT: Mr. D.D. Peacocke expressed his appreciation to the Society for the support he had received from the committees and members, and recognition of the staff for their loyal and dedicated service. He noted that the Physicians' Memorial Fund continued to grow but at a very slow rate. In spite of this, it had finally got to the position where it could undertake activities relating to its objectives. He concluded his report with an expression of concern regarding non-membership in the Society. He urged Branch officials to approach this problem with increased vigor to reduce the numbers to a bare minimum.

FINANCE COMMITTEE REPORT: Dr. W.C. Acker reported that the Executive Committee had approved the operating Budget for Fiscal Year 1982 as it appears in Reports to Council.

Council approved two resolutions relating to the Financial Statements reading: *"THAT the Financial Statements of The Medical Society of Nova Scotia for Fiscal Year 1981 be approved."* and *"THAT H.R. Doane and Company be retained as the Medical Society auditors for Fiscal Year 1982."*

Dr. Acker reviewed the details of membership dues increases over the past several years noting that they had been miniminal and at this time, the membership dues for Nova Scotia were the lowest for any division in Canada. He pointed to the need for increased finances in the years ahead for such items as rent in the order of $32,000.00 per year plus for expanding operations. Council approved the following resolution: *"THAT the membership dues for Ordinary Members of the Medical Society for Fiscal Year 1983 which commences October 1, 1982, be increased from $275.00 to $375.00,"* and *"THAT the dues for the other categories of memberhsip be increased by the same percentage."*

Regarding the move to Young Tower, there were questions regarding the future plans of the Society relative to buying or building. Dr. Acker indicated that it is intended that this will be given active consideration in the near future to ensure that appropriate plans are in place prior to the termination of the five-year lease.

HOSPITAL & EMERGENCY SERVICES COMMITTEE REPORT: Dr. J.W.I. Morse informed Council that his Committee had dealt extensively with proposals regarding TYPE III CARE in Nova Scotia, had met with the Executive Committee regarding this, and submitted a summation of these discussions to the Department of Health for consideration as plans develop.

MATERNAL & PERINATAL HEALTH COMMITTEE REPORT: Dr. Leo J. Peddle told Council that the problem relating to protection of physicians involved in deliberations regarding mortality events continues to be a problem. Attempts are being made to have Government amend the Provincial Statutes so as to provide this protection.

Dr. Peddle's report included an outline of the activities of the Reproductive Care Group as well as utilization of various subprograms which are offered.

Most importantly, the report included statistics on perinatal mortality in Nova Scotia. The data show the highly significant reduction in mortality during the period 1969-1980. The low perinatal mortality rate of 8.7 in 1980 is now one of the lowest in the World. The Chairman congratulated all physicians involved in obstetrical and neonatal care throughout Nova Scotia.

MEDICAL EDUCATION COMMITTEE REPORT: Dr. M.S. McQuigge reported that a principal point of concern for his Committee was the low level of communication and information exchanged between The Canadian Medical Association and Nova Scotia committees dealing with educational matters. Council approved his recommendation *"THAT the Nova Scotia representative to the C.M.A. Council on Medical Education also sit on the Medical Education Committee of the Society."*

MEMBERSHIP SERVICES COMMITTEE REPORT: Dr. David M. Andrews provided Council with a resume of the various activities and programs his Committee provides on behalf of Society members.

Dr. Andrews added that because of the rapidly changing world of Term Life Insurance his Committee was actively evaluating the Society's Program to see if changes to improve the coverage are necessary. He expected that his Committee would be making a full report on this during the forthcoming year.

Dr. Andrews concluded his report with reference to the Investment Club which is beginning to get off the ground. His Committee felt that this would be an important area of interest for many of its members, and it would be provided whatever support is possible.

OCCUPATIONAL HEALTH & REHABILITATION COMMITTEE REPORT: Council approved the following resolutions arising from Dr. Prossin's report. These are: (1) *"THAT the subcommittee chairmen of this Committee meet with The Medical Society of Nova Scotia Executive Committee soon to discuss some urgent concerns arising out of our work, discussion and developments during the past few years — such as:* a) *Education programs for physicians and others;* b) *Our role in stimulating development of health and safety systems in industry;* c) *A seminar or whorkshop with continuing medical education on Occupational & Environmental Health Update which would include concerns, new development systems and the leadership role of the Medical Society, etc.; and* d) *Further discussions with the Workers' Compensation Board, the Nova Scotia Federation of Labor, the Nova Scotia Manufacturers' Association, or Board of Trade, and the Government with the aim of development of a more comprehensive and correct system for dealing with the occupationally injured and disabled."* (2) *"THAT physicians be encouraged to consider the possibilities of vocational retraining before the patient has reached the point where the only solution seems to be application for Family Benefits."* (3) *'THAT physicians continue to upgrade the way in which they provide information when the possibilities for vocational rehabilitation are being assessed."* (4) *"THAT the subcommittees continue to encourage and support ongoing liaison with the Workers' Compensation Board."* and (5) *"THAT the Committee recommend medical education in the universities regarding the role of the physician in workers' compensation."*

Arising out of resolution number (3) was lengthy discussion relative to completion of forms and demands made upon the practicing profession by third parties. The view was strongly expressed that the satisfactory completion of forms was likely closely related to whether or not physicians receive compensation for so doing. Examples were presented of monumental requirements being placed upon physicians' time with absolutely no compensation contemplated. Arising out of the discussions was the following resolution: *"THAT the Committee recommend that an adequate fee be paid by the third party requesting the completion of the form referred to in recommendation* (3)."

Dr. Prossin's report on the Workers' Compensation Board Liaison Subcommittee indicated a relatively inactive year with plans for involvement in development of rehabilitation and occupational training programs.

PHARMACY COMMITTEE REPORT: Dr. T.J. Marrie's report summarizing his Committee's work during the past year was received for information. There were no recommendations included.

PRESIDENT'S REPORT: Dr. Alan J. MacLeod's report, exclusive of the Economics Committee portion of it which was presented by Dr. B.M. Chandler, follows in its entirety.

The year 1980-81 has been a busy one for your Officers and Executive Committee. Professional life is becoming more difficult and more demanding of the physician's time, effort and tolerance. More people and organizations are influencing the delivery of medical care, and your Society must be vigilant in monitoring these influences and reacting appropriately on your behalf. Also, many participants in the health care field present their problems and proposals to the Society for evaluation and advice. Even where there is disagreement in philosophy or fact, there is benefit to be derived from such communication. I cannot over-emphasize the importance of identifying and studying carefully every proposal and action that has the potential of affecting the delivery of medical care.

The Executive Committee Meetings were very gratifying to me and I see it becoming more representative of our members' views and more effective in debate. It is essential that each Branch select its most concerned and determined members to represent it on the Executive Committee. The individual member's responsibility is to study important issues carefully and debate them with fellow members so that their resolution will serve our profession and benefit our patients. It is also important that Branch Representatives on committees and assignments — e.g. the Nominating Committee, be chosen for experience, keen interest, and knowledge of Society memberhsip and history.

The Economics Committee, under the new Chairman, Dr. Brian Chandler, has worked long and hard on your behalf with the able assistance of our Economic Advisor "Doc" Schellinck. I can assure you that their task is frustrating and difficult, to say the least, as they negotiate with bureaucrats who can alter strategy at will, and who have no real motivation for the early settlement of our Tariff Review.

Over the past two years I have greatly enjoyed my visits to the Branches, and I am becoming more hopeful that attendance, discussion and input to the Society are increasing — for our professional survival it must! I earnestly ask every member to take an active part in Branch Meetings and to encourage fellow members to do the same. I believe that mutual understanding, derived from well-prepared debate, is the soundest base for Society strength and integrity. I know that it has helped me very much in facing our problems in these difficult times.

In January your Officers met with a representative group of Hospital Administrators and Trustees from across Nova Scotia. Very good position papers were presented outlining the roles, skills, prerogatives and objectives of each group. Frank discussions followed and summaries were written which will form a good baseline for future meetings. All agreed that the meeting was very worthwhile and that communication and understanding were greatly improved — to such an extent that a unanimous decision was reached to continue meeting on an annual basis. It must be remembered that these three groups — Physicians, Administrators and Trustees — carry the highest responsibilities for a good deal of health care delivery at the community level.

I need not remind you that discussions and meetings relative to the Parliamentary Task Force on Established Program Financing ranked high among the duties of your Officers. First, a presentation was made to the Task Force in May, and after the Report was released in late August, I went to Ottawa to a C.M.A. Conference called to study the Report and prepare our response. Your Society and the C.M.A. have gone to considerable lengths to provide you with summaries and arguments relating to the Task Force Report itself and to the Position of the C.M.A. and your Society. Please study these Briefs carefully. I have no doubt that the content of the Report related to Medicare and our collective response, are the most important and far-reaching issues that many of us will face in our future professional lives. Again, I ask you to study all relevant materials, as carefully as you can, and try to determine clearly and firmly where you stand. You may be sure that these vital matters will be before you every day in the months and years ahead. I can assure you that the C.M.A. and its Divisions are working continuously and as intelligently and vigorously as possible on our behalf. Our cause has been presented honestly and clearly to Governments, to the Political Candidates in our recent Nova Scotia election, and to the public at large. We do not want to see "State Medicine" in Canada! It has failed in Britain, Sweden and Australia!

Our relations with the media have been satisfactory and no serious errors or problems have arisen. I hope that we will all work to promote good relations, first and foremost with our patients, and with the media, as opportunities arise. Your Society is looking carefully at more organized and effective means of developing good public relations, realizing that we are often criticized, even ridiculed for our lack of skill and effort in this important twentieth century field. However, the line between hucksterism and public relations may seem very narrow to many of our members.

Although the fundamental role of the Society must remain the professional, political and economic welfare of its members, we must strive to support the educational and scientific foundations of our profession. We cannot grow as a profession without that intellectual base. Our relationship with Dalhousie University has remained strong and rewarding. Unfortunately, because of an exceptionally important new research opportunity, Dalhousie has required more space in the Sir Charles Tupper Medical Building, and we have had to move our office to new quarters. Although we are no longer close neighbours, we firmly believe that our professional and academic relationships will cotninue to grow and strengthen.

I must express my sincere thanks to Mr. Peacocke and his staff for their strong support throughout the year. It has been a very difficult year for Doug and he has shown great capability and devotion to duty. The amount of important business moving through our office increases every year and Doug's able management of it has served us all very well — Officers, Executive committee and members-at-large. We owe him and his excellent staff our sincere gratitude and we wish them well in the years ahead and ask only that they continue to serve us as they have in the past.

Finally, I wish to thank all of you who have given of your time and talents, in many ways, to our meetings and organization. A special thanks I extend to the members of the Executive Committee and Dr. Jerry Ross who, at great expense to themselves of time, effort and material, have carefully studied the important issues facing us and given us their very valuable opinions. Often differing points of view have required debate and resolution and I believe that it is in these discussions that we have matured most as a professional Society. Without your participation, we could never have the strong voice and spirit so essential to our professional strength and integrity.

Having served as your President will always remain for me a great privilege and honor.

Dr. Brian Chandler, Chairman of the Economics Committee of the Officers, then reported on the activities of his Committee and the difficulties it has faced and will face in the future. In particular, he spoke of the improved relations and communications with the Sections of the Society. He felt that this had greatly improved the Society's ability to better represent its members.

Dr. Chandler felt that the principal problems facing his Committee during the coming year would be devising a fair distribution of any fee increase — i.e. establishing ratios that everyone can live with and, secondly, undertaking work studies to determine more accurately appropriate values for various services.

Dr. Chandler pointed out that last year's increase was less than the national average and as a result the Society's income position relative to other divisions had slipped. This would require attention in the forthcoming negotiations. He continued on this subject pointing out the deteriorating position of the medical profession in relation to wage and salary indexes and the Consumer Price Index. These points as well would have to be addressed in the future.

Discussion on all aspects of tariff negotiations was wide ranging and included application of job sanctions, publicity, achievable goals, the attitude of Government and public acceptance of the physicians' position. Arising out of these discussions was the concensus that the membership should be briefed in considerably more detail on the overall economic situation relating to the medical profession. Council supported the Officers' plan that members of the Officers and

Economics Committee visit Branch Societies for this express purpose. Discussion ensued regarding the necessity for instituting a special membership levy in order to provide the financial backing for this increased activity. Council approved a resolution: *"THAT if necessary a levy of an appropriate amount be made by the Executive Committee, for one year, to assist in negotiations."*

SALARIED PHYSICIANS COMMITTEE REPORT: Dr. J.P. Welch's report circulated at the meeting was received for information, not having any recommendations.

REPORTS OF MEDICAL SOCIETY OF NOVA SCOTIA REPRESENTATIVES TO C.M.A.:

C.M.A. BOARD OF DIRECTORS REPORT: Dr. G.C. Jollymore provided a concise summary of the principal activities of the C.M.A. Board of Directors, during the past year. He provided Council with brief comments on current concerns being discussed by the Board.

C.M.A. COUNCIL ON HEALTH CARE REPORT: Dr. M.A. Smith, who had relinquished the role of representative to this Council, informed Council that Dr. Murray S. McQuigge had recently assumed this responsibility. He noted that the work of this Council was now directed to following up on the recently held C.M.A. General Council in Halifax.

C.M.A. COUNCIL ON MEDICAL ECONOMICS REPORT: Dr. A.H. Patterson was unable to be present for this section of the Meeting.

C.M.A. COUNCIL ON MEDICAL EDUCATION REPORT: Dr. J.D.A. Henshaw provided a comprehensive summary of C.M.A. activities relating to emergency medicine, under-graduate education, medical licensure, women in medicine, accreditation of under-graduate education, Canadians studying medicine abroad, sex education/adolescent medicine, graduate medical education in relation to accreditation of pre-registration programs, ambulatory practice, and practice eligibility for C.F.P.C. Certification.

Council approved his recommendations reading: (1) *"THAT The Medical Society of Nova Scotia supports the Certification Program in Emergency Medicine being developed by the College of Family Physicians in Canada."* (2) *"THAT The Medical Society of Nova Scotia endorse the principle that postgraduate training in Emergency Medicine should remain open to all licensed physicians."* and (3) *"THAT The Medical Society of Nova Scotia requests that the C.F.P.C. continues to provide practice eligibility route in Emergency Medicine."*

In relation to recommendation (1), Dr. Henshaw, responding to a question as to whether The Medical Society of Nova Scotia supports C.F.P.C. Certification Program in Emergency Medicine to the exclusion of other Emergency Medicine Programs stated that this indeed was not the case and that the resolution must be read in relation to number (2). Mr. Freamo of C.M.A. observed that the C.M.A. had established a Task Force to study this problem.

M.D. MANAGEMENT LIMITED REPORT: Dr. G.A. Sapp provided Council with a brief outline of the various interests and activities of M.D. Management. Specific aspects of some M.D. Management Programs were discussed with those present welcoming the opportunity to query their representatives.

C.M.A. - GENERAL

Following brief remarks by C.M.A. President, Dr. Leon Richard, Mr. B.E. Freamo and Mr. D.A. Geekie, general discussions continued on a variety of topics. In particular the membership was concerned about attitude of the Federal Government and the future of Medicare. Dr. Richard put forth the view that the Minister of Health appears to be developing an understanding of the problems facing physicians and might well become more responsive in this regard if sufficient effort is put forth by C.M.A. and physicians themselves. The Budget was also discussed and attempts made to assess what new problems this would create. Mr. Geekie spoke on the subject of lobbying, reminding that lobby is not a four letter word anymore it's a five letter word and a respectable activity. He made a strong plea that physicians as individuals would become increasingly involved in this regard. It was activity like this that applied pressures to politicians. It is a most effective means of altering their positions.

The general mood of Council was that the public did not really understand that it is potentially the greatest loser if governments in Canada continue to persist succesfully in their attempts to diminish and reduce their responsibility in relation to medical and hospital services. The need for the medical profession to defend the rights of their patients was highlighted by the following resolution passed by Council: "BE IT RESOLVED THAT The Medical Society of Nova Scotia will oppose by all possible means any further attempts to deprive patients of free choice of physician, or to deny patients their rights of reimbursement from the Government's Medical Care Insurance Plan for physician services without regard to mode of billing." The preamble to the resolution presented by Dr. N.L. Mason-Browne reads as follows:

"Our Profession has been labelled the greedy, rich bad boy of society. We have watched this with anger and dismay. Anger because the picture is false. Dismay because we know that the public has been fed with prejudiced and biased figures about our alleged incomes. We know that the real and relative dollar value of our incomes have been steadily eroded for years. The anger and dismay are such that many may leave for greener pastures in the South. Indeed in Glace Bay no less than six physicians out of a total of 25 have left or will be leaving within a six month period. Admittedly, I do not know why the six are leaving but their departure must mean that the remaining few physicians despite their best efforts will not be able to render the same high quality of patient care.

"Not only have we been labelled. We have also been threatened. First the threat of the Hall Report, then the threat of the Task Force Report, then the threat of the Budget, then the threat of the forthcoming Finance Ministers' Meeting.

"We now know the contents of the Budget. Many of us may be tempted to feel relieved or even complacent. But let us not be deceived. The Budget is a devious document. It is the products of a devious mind. It is a recession Budget. It is a Budget which will cost thousands their jobs, will cost thousands their homes, will cost thousands their businesses, and will cost thousands their chance for a higher education.

"Is this the way to contribute to the health of Canadians? Is this the preventive and cheap Medicare about which the equally devious Marc Lalonde used to preach to us about so earnestly?

"Some prevention!

"There are also more direct threats to the health of Canadians because of E.P.F. and Federal Fiscal Transfers are to be unilaterally reduced by substantial millions. Such measures cannot help but adversely affect the quality of care which we strive to give to the public.

"This is the thin edge of the wedge. Next year the Health Funding arrangements are scheduled for erosion. Let us not be lulled into assuming the good people in Ottawa have abandoned their plans for that time, and let us not forget that the Task Force Report is still very much in existence and, let us not forget that MacEachen has not finished with us.

"We have one of the best systems of Health Care anywhere in the World. Even the people in Ottawa acknowledge this, also acknowleding that Medicare is underfunded. Yet with the other hand the Federal Government is paradoxically reducing funding still further.

"Canadian Medicare is excellent thanks to a largely satisfied public, to — in Nova Scotia at least — our good relations with the Provincial Government, and, last but not least to our dedicated profession.

"That excellence in now threatened. The real tragedy — the real concern of the profession is that it is our consumers, the public, the

health of the public which is the target of the present threats.

"Among the essentials of an excellent health care system are that the public would have free choice of doctors and that the public would receive full benefit of Medical Insurance which it has paid for. These principles are in danger. Our profession is not geared to militancy, although militancy seems to have brought rewards in other, admittedly more affluent provinces. But now on behalf of our consumers, on behalf of the public health, perhaps the time for militancy has arrived.

"The public must know that we are concerned, alert and interested in the public behalf. The Provincial Government must know that we are ready to fight along side it on behalf of responsibility for the health of the citizens.

SECTION FOR ANAESTHESIA REPORT: Dr. J.P. Donachie reported that his Section continued to be active in the teaching of skills relating to both basic and advanced cardiac life support. As well, the Section undertook review of Anaesthetic Mortality and Morbidity in this Province. The following recommendations were approved by the Society: (1) *"THAT an Anaesthetic Mortality Review Committee be established, composed of four members; three from the Section for Anaesthesia and one from the Section for Surgery.* (2) *"THAT the members of the Committee be appointed annually by the Executive Committee of The Medical Society of Nova Scotia."* (3) *"THAT the Committee meet every three months to review cases. These cases will be all cases in the Province dying within 24 hours of surgery."* (4) *"THAT necessary legislation be sought to require all hospitals to report such deaths to the Committee, such report to include relevant parts of the chart and separate reports by both Anaesthetist and Surgeon, using forms prescribed by the Committee."* (5) *"THAT the Committee report to the Section for Anaesthesia annually for inclusion in the Section for Anaesthesia Annual Report to General Council of The Medical Society of Nova Scotia. All reports will be made in strictest confidence."* and (6) *"THAT the purpose of the Committee will be strictly educational. It is hoped that its work will contribute to raising the standards of anaesthetic practice in the Province."*

SECTION FOR GENERAL PRACTICE REPORT: Dr. M.S. McQuigge informed Council that the principal area of interest and concern of the Section this year was in the field of economics. Activity in this regard had been stepped up markedly, including release of a Section Newsletter to its membership. The following recommendations were approved by the Society: (1) *"THAT the Executive Committee of The Medical Society of Nova Scotia develop plans for a series of Blitz Meetings of the Society's Branches to discuss the fee negotiating process and the potential actions by Society members regarding this negotiating process."* (2) *"THAT the Economics Committee and Executive Committee of The Medical Society of Nova Scotia develop an acceptable ratio of income between general practitioners and specialists, and an acceptable method of calculating this ratio. This ratio could apply as a guideline to this year's allocation of the fee settlement."* A resolution put forth by the Halifax Medical Society reading *"THAT The Halifax Branch Medical Society recommends that proposals of the Economics Committee for the coming year be referred to the Branch Societies for discussion, as soon as possible after the Commission settlement for the previous year"* was debated by Council. Due to the complexity of the work of the Economics Committee in the early stages, communicating plans to the Branches at this time would likely serve no real purpose, hence the motion was subsequently DEFEATED.

SECTION FOR OPHTHALMOLOGY REPORT: Dr. J.H. Quigley reported on a very busy year for his Section. Principal areas of concern were the fitting of contact lenses including coverage by M.S.I. by optometrists as well as the use of diagnostic drugs by optometrists. The specifics of these problem areas were reported on through the Report of the Chairman of the Executive Committee. As well, the Section had been active in the matter of fee development, working closely with the Economics Committee in this regard.

SECTION FOR ORTHOPAEDIC SURGERY REPORT: Dr. A.B.F. Connelly reported on the interest within his Section in the establishment of a Medical Board of Appeal for the Workers' Compensation Board. He noted that his Section's proposal in this regard had not yet been reported on by the Occupational Health and Rehabilitation Committee. Dr. Connelly reported that his Section had discussed and agreed to explore the establishment of a separate Surgical Society of Nova Scotia. This item was debated at length and with emotion. Dr. Connelly stated that the issue had arisen in relation to frustration over fee revisions, but subsequently had been resolved. Numerous members, including the President, spoke to the importance of unity within the profession. It was subsequently moved *"THAT Council accept the Annual Report of the Section for Orthopaedic Surgery with the comment that Council deplores any move to form separate societies as that would divide the profession in its dealing with Government."*

SECTION FOR OTOLARYNGOLOGY REPORT: Dr. M.S. Sekaran reported that his Section had met a number of times during the year with the discussions being confined to Fee Schedule matters, including such things as support of balance billing and the concept of binding arbitration as a possible approach to achievement of adequate settlements.

SECTION FOR SURGERY REPORT: Dr. W. H. Lenco reported on the concerns of his Section regarding the impending shortage of surgeons in the Province and Atlantic Canada, principally because those discontinuing surgery are not being replaced and the average age of surgeons is steadily rising.

SECTION FOR PSYCHIATRY REPORT: Dr. G.A. Fraser reported on the meetings held by his Section to discuss the Psychiatric manpower problem in the Maritime Provinces, plan attempts to have a rotation in Psychiatry included in the Interne rotation system. Dr. Fraser also reported that psychiatry continues to be one of the lowest paid specialties in Canada and that this could well be having an adverse effect on recruitment.

SECTION FOR UROLOGY REPORT: Dr. S.G. Lannon's report, containing no resolutions, was received by Council for information. He reported on the concerns within his Section regarding fees.

REPORTS OF REPRESENTATIVE TO OTHER ORGANIZATIONS:

MSNS REPS. TO DIAGNOSTIC IMAGING COMMITTEE REPORT: Dr. J.A. Chadwick and H.R. Robby jointly represent the Society on this Government Committee. Dr. Roby provided Council with a comprehensive report on the activities of this Advisory Committee during its first year in being. The Committee had discussed the concerns of the Yarmouth Regional Hospital relative to Ultra Sound equipment. Resulting partly from their recommendations was approval of the equipment for the Yarmouth Hospital. Discussion also took place within the Committee on the subject of training of technicians for work in Ultra Sound. Detailed plans relating to this will be considered in the near future.

MSNS REPS. TO DRUGS & THERAPEUTICS COMMITTEE REPORT: Drs. J. Gray & G.C. Jollymore represent the Society on this Committee of the Commission. Dr. Jollymore reported that the 2nd edition of the Drug Formulary would be released in the near future with an encouragment to physicians to give consideration to costs when prescribing for their patients. Dr. Dunsworth spoke on this point and reaffirmed the necessity of emphasizing this point in the training programs for medical students and internes.

MSNS REPS. TO JOINT LABORATORY SERVICES COMMITTEE REPORT: Drs. S.K. Kini & S.E. York represent the Society on this Committee. Dr. York reported to the meeting that the principal concerns dealt with during the year related to pathologists, their type of practice including workloads and remuneration. It was noted that the current method of payment does not provide sufficient funds for paying the required number of pathologists based on actual

workloads. Currently the Committee is undertaking a review of requirements for pathologists in various hospitals throughout the Province.

MSNS REP. TO KELLOGG HEALTH SCIENCES LIBRARY REPORT: Dr. Winston Parkhill's report was not dealt with by Council; therefore, its recommendation that the Library Committee include a physician from outside Halifax/Dartmouth will appear on a future Executive Committee agenda.

MARITIME MEDICAL CARE INC. — PRESIDENT'S REPORT: Dr. D.A. MacFadyen, President, provided Council with a detailed report of the activities of Maritime Medical Care Inc. Board during the past year. A variety of interesting statistical bits of information were presented in the process. It was noted that the net loss for 1980-1981 of $50,000. was somewhat reduced from the previous year loss of $113,000. Efforts are continuing to change this to a profit situation.

MSNS REPS. TO MEDICAL ADVISORY COMMITTEE ON DRIVER LICENSING REPORT: Drs. C.C. Giffin and L.P.M. Heffernan represents the Society on this Department of Highways Committee. Their report included detailed statistical summary of problems dealt with by the Committee. The workload of the Committee is diminishing particularly in terms of alcohol involvement and this is attributed to tougher legislation which came into effect in September 1975. Referred to was the assistance provided by the Commission on Drug Dependency in the work of the Committee.

MSNS REP. TO NOVA SCOTIA SAFETY COUNCIL REPORT: Dr. J.P. Anderson reported that the Council had been active in a wide range of areas of concern including use of helmets by motorcyclists and seat belts in motor vehicles. His report was received for information.

MSNS REP. TO NOVA SCOTIA LUNG ASSOCIATION REPORT: Dr. R.T. Michael reported in some detail on the work of the Association during the past year, referring to such items as the Easy Breathers' Club, the Respiratory Interest Group, the Family Asthma Program, Smoking Withdrawal Programs, and work with other organizations in attempts to diminish the wide range of problems which fall within the purview of this organization's interests.

MSNS REP. TO PHYSICIAN MANPOWER SUBCOMMITTEE REPORT: Dr. J.F. Hamm's report provided Council with a summary of the work of the Committee during the past year. It was noted that the Committee includes representatives from the Department of Health, the Faculty of Medicine, the Provincial Medical Board, the Health Services and Insurance Commission, and the Medical Society. Dr. Hamm said the principal concern of the Committee was determination of future needs of physicians, particularly specialists, as well as dealing with immigration requests brought to the Committee's attention for recommendation.

MSNS REP. TO PROVINCIAL MEDICAL BOARD OF NOVA SCOTIA REPORT: Dr. G. MacK. Saunders, one of six Medical Society appointees to the Provincial Medical Board, reported that in his experience there has been a marked increase in the activities of the Provincial Medical Board over the past decade, with considerably greater involvement in the actual practice of medicine. The wide range of activities in which the Board is involved as reported by Dr. Suanders was impressive. Arising out of this increased activity has been the necessity to increase the annual licensing fee to $100.00 commencing in 1982.

R.H. COMMITTEE DIRECTOR'S REPORT: Dr. Leo J. Peddle informed Council that this Committee continued to provide a threefold program of prevention, education, and service during the past year. His report provided details of these various activities. Included with his report were statistical tables relating to compliance rate in Nova Scotia for the injection of Rh IgG in 1980 as well as a listing of numbers and types of patients referred to the Committee during the year.

MSNS REP. TO ST. JOHN AMBULANCE ASSOCIATION PROVINCIAL ADVISORY COMMITTEE REPORT: — Dr. Gillian Lawrence's report was presented by Dr. J.D.A. Henshaw on her behalf as she had to leave Council early. Outlined were the activities of the Association in relation to training service, liaison with W.C.B.'s in accident reduction programs, programs in schools and C.P.R. training. Council approved two recommendations: *"THAT Mandatory First Aid Training for Fire Brigades be supported by The Medical Society of Nova Scotia;;* and *"THAT The Medical Society of Nova Scotia support province-wide inclusion of First Aid in the curricula of Grade 9 & 10."*

ANNUAL MEETING:

On two 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 which appears subsequent to these Transactions. Additionally, the membership heard and approved the Report of the Nominating Committee which reads as follows:

APPOINTMENT OF BRANCH REPRESENTATIVES TO THE 1982 EXECUTIVE COMMITTEE: Antigonish-Guysborough — Dr. Rolf Sers; Bedford-Sackville — Dr. R.A. Killeen; Cape Breton — Drs. B.S. Ignacio & P.K. Cadegan; Colchester-East Hants — Dr. C. F. Bridge; Cumberland — Dr. V.M. Hayes; Dartmouth — Drs. M.F. Moriarty & E.C. Ross; Eastern Shore — Dr. W. C. Brown; Halifax — Drs. A.G. Cameron, J.B. Ross & J.W. Stewart; Inverness-Victoria — Dr. R. Stokes; Lunenburg-Queens — Dr. W.H. Lenco; Pictou — Dr. C.A.L. Young; Shelburne — Dr. F. Markus; Sydney — Drs. N.L. Mason-Browne & B.C. Trask; Valley — Drs. M. Kazimirski & A.S. Dill; and Western — Dr. R.J. Muise.

APPOINTMENT OF BRANCH REPRESENTATIVES TO THE 1982 NOMINATING COMMITTEE: Antigonish-Guysborough — Dr. B.R. Steeves; Bedford-Sackville — Dr. Rosemarie Taylor; Cape Breton — Drs. M.E. Lynk & E.B. Barrett; Colchester East Hants — Dr. K.B. Shephard; Cumberland — Dr. R.A. Burden; Dartmouth — Drs. G.C. Pace & M.W. Butters; Eastern Shore — Dr. P.D. Muirhead; Halifax — Drs. A.G. Cameron, J.B. Ross, & J.W. Stewart; Inverness-Victoria — Dr. R. Stokes; Lunenburg-Queens — Dr. G.C. Jollymore; Pictou — Dr. C.R. Elliott: Shelburne — Dr. J.H.L. Robbins; Sydney — Drs. D.E. MacKenzie & P.F. Murphy; Valley — Drs. R.D. Stuart and G.M Trueman; and Western — Dr. R.J. Muise.

The following nominations were confirmed: President-Elect — Dr. E.V. Rafuse of Halifax; Chairman, Executive Committee — Dr. G.H. Ross of New Minas; Vice-Chairperson — Dr. Vonda M. Hayes of Amherst; Treasurer — Dr. W.C. Acker of Halifax; and Honorary Secretary — Dr. R.D. Saxon of Antigonish.

The 128th Annual Meeting of The Medical Society of Nova Scotia adjourned at 12:30 p.m., Saturday, November 21, 1981.

Presidential 'Valedictory' Address 1981

Alan J. MacLeod, M.D., C.M., F.R.C.P.(C),
Halifax, N.S.

It has been an honor and privilege to serve as your President. During the year, as I talked with physicians, many citizens and the media, I saw a high degree of professionalism in the physicians of Nova Scotia, in very difficult times. This professionalism is hard to maintain, in an age of materialism and self-gratification — and it is now almost unique to physicians! It begins with arduous formal education, and a comprehensive, systematic knowledge of human biology and pathology. It continues with increasing clinical responsibility, legislated licensure and a great deal of self-regulation and autonomy. Finally, it requires compassion, sound judgment, responsibility and accountability. Nothing less is good enough to serve those who are ill, and there are no short cuts! Thus, medical care, in whatever form it may take, must remain the responsibility of physicians. It may be delegated but it can never be abandoned!

Why are the profession and practice of medicine becoming so increasingly difficult? We must critically examine these issues. I believe that there are three main reasons — the state of the society in which we live, the irrational and extreme expectations and demands of this society, and the rapidly increasing influence of non-medical persons on the delivery of health care. These problems tend to divert us from our primary responsibility which is, first and foremost, the care of those who are ill. The social engineers of the World Health Organization have defined health as "a state of complete physical, mental and social well-being, and not just the absence of sickness or infirmity". What an opportunity for glorified clerks with pretentious titles and meaningless degrees to play doctor! The practice of medicine is NOT social work, nor can it be effective if it is directed and controlled by social workers and accountants! ONE must be productive to be truly merciful in this age.

The problems of our age affect us all, and have been addressed most clearly by Solzhenitsyn at the Harvard Commencement in June 1978. Fresh from the concentration camps of the great Soviet experiment in Socialism, he looked at the west, and this is what he saw — great material wealth, much of it worthless goods and services — freedom titled in the direction of evil, to satisfy every instinct and whim — the great power of the media to distort, and to promote intellectual and moral mediocrity and license — almost no voluntary restraint, or mercy or sacrifice — individual rights so extreme that society is defenseless against certain individuals and groups — one cynic has called this "the tyranny of the disadvantaged". He goes on "we have placed too much hope in social and political reforms", and asks "are wages and gasoline our highest priorities"? He says that Western Society looks good only because of a deceiving, superficial veneer. This is repeated in comedian Flip Wilson's bitter maxim "what you see is what you get", portraying a soulless emptiness in many products and services. Men can walk safely on the moon, but not in their own cities. Personal privacy is essentially lost. In education, academic standards are replaced with programs of "self-expression", "sensitivity", and "personal fulfillment", promoted with meaningless multi-purpose jargon. Excellence is called "elitist" by vested interests whose survival depends on mass mediocrity — and still, hundreds of thousands of Canadians are functionally illiterate.

The demands of our society are insatiable, promoted by advertising and deceit, through the lying face of television and the relentless peer pressure of the lowest common denominator - directed at the young, the impressionable and the insecure. A panacea is promised for every problem, real or imagined. Everyone must have a pain-free, anxiety-free, long and vigorous life but without any discipline, self-restraint or personal responsibility — free medical care for every symptom — and soon, state babysitters for working mothers? I need not tell you that many of the problems you see in your practices are self-induced. Every possible social and moral problem is being medicalized by those who are "fashioning our just society".

The practice of medicine is increasingly influenced by persons who have absolutely no knowledge of medical practice and to whom Medicare is a political and bureaucratic Godsend. They promote such vagaries as "total health", "broad social objectives" and "social consciousness" which give them material to work on forever, without standards or criteria, or ever facing a day of reckoning, as they increase their staffs, their commissions of inquiry, and their own welfare and security. They produce "shopping lists" of good things and ceaselessly "invent" new needs. They try to solve deeply-rooted social and medical problems with "nine-to-five" sensitivity and other peoples' money. In Britain, eight of them go into the National Health Service for every doctor, and the local health councils now have four levels of administration, instead of the original two. To these faceless bureaucrats, administration is more important than analysis, and regulation more important than results. To them health care is an industry, and to control it they must control physicians — and, every day many politicians and bureaucrats are trying to find new ways of doing this. I see a great danger that we are being bought with our own assets. We must be ever on guard against this insidious erosion of our primacy in medical care delivery.

In these circumstances we are asked to be competent, caring, resourceful — as well as scientific, confident and aggressive in facing complex human problems. Yet, without any concern for our personal and professional welfare. But our profession has displayed these high qualities for many, many years — better than any others in our society, and we have never needed lessons in "compassion for the disadvantaged" from well-fed bureaucrats and social planners.

How can we survive as a profession in these difficult times? I believe that we must return to the foundations of our craft so carefully stated in order by Osler — the care of the patient, the investigation of disease and the teaching of medicine. Caring means being available, listening, observing, advising, relieving and sometimes curing. These complex, intensely personal services can never be replaced by the miracles of modern medical technology — but hopefully they can be wisely and mercifully strengthened. We must investigate disease in all our clinical duties, with every reasonable means, and at every opportunity, and through the intellectual and material support of our colleagues in research, who pursue, step by small step, the increasing complexities of biological science. Do not forget that we must make friends and alliances! Finally, we must as professional experts, teach by word and example the appropriate aspects of our craft to our colleagues, students, nurses, allied health professionals and finally, and most important of all, our patients.

Now it is always comforting to wax philisophical — but you know that this is a real world, presenting us with real and specific problems in our clinical duties and our professional lives. John Stewart Mill has said "one's rights and interests are defended only by oneself" and in closing, I will return to what I said only one year ago when I took this

chain of office. We have two strengths — the quality of our patient care and the strength and integrity of our medical organizations. The goals of our patient care must be the highest that we can set for ourselves, and the highest seen in our society — anything less is not good enough! The strength and integrity of our organizations derive from their members. Officers and committees can only consider and act upon the concerns, convictions and support of the membership. We must remain united, visibly and in fact we must share our talents and our burdens. There must be no petty, self-indulgent quarrels between generalist and specialist, or specialist and specialist, or scientist and clinician or town and gown. Our art and science are too worthy to debase with jealousy and selfishness, and we must keep our own house in order!

I ask every member to take time to look at our problems, to discuss and debate them with colleagues, and to try to resolve them in a strong, active and united professional organization. Your Officers and Executive Committee need the input and support of every member, and every Branch and Section, if we are to remain free, united and truly professional. There is no longer any "free ride" in our professional journey — and the state, with its ever-increasing powers, is eagerly waiting to make us all second-class civil servants with control of our numbers, our locations, specialties, incomes and, most serious of all, our patterns of practice; in such circumstances our professionalism will have ended entirely! I fear — I hope not — that it may already be too late! Thank you most sincerely for a wonderful year! □

ANNUAL MEETING EXHIBITS

The Medical Society of Nova Scotia wishes to express its sincere appreciation to those firms who exhibited at its Annual Meeting in November 1981 at the Hotel Nova Scotian.

Abbott Laboratories
Anca Incorporated
A & P. Appledore Canada Limited
Boehringer Ingelheim (Canada) Limited
Can-Med. Surgical Supplies Limited
Dalhousie University — C.M.E.
Hoffman-LaRoche Limited
McNeil Labs (Canada) Limited
Miles Ames Division
Ortho Pharmaceutical (Canada) Ltd.
Pennwalt of Canada Limited
Pfizer Company, Limited
Reed & Carnick
Ross Laboratories
Rorer Canada Inc.
A.H. Robbins Canada Limited
Smith, Kline & French (Canada) Ltd.
Winthrop Laboratories

NOTE: Contributions towards the Society's Annual Meeting were received from Frank W. Horner Limited (binders), and financial contributions from Merck Sharp & Dohme Canada Limited and Schering Canada 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 are encouraged to convey their gratitude by giving the exhibitors' representatives an extra expression of appreciation on their next encounter.

Pictorial Highlights
128th Annual Meeting

Dr. Alan J. MacLeod delivering Valedictory Address at the end of the 1981 Annual Meeting of The Medical Society of Nova Scotia.

Dr. Margaret Churchill, Past President, Dr. Gerald Sheehy, Minister of Health, and Dr. Alan J. MacLeod, President share a serious moment following the Ministers annual address to the Society. The recent Federal Budget possibly?

What do you mean "the good old days", whats wrong with now"? Sandy Cameron, Chuck McNeil, Murdock Smith, Joe Hyndman, Wayne Putnam and Art Parsons enjoy themselves during Banquet at the 1981 Annual Meeting.

Dr. Leon Richard, President Canadian Medical Association shown addressing members and spouses at lunch during 1981 Annual Meeting.

Dr. Gerald Sheehy, Minister of Health is shown addressing the Society during the 1981 Annual Meeting.

Society members and guests are greeted by Dr. & Mrs. Murdock Smith, Dr. & Mrs. Leon Richard and Dr. & Mrs. Alan J. MacLeod as they arrive to enjoy the 1981 Reception Banquet & Ball.

Two delightful ladies enjoying an important moment as Margaret Churchill presents Catherine MacLeod with a gift recognizing her support of her husband, Alan, during his term of office as President. Dr. MacLeod spoke eloquently of this support during his farewell remarks.

Mrs. Leon Richard is presented with a gift from the Medical Society presented by Mrs. Catherine MacLeod for her service as CMA Presidents Wife.

Dr. Gerald Sheehy, Dr. Leon Richard, Dr. Murdock Smith, and Dr. Ed Rafuse, President-Elect enjoy a moment together during the Society's Annual Meeting Banquet.

Dr. Murdock Smith, newly installed as President of The Medical Society of Nova Scotia receives congratulations from Dr. Leon Richard, President Canadian Medical Associations. Dr. Alan MacLeod, Immediate Past President, shares this important moment with Dr. Smith.

Dr. Murdock Smith of Sydney President, The Medical Society of Nova Scotia addresses the membership immediately following his installation by Dr. Leon Richard, President, Canadian Medical Association at the 1981 Annual Meeting of the Society.

THE NOVA SCOTIA MEDICAL BULLETIN

Published by

The Medical Society of Nova Scotia

GUIDELINES FOR AUTHORS

In 1978, a number of American, British and Canadian editors of medical journals met in Vancouver, to establish a common format for the submission of papers, and their deliberations resulted in the "Declaration of Vancouver". The Editor and the Editorial Board of the *Bulletin* have decided to adopt this new format, beginning in 1981, and the changes are chiefly in the style used for citing references.

The entire manuscript should be typed double-spaced on one side only, with generous margins on all four sides. Tables should not be included in the text but typed on separate pages, as should the references and the legends for any figures and illustrations.

Non-metric units should not be used in scientific contributions. Parts of the SI system are controversial or unfamiliar, especially concentrations of substances, gas tensions, blood pressure and radiological units, so that authors should provide conversion factors. Abbreviations should be defined when first mentioned and, if numerous, the author should provide a glossary which will be printed separately in a prominent place in the article.

In general, papers reporting on studies should adhere to the following sequence:

a) **Title page** — title of article (concise but informative); first name, middle initial and surname of each author, with academic degrees; names of department or institution to which the work should be attributed; name and address of author responsible for correspondence or reprints; source of support (if any).

b) **Summary or Abstract** — not over 150 words, summarizing the purpose, basic procedures, main findings and principal conclusions.

c) **Materials and Methods** — describe the selection of subjects, the techniques and equipment employed, the types of data collected, and the statistical tests used to analyse the data.

d) **Results** — describe in logical sequence, using tables and illustrations.

e) **Discussion** — emphasize new and important aspects, and the conclusions that follow from them. Recommendations, when appropriate, may be included.

f) **Acknowledgements** — only those persons who have made substantial contributions to the study.

g) **References** — usually limited to 10 for short papers and to a maximum of 20 for review articles. Number in sequence, in the order they are first mentioned in the text, with journal titles abbreviated as in *Index Medicus*.

Examples of the new format are:

1. Journal articles — list all authors when six or less (surnames followed by initials without periods); when seven or more, list only the first three and add *et al.*

Epstein SW, Manning CPR, Ashley MJ, Corey PN. Survey of the clinical use of pressurized aerosol inhalers. *Can Med Assoc J* 1979; **120:**813-816.

2. Book —

Fletcher C, Peto R, Tinker C, Speizer FE. *The Natural History of Chronic Bronchitis and Emphysema.* Oxford: Oxford University Press, 1976.

3. Chapter in book —

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h) **Tables** — type each on a separate sheet, number consecutively with *roman* numerals. Supply a brief title for each, give each column a short or abbreviated heading, and reserve explanatory material for footnotes.

i) **Figures and Illustrations** — professionally drawn and photographed, as glossy black and white prints, numbered consecutively with *arabic* numerals. List all legends on one page and state magnification of photomicrographs.

Mailing address: Editor,
The Nova Scotia Medical Bulletin,
Sir Charles Tupper Medical Building,
10th Floor,
University Ave., Halifax, N.S.
B3H 4H7

Ultrasonic Imaging of the Head In Infants and Young Children

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Ultrasonography has been used in examination of the head since 1955. For several years, only A-mode or one-dimensional ultrasonography was available. This technique is quite limited, since it depends on the presence of a highly reflecting interface or tissue plane lying perpendicular to the incident beam. It does not display useful information regarding the nature of the tissues through which it passes. Hence, in the head, information is limited to visualization of structures such as the falx cerebri, the walls of the ventricles and other fluid-filled cavities and moving structures with vascular pulsation.

In order to capture useful images of the tissues through which the ultrasonic waves are transmitted, some form of two-dimensional display is required. The earliest reference to imaging the brain in this manner was in 1963 by Vlieger *et al*,[15] who reported results using B-mode static imaging technique. Unfortunately, the well ossified skull constitutes a considerable physical barrier. However, in infants and young children the open fontanelles and sutures can be used as a bone-free acoustic "window", allowing some degree of access to intracranial structures.

In 1974 and 1975, Kossoff *et al*,[19] and also Garrett *et al*,[5] reported visualization of normal and dilated ventricles in infants. A craniopharyngioma demonstrated by gray-scale ultrasonography was described by Shkolnik[13] in 1975. The technique of using the open fontanelle and sutures was pioneered by Babcock *et al*[1] in Cincinnati, who used static imaging B-mode gray-scale equipment. The images obtained show detailed anatomy of most of the ventricular system and also some aspects of cerebral and other tissues. The information displayed is somewhat similar to that of a limited first-generation unenhanced C.T. scan, without the facility of data manipulation. Ultrasonography does not involve the hazard of ionizing radiation, and depends on different physical properties from those of the C.T. scan. Unfortunately, the static imaging technique used by Babcock must be limited to patients who do not require an incubator and must be performed in a diagnostic department, since the arm of the scanner is delicate, cumbersome and requires overhead space. In spite of these disadvantages, and its relative lack of sophistication compared with C.T., the impact of its clinical value was immediate.

While Babcock's painstaking pioneer work was evolving in the United States, Pape *et al* [11] in London, England, used the open fontanelle in infants for real-time ultrasonographic imaging with a linear-array, mobile scanner very similar to that available for obstetrical studies. Although it could be used in the incubator, this equipment was not designed for intracranial imaging, having poor resolution of fine detail and possessing virtually no gray-scale capability. Again, the potential value of intracranial imaging through the open fontanelle, with emphasis on using portable equipment in the incubator, gave immediate momentum to the development of better equipment, designed to incorporate resolution of fine detail with gray-scale together with portable real-time capability.

The recent advent of this type of equipment in North America has already proved to be a major advance in organ imaging in many parts of the body. We can now, for the first time, obtain detailed images of the brain including that of the very small premature infant in the incubator. Life-support systems are left undisturbed; the risks attendant upon transporting such a patient are eliminated. Furthermore, no sedation is required.

CLINICAL MATERIAL

At the Grace Maternity Hospital and at the I.W.K. Hospital for Children, radiologists used ultrasonographic equipment for the open fontanelle technique as soon as it became available. These studies have been limited by the type of machine used. In the early years, we had only real-time non-gray-scale equipment for portable examinations.

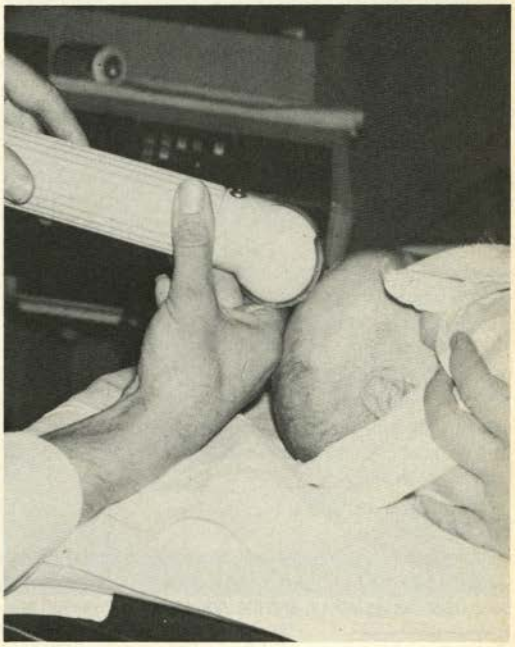

FIG. 1 A cerebral ultrasonographic study is being made through the anterior fontanelle of a newborn. The beam is in the sagittal plane.

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At the former hospital, a new real-time gray-scale mobile machine* has been in service for the past six months. At the time of writing, we have performed 30 studies in 23 infants using the open fontanelle technique. (Fig. 1,2) Mid-line structures and their displacement, normally ventricular anatomy, hydrocephalus, intraventricular and intracerebral hemorrhage have all been demonstrated. Several of the earlier patients also had C.T. scans, which have shown close correlation with the ultrasonographic findings.

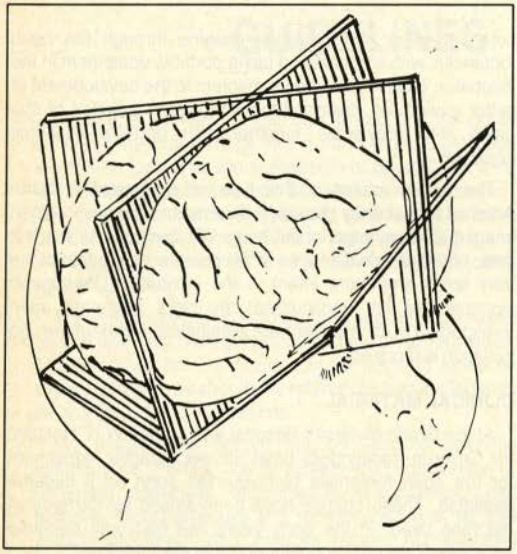


FIG. 2 Sagittal and coronal planes through the anterior fontanelle. Subfrontal and posterior fossa planes through the open sutures.

Case I: Baby K.

A small premature female infant of 29 weeks gestation, birth weight 1020 Gms. developed dusky spells soon after delivery. Respirator therapy was necessary and the dusky spells continued. Early in her management, lumbar puncture showed xanthochromic CSF with low sugar and elevated protein. The ultrasonographic image of the brain in the coronal plane showed the lateral ventricles to be of normal size. A band of dense echoes (see Fig. 3) interpreted as a small subependymal hemorrhage was noted on the lateral wall of the anterior portion of the body of the left lateral ventricle probably in the caudate nucleus.

About six weeks later, these findings had diminished considerably. The infant progressed well and was discharged home at 12 weeks.

Case II: Baby C

A premature male infant of 29 weeks gestation, birth weight 1140 Gms. breech vaginal delivery. Demerol had been used during labour, and the infant was asphyxiated and depressed at birth. Congenital pneumonia was suspected on the basis of acute funistis, leukocytes in the tracheal aspirate, and elevated sedimentation rate. He required respirator therapy but remained dusky, and developed severe RDS. Recurrent acute dusky spells and abdominal distension remained a problem.

*At the Grace Maternity Hospital, the real time gray scale protable ultrasonographic studies were made with the Diasonics Wide Vue Scanner machine (small focus probe). All illustrations are derived from this equipment.

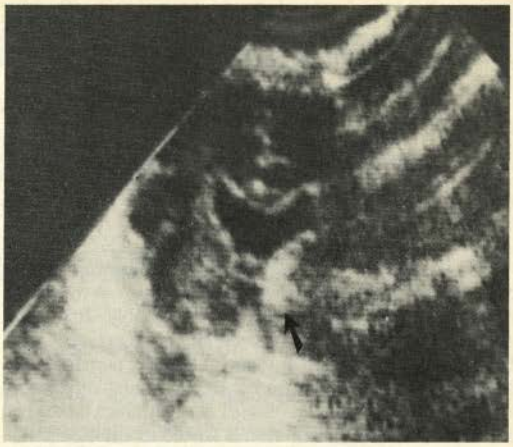


FIG. 3 Case I, Baby Girl K.
Ultrasonographic image of the brain in the coronal plane. The ventricles are slightly enlarged. There is a zone of increased echo density in the sub-ependymal area beneath the lateral wall of the left lateral ventricle (arrows) reported as a sub-ependymal hemorrhage probably in the caudate nucleus.

On Day 2, the hemoglobin dropped from 20 Gms. to 9 Gms. On Day 3, seizure activity without localizing signs was noted. There was frank blood in the CSF on lumbar puncture.

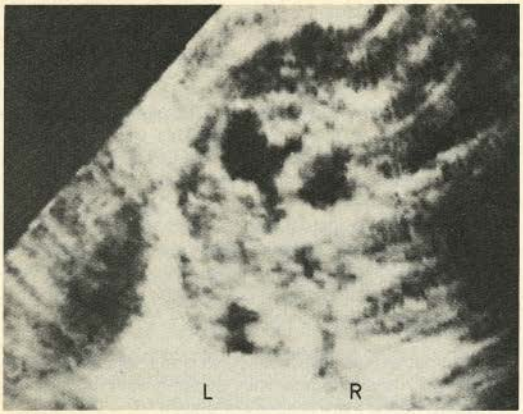
On Day 5, the first ultrasonographic image of the brain was performed. It was, however, quite limited owing to scalp vein therapy and edema. However, quite extensive areas of abnormal echodensity were demonstrated bilaterally in contrast to the usual pattern of normal brain tissue, indicating large areas of intracerebral hemorrhage.

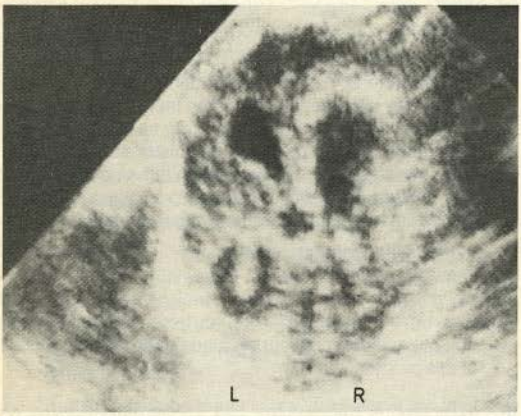
The RDS slowly resolved.

On Day 12, a second ultrasonographic imaging of the brain showed hydrocephalus developing, and a quite extensive fine echo pattern present in the fluid of the right lateral ventricle indicating intraventricular hemorrhage. Also there was an extensive area of increased echo density in the right cerebral hemisphere adjacent to the lateral ventricle producing gross distortion of the anterior horn and indentation of its lateral wall (Fig. 4 a, b, c). On this day, the clinical suspicion of hydrocephalus was reported.

On Day 19, the third ultrasonographic study showed increase in the degree of hydrocephalus and further evolution of the intraventricular and intracerebral hemorrhage (Fig. 5).

On Day 23, a CT scan confirmed the ultrasonographic findings (Fig. 6). Later the infant did not require the respirator. A CSF shunt was performed to control the progressive hydrocephalus. However, apneic spells recurred and the respirator became necessary once more.





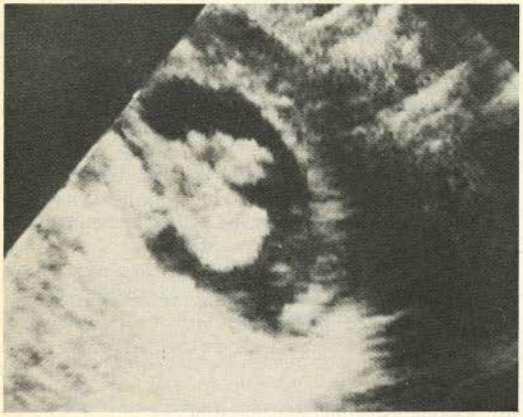


FIG. 4 Case II, Baby Boy C. — Day 12

a) AP (coronal)
b) Modified coronal (bregma — foramen magnum)
c) Left lateral

The ventricles are moderately enlarged, the right lateral ventricle shows increased density of ventricular fluid and considerable indentation from the lateral aspect from an extensive area of abnormal echo densities representing intracerebral hemorrhage. The left lateral ventricle contains a large blood clot close to the foramen of Monro and liquid blood posteriorty.

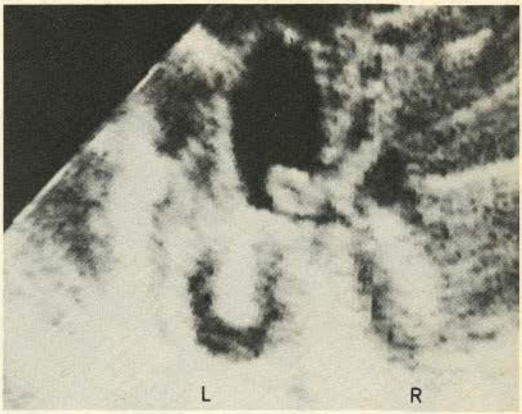


FIG. 5 Case II, Baby Boy C. — Day 18

a) Modified coronal (bregma — foramen magnum)

The hydrocephalus has become more marked, the anterior horn of the right lateral ventricle is considerably compressed, its contents show increased density representing intraventricular blood and the adjacent cerebral tissues show an abnormal echo pattern representing intracerebral hemorrhage.

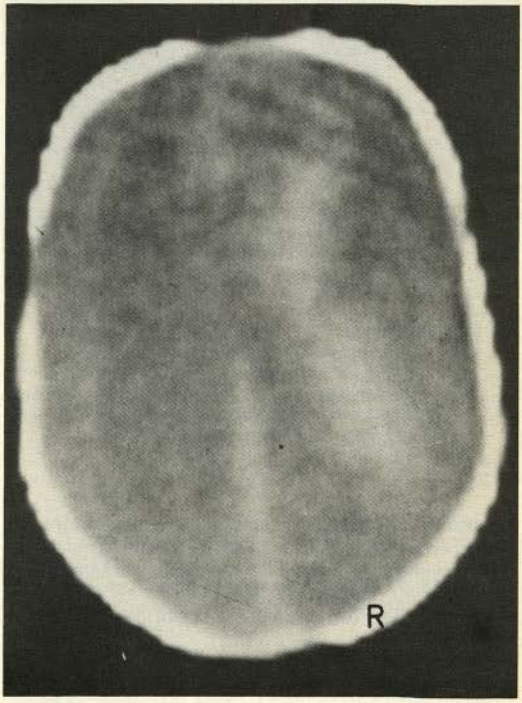
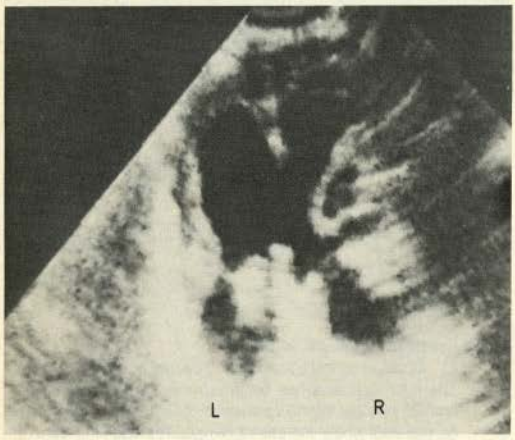


FIG. 6 Case II, Baby Boy C — Date 23

CT scan shows progressive hydrocephalus, and a large area of increased density in the right cerebral hemisphere indicating intracerebral hemorrhage and also intraventricular hemorrhage.

On Day 37, the fourth ultrasonographic study of the head showed extreme hydrocephalus. The cerebral mantle was only about 3mm. thick. Evolution of the intracranial hemorrhage was well shown (Fig. 7 a, b).



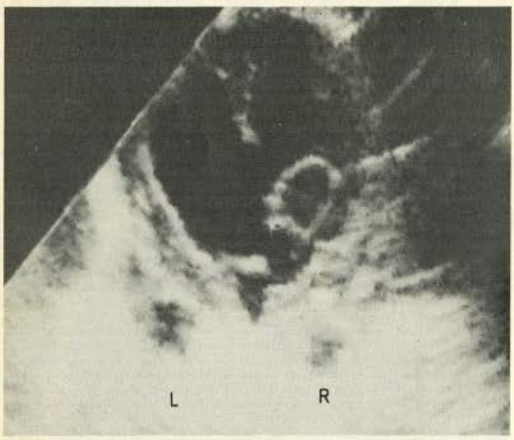


FIG. 7 Case II, Baby Boy C — Day 37
a) Modified coronal (bregma — foramen magnum)
b) Modified coronal (bregma — occiput)
The hydrocephalus has become extreme. The extensive intracerebral hemorrhage on the right shows a tendency towards encapsulation and liquefaction.

Later the clinical condition deteriorated and the infant died at two months of age. Autopsy confirmed the extreme degree of hydrocephalus and multiple areas of old focal intracerebral hemorrhage. There was also terminal meningitis, pneumonia, biliary cirrhosis and hydrops of the gallbladder.

DISCUSSION

Recent reports have hailed mainly from North American centers, describing the clinical value of ultrasonography of the head in infants and children. In these recent studies, it is evident that modern equipment combining high resolution gray-scale real-time mobile capability has proven superior in capturing information which may at times be rather elusive. The older static imaging B-mode gray-scale machines, and those real-time non-gray-scale machines designed primarily for obstetrical or ophthamologic imaging have been superseded.

Correlation with conventional C.T. studies has been remarkably high in many respects. This close correlation depends largely on the physical properties of tissues under study, which can be summarized as follows:

a) The normal ventricular fluid has a characteristic density on C.T. and has constant transmission characteristics for the ultrasonic beam. Hence, there has been very close correlation between C.T. and the ultrasonographic image with respect to ventricular size.[4,8,10]

b) Intracranial fluid collections have characteristic densities on C.T. and characteristic patterns with ultrasonography, hence there is good correlation.[2,8]

c) Blood in the ventricles, either liquid or clotted, produces characteristic densities on C.T. and also produces recognizable abnormal echo patterns within the ventricles on the ultrasonograph, hence there has been close correlation of the two mehtods.[6] (our case II). However, the choroid plexus must not be mistaken for adjacent hemorrhage on the ultrasonograph, since clotted blood may surround the plexus itself, producing an enlarged composite image with a rather similar silhouette.

The ultrasonographic diagnosis of intraventricular hemorrhage is of value in the small premature infant, since 44 per cent of neonates weighing less that 1500 Gm. have intraventicular hemorrhage.[3] Many of these do not have overt clinical evidence early in the evolution of this process.

d) Intracerebral hemorrhage has an evolving pattern on C.T. and at a certain stage in its natural history it may become isodense with the adjacent brain tissue and hence may not be recognized. This is especially true where the area of hemorrhage is small as is characteristic in the head of the caudate nucleus. It is here that the ultrasonograph excels and is superior to the most modern C.T. techniques.[6,7,10] However, where the hemorrhage is not isodense with the brain, C.T. is superior in showing the extent of a large hemorrhage, or its location in a site of limited access to the ultrasonic beam, as in the occipital horns.[10]

An ever-widening spectrum of other intracranial lesions is becoming recognized, as better equipment and increased proficiencey with the technique is developed. The literature to date contains reports on the following:

a) Various cranial and intracranial lesions:
— Brain tumors,[2,4] including lipoma of the corpus callosum[12]
— Cerebral calcification of toxoplasmosis[12]
— Cerebral edema[2]
— Porencephaly[2]
— Hydranencephaly[2]
— Microcephaly[2]
— Arachnoid cysts[2]
— Aneurysm of the Great Vein of Galen[12]
— Dandy-Walker cyst[12]

— Absent corpus callosum[2]
— Occipital encephalocele[2]
— Cephalhematoma[2]

b) Subtle evidence on ultrasonography — incorrectly reported as negative: — Sagittal sinus thrombosis[2]

c) Lesions not demonstrated by ultrasonography as yet — Kernicterus[2]

d) In one center, the reliability of ultrasonography in the management of neonatal hydrocephalus has been such, that where the ultrasonic study confirmed the clinical suspicions, ventricular shunting has been performed without recourse to other imaging studies.[2]

A word of caution should be mentioned, since the present equipment has an inherent defect comprising near-field artifacts which may obscure small collections of fluid in the interhemispheric fissure. Therefore, extra-axial fluid collections unless large, could be missed.[2] Also, since far-field resolution diminishes, the radiologist must be careful to obtain maximum accessibility through available acoustic windows in the infant's skull.

SUMMARY

Recently considerable advances have been made in ultrasonography of the head in infants and young children. This has largely been due to:

1. The availability of portable real-time gray-scale (high resolution) equipment. Although the images may have slightly less detail than the best static imaging B-mode scanners and the automated water-path delay scanners, they give adequate information to be diagnostic for a variety of conditions.
2. The study can be made in the incubator in the intensive care unit, without disturbance of life-support systems. This is particularly important for sick premature infants.
3. The time taken for such a study is usually about 15 minutes, which is considerably less than the 30 minutes required for the static imaging B-mode scanners in the Department of Radiology.
4. Sedation is not required.

These advances have become sufficiently well established to cause no less an authority than Juan M. Taveras[14] to write an editorial on the subject in the *American Journal of Neuroradiology*. He concludes "it is evident that in the newborn, sonography of the head has now replaced C.T. as the primary mode of investigation and that C.T. scanning should be reserved for special situations such as the confirmation of intracranial hemorrhages of all types and to determine the presence of a tumor that may have been suspected by sonographic examination."

We share this opinion, and would venture the prediction that with the increasing availability of appropriate ultrasonographic equipment and increasing clinical experience, the ultrasonographic imaging of the head in the infant and young child will become the standard initial neuroradiologic imaging study. It is reliable, safe, non-disruptive and relatively economical. The value of ultrasonic imaging in obstetrics has been proven for many years. It is anticipated that this technique will prove to be of similar importance in neo-natal care. □

ACKNOWLEDGEMENTS

My thanks are due to my radiologist colleagues Drs. E. B. Grantmyre, T. R. Lawrie, C. L. Belcourt and J. R. Jackson for their encouragement in this work; to the staff of the departments of radiology and neonatalogy of the Grace Maternity Hospital and the Izaak Walton Killam Hospital for Children for their interest and co-operation; to Professor D. B. Fraser, Professor and Head, Department of Radiology, Dalhousie University, Professor J. A. Collins, Professor and Head Dept. of Obstetrics and Gynecology Dalhousie and Dr. A. Allen, Neonatalogist, Dalhousie University and Grace Maternity Hospital for editorial assistance; to Mr. Coughran and Mr. Merriman, Audio-visual Department, Izaak Walton Killam Hospital for Children for the illustrations, to Joan MacVicar for Figure 2 and to Miss Mary Nicholson and Miss Nancy Judge for their unfailing secretarial help.

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Workers' Compensation

DOES IT CONCERN NOVA SCOTIA'S DOCTORS?

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Workers' Compensation in the minds of many physicians, no doubt, conjures images of conducting somewhat uninspiring physicals (normally on the musculoskeletal system) and more of the endless completion of forms.

From the physician's point of view, this perception may well be justified for the vast majority of compensable cases in Nova Scotia at present are due to injuries and the patient's doctor is required to assess the injury and dispassionately fill out a "Doctor's First Report"(a) form on the accident and resultant disability and may not be further involved in follow-up (e.g. rehabilitation). To the physician, the procedure for the most part represents yet more bureaucratic hassle for which he/she does not get adequately paid, but to the patient who is partially or totally disabled by illness or injury, the accurate assessment of disability and the prompt submission of properly completed forms by the physician represents the key to receiving an uninterrupted income. While making this point might seem trite, it is surprising how many are not clear on the mechanisms involved in Workers' Compensation or even on the differences that exist among workers' compensation, unemployment insurance, welfare, and various types of pension, including Canada Pension. (The reader will find useful a review of Workers' Compensation in Canada in the Labour Canada publication on the subject).[1] Nevertheless these differences are of critical importance to the worker to whom it is essential to be thought of as a worker and not as a recipient of handouts.

Needless to say, the psychosocial impact of disability, particularly with respect to self image of the worker, is difficult enough to bear without the added stigma of being considered the beneficiary of social assistance.

The distinction to be made between the classical forms of social assistance e.g. welfare, pension, unemployment insurance, or private insurance schemes on one hand, and compensation for disability incurred while working, on the other, is that workers' compensation in Canada is *collectively* financed by employers rather than by either the immediate employer of the injured worker or by the entire community as is social assistance.

HISTORY OF WORKERS' COMPENSATION

Some perspective might be gained by outlining a brief history of workers' compensation as it exists in Nova Scotia.

(a) Although a considerable and ever-increasing number of injuries the physician sees are, in fact, *illnesses* and not injuries the "Doctor's First Report" form is designed specifically for gathering information on accident-caused *injury*.

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At the turn of the century, the common law system in Canada was essentially similar to the system existing in Great Britain. Up to that time, with regard to industrial accidents and illnesses (the latter, hardly acknowledged to exist then), the only recourse an injured worker had was through the courts, following the procedures of tort litigation. The essence of such a system required the assumption of a negligent employer and a blameless victim. The outcome teetered on the vagaries of the court system prevalent at the time and the ability or will of the employee to obtain adequate counsel.

In short, the system proved to be inconsistent in meting out justice and, therefore, often was unfair to both employees and employer. The high insurance premiums borne by many companies, the threat of economic ruin following litigation, and the low morale among the workers ever-cognizant of the adversary system, led eventually to a move to replace this means of obtaining recompense for injury with a more equitable and certainly less potentially destructive system. Accordingly, the concept of a type of "no fault" insurance was born, with the first steps being taken in Ontario. Sir William Meredith, then Chief Justice of the Supreme Court of Ontario, completed a study on the matter and submitted a draft of the proposed legislation in 1914. The bill enacting Workmen's Compensation, was passed by the Ontario Legislature and became law on January 1, 1915. Manitoba and British Columbia enacted similar legislation in 1916, followed by Nova Scotia (1917), Alberta and New Brunswick (1918), Saskatchewan (1919), Quebec (1931), Prince Edward Island (1949) and Newfoundland (1951)[2]

In the United States, the first Workmen's Compensation laws were passed in the decade 1910-1920, varying widely in their scope and benefits at the state level[3]. The concept of Workers' Compensation thus had resulted in an historic trade-off. The essence was that workers were guaranteed protection against income loss due to industrial injuries, irrespective of fault, in return for a legally binding waiver of the right to sue their employer and collect full damages for all losses (this protection included hospital, medical and rehabilitation costs). While fund investment strategy, mechanisms and amounts of payments for injured workers, and the inclusion or exclusion of industries participating in the plan have all changed substantially since its inception, the main component in workers' compensation that the *physician* sees even now has not changed — that is the provision of compensation for injury due to *accidents* and the promotion of accident prevention. The major component that the physician has *not* yet seen, for the most part, is the provision of compensation for disability due to *illnesses*. Hence the obvious major shortfall of the Nova Scotia compensation system today as it concerns physicians most, and one that will doubtless be changed radically within the next several years[4], appears to be the failure to address

adequately the concept of occupational *illness*[b]. Occupational illness is in every way (from administratively to medically), fundamentally different and more complex than injury due-to-accident.

Time will no doubt prove that not only will Workers' Compensation Boards in Canada have to come to grips with the concept of occupational illness but just as important, so will practising physicians.

OCCUPATIONAL ILLNESS vs. ACCIDENT/INJURY

As complex and difficult to administer as the third party liability claim for industrial accident is, it is "small potatoes" compared with the spectre of industrial disease which looms just over the horizon of the next decade. This is because the paradigm of occupational *disease* (= illness) is qualitatively different from that of *accident*. The essential distinction between the two comes in the dimensions of time, place, and fault. These might best be illustrated by comparing examples of accident/insury (e.g. "slipped disc" i.e. disc rupture) with illness (e.g. asbestosis, a form of pneumoconiosis). Whereas the back injury is acute and can be pinpointed in time and, therefore, place and similarly, therefore, 'fault' can be ascertained, pneumoconiosis is a progressive condition, typically having a long latent period and, therefore, time, place, and fault cannot easily be specified. It does not take much imagination to foresee the confusion which arises, when, for example, a worker files a claim against his present employer (for whom he has worked for five years) for asbestosis or bronchogenic carcinoma when his prior work experience for twenty years also caused him to be exposed to asbestos, or silica, or chemicals.

What is the cause of the pneumoconiosis? When did the initial exposure occur? Is there a synergistic effect with other occupational contaminants whose effects are even, as yet, unknown? What part does non-occupational exposure (e.g. smoking) play? Who is at fault? These are but a few of the questions that would have to be answered. Imagine trying to retrace an employee's work history back for 25 or 30 years and to determine the exposure periods to various environmental contaminants and their relative contributions over a period of time that cannot, as yet, be specified by medical estimates! Nevertheless, there is no doubt that the connection between occupation and disease will be eventually established more firmly[c], and this will result, therefore, in a qualitative change in the composition of compensation claims and correspondingly in the role of the claimant's physician. The medical practitioner will not only have to diagnose occupational illnesses correctly,[5,6,7] and treat them[d] in the context of traditional goals i.e. involving the physical well-being of the patient, but also will have to diagnose correctly in order to ensure the *economic* (and, therefore, social) well-being of the patient, for it is the physician whose responsibility it is to "connect" the patient with the current system of compensation for workers illness/injury that exists here.

HOW THE WCB WORKS

Under the present system, when a worker is injured or is ill because of work-related causes and cannot continue working, he/she submits a claim to the WCB. The worker's employer also submits an "Employer's Report of Accident", his/her physician submits a "Doctor's First Report" and all of these WCB documents are considered together by board physicians and claims officers in initiating the process. Of all documents, the "Doctor's First Report" form is clearly the most critical, for it is upon the information provided by the claimant's physician that a judgment is made as to whether or not the disability was caused by the work environment.

If the claim is accepted, the worker receives payment starting from the day the disability occurred such that the disabled worker's income totals 75% of the average weekly earnings over the previous twelve months.[10]

Appeals of Board decisions are made to the WCB Appeal Board for the most part. However, on questions of law or of the Board's jurisdiction, either the claimant or the WCB may submit a case to the Nova Scotia Supreme Court, Appeal Division, for a decision.[1] The task of maintaining continuous financial security for the disabled worker is onerous, indeed, and large bureaucracies have been set up in the more populous provinces to handle the large volumes of claims. The Ontario Board, for example, with 3,000 employees, handles 450,000 claims per year.[11] The Nova Scotia Board with some 100 employees[12] handled a caseload of 32,800 claims in 1980.[13] Although the present system in Nova Scotia has worked quite well until now, it is only because firm connections have generally *not* been made between occupation and disease (as opposed to injury), and illnesses generally have not been claimed. The machinery of the Workers' Compensation Board is, therefore, not equipped to handle such claims and, consequently, handles very few. An additional factor may well be the underdiagnosing of occupationally related illnesses. These go hand-in-hand with the public's general lack-of-awareness concerning environment and health (but this is rapidly changing).[14]

It follows, therefore, that claims for occupational illness as compared to accident are grossly under-represented considering their true incidence. Consider the following: Around 80% of premature deaths among adult Canadian workers stem from disease of one kind or another. About 95% of the recipients of total disability benefits under the Canada Pension Plan are disabled by disease rather than by accident. Yet, only 2 to 3% of workers' compensation claims and pensions are awarded to victims of disease-based disabilities.[11]

(b) "Occupation" or "industry" is taken in its broadest sense in this context and includes not only the classical 'hard' industries and their workers, but also white collar workers, clerical workers, and indeed, anyone who gets paid for doing a job.

(c) The reader will likely already be able to point out examples of "firm" connections between industry and disease. Even in the current Workers' Compensation Act for Nova Scotia (formerly called Workmen's Compensation Act in 1968, but amended to its present title in 1979)[8] Section 9A calls for automatic compensation for any worker who has worked in a coalmine for 25 years. In other words, the cause-effect relationship between coalminers pneumoconiosis and working in a coalmine for a long time, is automatically assumed.

(d) One hopes that in the future, medical insurance schemes would provide for the payment of physicians for any involvement on their part in follow-up and prevention of illnesses and not just provide the traditional fee-for-service for diagnosis and treatment. The involvement of physicians in disease *prevention*[9] is not a new problem and has been addressed previously. At any rate, this primary prevention, most effectively brought about by some measure of physician-employer liaison, is rarely seen at present.

THE SITUATION IN NOVA SCOTIA

In Nova Scotia, in 1980, less than 1% of 32,837 claims were for occupational illness.[15]

A glance at the Workers' Compensation Act for Nova Scotia (passed in 1968)[10] suggests one reason why occupational illnesses are so obviously under-represented in WCB claims. But for silicosis, coal miners pneumoconiosis and radiation which are given some special mention, only one section of the act (containing 164 sections) is devoted to industrial diseases. "Schedule "A" of the Act (Reproduced in Table 1) lists the industrial diseases which "exist" in Nova Scotia.

TABLE I

REPRODUCTION OF "SCHEDULE A" OF WORKERS' COMPENSATION ACT FOR NOVA SCOTIA[10]

Disease	Description of Process
Anthrax	Handling of wool, hair, bristles, hides and skins
Carbon Monoxide Poisoning	Any process or work involving exposure to carbon monoxide
Lead poisoning or its sequelae	Any process involving the use of lead or its preparations or compounds
Mercury poisoning or its sequelae	Any process involving the use of mercury or its preparations or compounds
Phosphorus poisoning or its sequelae	Any process involving the use of phosphorus or its preparations or compounds
Arsenic poisoning or its sequelae	Any process involving the use of arsenic or its preparations or compounds
Ankylostomiasis	Mining
Subsutaneous cellulitis of the hand (Beat Hand)	Mining
Subcutaneous cellulitis over the Patella (Miner's beat knee)	Mining
Acute bursitis over the elbow (Miner's beat elbow)	Mining
Frost-bite	Any outdoor work
Dermatitis venenata	Any industrial process involving the handling or use of irritants capable of causing or producing dermatitis venenata
Epitheliomatous cancer or ulceration of the skin	Handling or use of tar, pitch, bitumen, mineral oil or paraffin, or any compound, products or residue of any of these substances
Coal miner's pneumonoconiosis	Coal Mining
Tenosynovitis (simple)	Any process involving constantly repeated vibrations or excessive use of muscles of arm, forearm, hand, leg, ankle or foot
Any disease or disability due to exposure to x-rays, radium, or other radioactive substances	Any process in the refining of radium or other radioactive substances or involving exposure to x-rays

On the other hand, a truer representation of occupational diseases would come under major headings in any good reference on occupational health (e.g. Zenz,[3] Hunter,[16] NIOSH[17]) as follows:

Physical/Chemical:

Pneumoconiosis (organic and inorganic)

Chemical:

Toxic organic chemicals (in addition to carbon monoxide)
Toxic inorganic chemicals (in addition to lead, mercury, phosphorus, and arsenic)
Halogenated hydrocarbons and pesticides
Carcinogens
"Allergic" respiratory diseases (e.g. farmer's lung)
Dermatoses (in addition to those due to polynuclear aromatic hydrocarbons)

Physical:

Biomechanical problems (e.g. low back pain)
Vibrations (in addition to tenosynovitis)
Heat/cold stress (in addition to frostbite)
Noise
Ionizing/non-ionizing radiation
Aerospace/diving/compressed air
Fibrous glass

Psychosocial:

Work stress
Shift work
Alcoholism and drugs

and the list could go on. The point is, that sooner or later the specific legal connections between workplace and diseases will be established and as the diseases, in fact, generally become recognized in the statutes, legislation providing for appropriate compensation for work-related *illnesses* will be forthcoming here in Nova Scotia.

THE FUTURE: WHAT THE PHYSICIAN IN NOVA SCOTIA CAN EXPECT

In the long run, it may prove to be impossible to sort out the myriad components that contribute to even apparently well-known types of industrial disease, the major problems stemming from, as mentioned earlier, the latency period and intervening factors between exposure to the disease-causing agent and the diagnosis of the specific disease. In this light, the task of assigning third party tort liability as we now know it, will become a nightmare, and the solution may well be to provide a guaranteed income to any (every) worker who becomes ill *for any reason*. The cost for funding this broader form of financial assistance would not be borne strictly by industry (as they are now under the current Workers' Compensation Act), but would be integrated within other components of social assistance. In this sense not only would an individual industry not be faulted (this does not preclude the possibility of class action suit against a particularly negligent employer) but industry in general would be held faultless in terms of causing illness — in fact the term "Occupational Illness' may become obsolete (and the term 'Environmental Illness' may become popular).

When this happens, the role of the specialist in occupational diseases will change significantly, since no *a priori* judgement would have to be made as to whether an illness could be occupational or not. *All* physicians would, no doubt,

be attuned to diagnosing and treating environmental illnesses[e] in this chemical age.

Three factors will forge the future of health care with regard to occupations:

1) As employee awareness of health, safety, and employee rights grows, the number of WCB claims for occupational *illness* will rise astronomically (there are signs in North America that this is already beginning to happen).

2) As physician awareness grows,[14,18,19] the number of diagnosed cases of occupationally related illness will increase significantly.

3 As the awareness of the general public and politicians grows[20] and as the inerita of bureaucratic processes in the field of health care lessens, the laws governing workers' health will become more all encompassing.

It is hard to foresee which of these three factors will prove to be the catalyst that will create the reaction of the other two (I, personally favour the first one), but any way one cuts it, physicians will be significantly more involved in occupational health issues than they are now. The paperwork, report writing, and completing forms[f] for compensation claims for the patient, and the court appearances as an expert witness will take more of the physician's professional time and not less. The involvement of the general and family practitioner in the broader aspects of community health, environmental and occupational health and in *primary prevention* through direct liaison with industry will increase. Even traditional specialists will slant their trade towards the occupational arena (this is already being done by some lung specialists in Canada).

WHAT IS TO BE DONE?

The involvement of physicians on individual bases in occupational health issues adds up to active participation of the medical profession collectively. Such participation is particularly important in light of the inevitable burgeoning of the field of occupational health in that *lack* of initiative by the profession will mean more dictating to the profession by the law-makers.

The following are, in general terms, some of the areas where the medical profession might contribute:

Physicians can make it their business to understand the concept of workers' compensation, its mechanisms and machinery — particularly as it applies to them.

The more ambitious might provide (unsolicited) feedback to the WCB, Departments of Health or Labour regarding the outside physician's role with reference to, for example, the "Doctor's First Report" form — how can it be improved? What sort of information is needed? In addition (and this is axiomatic), physicians should make it their particular business to stay abreast of latest developments in occupational health issues (contact the Department of Continuing Education for seminars and short courses), labour law as it applies to physicians, and medical jurisprudence. This is particularly important in light of the glaring absence of adequate treatment of these subjects at the undergraduate level of medical training. To the general or family practitioner, keeping up with these matters may prove to be far more relevant than keeping up to date with, for example, all the newest surgical techniques.

Medical educators, inured by the philosophies of the traditional departments within medical schools (Medicine; Surgery) must be prepared to shed the shackles of conservatism and provide the vital training at the *undergraduate* level.

Such progressive action by practitioners and educators will lead us in this very important area of social medicine — into the twenty first century. □

ACKNOWLEDGEMENTS

I wish to express many thanks to my brother, Paul Cappon, MD., Ed Tupper, P.Eng., of the Department of Health, Pat Clahane, LL.B., and Gordon Gillis, LL.B., of the Department of Labour for their helpful criticisms of the manuscript, and to the Occupational Health Division of the Department of Health for providing environmental support.

(e) It is too facile to presuppose that *all* illnesses are of environmental etiology. Indeed, while the etiology of certain diseases, for example cancer, may prove to be largely environmental, in the stricter usage of the term 'environmental illness', (and the one that is used here) only those diseases which result more or less directly from man's activities in altering the natural environment by physical or chemical means are thought of as environmental. The agents involved in environmental illnesses are noise, chemicals, radiation, heat, mechanical stress and emotional stress. While these stressors themselves may be difficult to pinpoint, the *diseases* that they cause, manifesting themselves nonspecifically as they do, are often impossible to distinguish from classical disease (this is, as any student of pathology knows, because tissues respond to a limitless number of insults in only a limited number of ways). The diseases of aging (such as atherosclerosis, panlobular emphysema, dementia), infectious diseases, certain metabolic diseases (diabetes), or degenerative diseases (rheumatoid arthritis) are not environmental, whereas those resulting from man's impact on the environment (and the converse) are (e.g. angiosarcoma of the liver). In this sense occupational illnesses are a classical subset of environmental illness.

(f) One would hope that the *number* of forms to be filled in by the physician will not increase in Nova Scotia, but that the *quality* will. At present, except for a special form for pneumoconiosis, the "Doctor's First Report" form asks for information entirely related to *injury* and not applicable to *illness*. The statistics on illnesses accruing from such collective information vital for follow-up and primary prevention as they are, are therefore practically non-existent in Nova Scotia.[15, 21]

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References continued on page 192.

An Odyssey Unfinished*

B. J. S. Grogono**, M.B.,
Halifax, N.S.

His socks were wet
moist from the cold memories
of the grey Atlantic
licked by the lingering promise
of a dream
that linked his boundless imagination
with reality.

His face was set
cast against the cutting edge
of the morning
shaped by the searing agony
that clipped his grim determination
with sincerity.

Many a Hero
embarking from this rugged lair
where ocean giants
combat in deadly rivalry
has cast his soul
upon this wild celestial air
some conquered
some faded into oblivion.

No Hero
He, who like an Athenian messenger
embarked upon a gargantuan marathon
and bathed his dreams
in simple ceremony
and laughter

The Foxtrot he called it
Something between a Hopscotch and an Irish Jig

Pounding incessantly
mile after mile
constant, continually
yet all the while
blistered, bleeding
always in pain
counting, counting
again and again
somehow suspended
twixt Heaven and Hell
a body and soul
tolling a bell

Tolling estatically
day after day
Charismatically shattering
indifference away
playing, cajolling
a pied piper's call
triumphant, resounding
a message for all

A small band followed
united
unabashed
lashed by the jealous fury of the winds
that sought to quell the noble force
that rivaled their omnipotence

The tide
slowly erodes the solid beaches
of a sandy coast
gaining momentum from the massive weight
of Neptunes might
succeeding gracefully to transpose
beauty
to an ever changing landscape.

So slowly
the persistent passion of this journey
picked out the thorny covering of our souls
to lay them bare
and change our abject attitudes
of selfishness.

A smattery of friends
a journalist
a polka dotted mayor
a family joined by a common bond
surveyed the scene
illumined by the thrill of his desire
to help the misery of man.

*Based on a book *"Terry Fox-His Life"* by Leslie Scrivener, MacLelland and Stewart, 1981.

**Chief of Orthopaedics, The Halifax Infirmary, Halifax, N.S.

Some sat in a van
some jogged
some gathered laurels and flowers
as they ran
they garnished love with praise;
some waved
some children collected
cheered
priests, families bereaved
old ladies
businessmen, police
atheists and athletes
professors
politicians
mayors galore
media amassed,
until the whole world
opened a new corridor
of hope.

The desperate sadness
the loneliness
the crass indifference
the abominable accruements of cancer
the cruelty of fate —
burnt out with scorching flame
to set this trail ablaze!

His foxtrot
has not ceased
his strong relentless beat
throbs on
a global orchestra
conducted
by the glory
of a Great Canadian's Dream!

B.J.S.G. ©1981

APPRECIATIONS

Dr. Henry Kenneth Hall

Born in Kamloops, British Columbia, reared mostly in Kelowna, Ken completed his high school in Vancouver and after doing his pre-medical requirements at U.B.C., he came to Dalhousie Faculty of Medicine to join an accelerated course which he finished in September, 1944. This included interne service at the Kentville Sanatorium, Camp Hill Hospital and Saint John, New Brunswick. After graduation he was sent to Yarmouth, then took a tropical medicine course at Walter Reed Hospital in Washington, D.C. and served in Panama.

When the war ended, Ken opted for Psychiatry and began his training at the Nova Scotia Hospital and the Psychiatric Clinic where he met and married Barbara Wagstaff, a social worker at the Clinic.

In January of 1947, Ken enrolled in the residency program under Dr. Oskar Diethelm at the New York Hospital (Department of Psychiatry, Cornell University.) Barbara worked as a social worker in Memorial Hospital (now Sloan Kettering) in New York City.

In January, 1950, they returned to Halifax. Ken joined the Department of Psychiatry at Dalhousie and opened a private practice. He obtained his Royal College certificate in that same year.

In 1951 their first child, Deborah, was born, and Kathleen in 1956.

Over the past thirty years Ken has been an active teaching member of the Department of Psychiatry, Dalhousie University, and has maintained an extensive private practice. He has served as an active member of many committees: The Medical Society of Nova Scotia — Economics, Executive; The Nova Scotia Psychiatric Association — Economics; The Canadian Psychiatric Association — Ethics, Legislation; Medical Review Board, MSI — Member; Medical Review Board, Motor Vehicle Branch — Member; Medico-Legal Society; and many committees of the Victoria General Hospital and Camp Hill Hospital.

His death on September 30 , 1981 — after a valiant battle with his illness — although not unexpected, left a pall of gloom on the medical community. Ken will be missed by his family, his peers, and his many patients for whom he had been a source of strength. Our whole community has lost a steadfast, high-minded resourceful doctor, and we are all the poorer for his passing.

I would like to express, on behalf of the *Bulletin,* The Medical Society of Nova Scotia and the medical community as a whole, our appreciation of his life and extend our sincere sympathy to his family.

J. F. Nicholson, M.D., F.R.C.P.(C)
Professor Emeritus of Psychiatry

Dr. James Taylor Balmanno

Doctor James T. Balmanno, M.D.C.M., F.R.C.P. (C), 61, of Carleton, Yarmouth County, died May 29, 1981 at Yarmouth Regional Hospital.

Born in Dunfermline, Scotland, he was a son of Robert and the late Williamina (McGhie) Balmanno. He came to Joggins, N.S. at an early age and was educated in the local school system and Mount Allison University before serving overseas with the R.C.A.F during the Second World War. After the war, he entered Dalhousie University Medical School and graduated in 1949. He did his post-graduate training in surgery in Boston City Hospital. He then returned to Nova Scotia and practised in Weymouth for some time and was associated with Digby Hospital. In 1957 he moved to Yarmouth and established a practice in General Surgery.

As a surgeon and former Chief of Surgery at the Yarmouth Regional Hospital, he was devoted to upgrading the quality of care in that institution and made himself always available, treating the ills and solving the medical problems of scores of people, a job he did so splendidly well that he was not only admired and appreciated by all his patients but equally by his colleagues. As a clinician, his judgment was very sound and as a surgeon he was very skillful and swift.

He was a member of The Canadian Medical Association and The Medical Society of Nova Scotia and was an executive member of the Provincial Medical Board and of the Western Branch of The Medical Society of Nova Scotia. He served as Chief of Surgery and member of the Medical Advisory Board of Yarmouth Regional Hospital for several years.

He had many hobbies. He was a member of the Chebogue River Aquatic Club, a member of the Flying Club and a scuba diver. Fishing was one of his favourite hobbies.

He is survived by his wife Katherine, the former Katherine MacLennan, two daughters, Katherine Balmanno-Segers of Vancouver, B.C. and Jane Balmanno, Halifax, a sister Margaret (Mrs. John Maclean) Pictou, and his father, Robert Balmanno, Yarmouth. He was predeceased by an infant daughter, Margaret Jean.

Dr. Balmanno provided an excellent and admirable service to all that approached him. He gave the best of his energies and talents to the people of Yarmouth, Clare and adjoining counties. His devotion to his work made his relationships with patients very special. He will be sorely missed.

Raj Parkash, M.D.
Yarmouth, N.S.

Dr. J. Arnold Noble

Dr. J. Arnold Noble passed away at his residence, Solbacken, Glen Margaret, on September 25, 1981.

Dr. Noble was born in Campbellton, N.B., on June 9 , 1906, and moved to Sydney at an early age where he received his primary education. He attended Acadia University and graduated with a B.A. in 1926.

Arnold was one of the early adventurers who attended Edinburgh University where he received a MB., ChB. in 1930. He stayed in Edinburgh a further three years at the Royal Infirmary, where he qualified for the FRCS (Ed.) in 1933. He also distinguished himself in another way, being the only Canadian to Captain the Rugger Team of the University.

He returned to Halifax to begin surgical practice, becoming an Associate Surgeon at the Victoria General Hospital, Lecturer in Surgery and Demonstrator in Anatomy, as well as a Consultant to Camp Hill Hospital. In 1939 he received his FRCS (C) and began a Military career which took him to England and Italy where he commanded several Hospitals, in particular the 9th Canadian General Hospital. He was promoted to Colonel and received the O.B.E. for his distinguished military service.

In 1945 he returned once again to Canada and two years later became Officer in Charge, Surgery, at Camp Hill Hospital until his retirement in December 1971. During this time he became Associate Professor of Surgery and contributed much to the education of many classes of Medical Students and Dental Students to whom he demonstrated Oral Surgery.

Dr. Noble will be remembered by many Residents in Surgery to whose career he contributed much, particularly in those fields where he was a pioneer and innovator. He gave of himself to every veteran who required surgical services, organizing a Surgical Unit which was a model for the care and rehabilitation of the many disabled veterans in the Province.

During his life, and particularly after moving to Glen Margaret, he became an avid gardener. He enjoyed long voyages on ocean freighters and saw much of the world this way, sharing with us many unique experiences.

Dr. Noble is survived by his wife, the former Carolyn Chipman, two sons, Jonathon of Halifax and Peter of Mississauga, Ontario, and four grandchildren.

Dr. Noble was a person who could only command the highest respect for his personal and surgical achievements. He became a model for every patient in the manner he conducted himself through two particular crises from which he rebounded with enthusiasm. It was a well deserved honour for him when he was appointed Surgeon to the Queen during her visit to open the Tupper Building in 1967. His dedication to teaching and to the veteran, his equanimity in the face of calamity, and above all, his dedication to his fellow man, should be a model for us all.

H. M. Simms, M.D.
Halifax, N.S.

BEGINNING COURSE IN CLINICAL HYPNOSIS

March 26-27, 1982, Sir Charles Tupper Medical Building, Halifax. Sponsored by Clinical Hypnosis Society of Nova Scotia — cost $150.00.

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B3H 1Y6

Personal Interest Notes

SENIOR MEMBERSHIP CITATIONS
THE MEDICAL SOCIETY OF NOVA SCOTIA

Dr. Gordon L. Silver

Dr. Alan J. MacLeod congratulates long time friend Dr. Gordon Silver as he confers upon him Senior Membership in The Medical Society of Nova Scotia.

Dr. Gordon L. Silver was born in Halifax on August 7, 1911.

He was educated in Halifax schools and in Kings Collegiate School. He entered Dalhousie University in 1928 and graduated with M.D.C.M. in 1935.

He began General Practice and practice in Obstetrics in Sherbrooks, N.S., in the same year.

Reluctantly, he gave up practice in Obstetrics in 1967 and he is now — after 46 years of service to the community — retiring from Family Practice.

Dr. Silver was a member of the staff of St. Mary's Hospital, Sherbrooke, from 1936 and an Associate Staff member of St. Martha's Hospital, Antigonish, from 1949. He is a member of C.F.P.C.

He was a member of Antigonish-Guysborough Medical Society — a very active member and its past president — since 1936 and a member of The Medical Society of Nova Scotia for the same number of years. He served for several years on the Executive of The Medical Society of Nova Scotia representing the Antigonish-Guysborough Branch.

Dr. Silver is an excellent bridge player, and avid hunter and a real expert in fishing.

He always had great help and support in the practice of medicine and in all his activities from his wife Ruth. They have two sons and several grandchildren.

To express their gratitude for his devotion to duty and show their high esteem for him, the Community of Sherbrooke honoured Dr. Silver and his wife with a Testimonial Dinner in 1978. Very many people in the area, who were brought to this world by him, were wearing on that day a button with these words: "I am Doctor's Silver Baby".

Mr. President, I am very happy and pleased to present Dr. Gordon L. Silver to you, for the honour of Senior Membership in The Medical Society of Nova Scotia.

W. Guzdziol, M.D.
Antigonish-Guysborough Medical Society.

Dr. Audley A. Giffin

Dr. A. A. Giffen of Kentville is seen following installation as Senior Member of The Medical Society of Nova Scotia by Dr. Alan J. MacLeod.

Audley Atwood Giffin was born on April 13, 1906 in Halifax, Nova Scotia. His parents hailed from Shelburne. He was educated within the Halifax school system and entered Dalhousie University in 1924, gaining his BA in 1927 and his MD in 1931. Thereafter he worked for three years at the Nova Scotia Sanatorium, and following that he was appointed House Surgeon at the Royal Victoria Hospital, Montreal in 1934. In 1935 he became Resident Surgeon at the Children's Memorial Hospital in Montreal, being appointed acting Superintendent of that institution the same year.

He returned to Nova Scotia in 1936, initially establishing a practice in Bridgetown. During that year he married Muriel Hubley of Kentville, herself a registered nurse and qualified lab technician, whom he had met while working at the Sanatorium.

The Giffins moved to Kentville in 1939 where Audley was appointed to the staff of the B.F.M. Hospital. On the outbreak of war he volunteered for active service, and was called up in 1940 into the Royal Canadian Navy, where his lifelong love of sailing doubtless stood him good stead. He lost no time in making his mark upon the Navy. Starting as Surgeon Lieutenant in HMCS Assiniboine, he moved to become principal medical officer of the RCN Hospital in Newfoundland, and thereafter Surgeon Commander and Senior Medical Officer to the Newfoundland forces. He then returned to Halifax as Surgeon Captain and Command

Medical Officer for the Canadian Northwest Atlantic Command. His wife accompanied him to Newfoundland and there presented him with two sons; David, now a chartered accountant, and Michael, an architect, now Architectural Director for the Manitoba Government.

Dr. Giffin returned to Kentville and the B.F.M. Hospital in 1945, and there established a large and busy family practice, with a special interest in obstetrics and gynecology. On his return to Kentville he devoted his tremendous drive and energy to the service of the community. He became a Municipal Councillor in 1945-46. He became Chairman of the School Board for six years and at the same time was Chairman of the Board of the B.F.M. Hospital and President of the Kentville Hospital Association from 1952 to 1965. From 1945, when the B.F.M. Hospital had 39 beds, until 1964 when the present building was completed with over 100 beds, Dr. Giffin supervised and managed the affairs of the Hospital. He became President of the Valley Medical Society.

He was appointed as Chairman of the Research Commission of the Medical Society of Nova Scotia, the Commission that prepared the briefs presented to the Royal Commission on Health Services and to the Nova Scotia Government. These briefs prepared the way for medicare in Nova Scotia. Our present system of health care insurance, administered jointly by MSI and MMC, is a tribute to Dr. Giffin's wisdom and foresight. He also served as President of Maritime Medical Care for a number of years in the 60s.

Dr. Giffin retired from active practice in 1979, and together with his wife, Muriel, his companion for 45 years, now has time for his other interests. These include his family, his home and his extensive library.

Mr. President, it is my pleasure to present Dr. Audley Atwood Giffin for the award of Senior Membership in The Medical Society of Nova Scotia.

J. D. A. Henshaw, M.D.
Valley Medical Society

A number of physicians who have become medical sleuths as a form of relaxation, pursuing the diagnosis of famous historical figures, have inevitably banded together to form the convivial Society for The History of Medicine.

Its founder is the neurologist, **Dr. T.J. Murray,** who has ascribed Dr. Samuel Johnson's compulsive, twitching behavior to Gilles de la Tourette syndrome. Its secretary-treasurer is **Dr. Stephen F. Bedwell,** who offers a solution for the mysterious death of the Duc D'Anville, on the shores of Bedford Basin, at 3 a.m., September 27, 1746.

Both men were speakers at the Society's dinner meeting, early in December in the University Faculty Club on the campus of Dalhousie University.

Membership is open to any interested person and spouse and, although barely three months old, members number more than 50, including **Dr. E. Carl Abbott** whose special interest is in diagnosing the ailments of musicians of the classicial period; and **Dr. Allan E. Marble,** a bio-medical engineer in the forefront of modern cardio-vascular research, and with a keen interest in the history of physicians and medicine in Nova Scotia.

Dr. Judith Gold, Associate Professor of Psychiatry, Dalhousie University, became the President of the Canadian Psychiatric Association at last month's Annual Meeting in Winnipeg. The entire Department of Psychiatry offers congratulations to Dr. Gold and is extremely proud of her accomplishment in becoming the first woman President of any major psychiatric Association in the English-speaking world. Dr. Gold has also had a distinguished academic and research career. She has presented many papers at the Canadian Psychiatric, the American Psychiatric and in a number of countries of the world. She is currently going to Hong Kong for this purpose. Dr. Gold is a most impressive representative of the women psychiatrists of Canada and of all of us in the Canadian Psychiatric Association. We wish her the very best for her year of Presidency.

Dr. Patrick Flynn and **Dr. Gerald Gray** presented a paper at the Annual Meeting of the Canadian Psychiatric Association in Winnipeg on "The Placebo Response in a Mental Hospital Setting".

Dr. R.O. Jones presented a paper at the Canadian Medical Association in Halifax in August on "Psychiatric Problems of the Elderly", and at the Canadian Psychiatric Association in Winnipeg on, "The Effect of the Current Atomic Bomb Threat on Personality Development".

Dr. George Fraser, Head of Psychiatry at the Canadian Forces Hospital in Halifax is the President-elect of the Atlantic Psychiatric Association. He will take office at the meeting of this Association in Cornerbrook on October 29 - 31. Dr. Fraser will present a paper on "Group Therapy" at that meeting, and papers will also be presented by Drs. F. A. Dunsworth and R. O. Jones.

Dr. R. O. Jones was honored by an appointment as an Officer of the Order of Canada in late June of this year. Investiture will take place in Ottawa on October 21st.

Dr. Vernon W. Krause, director of laboratories at the Izaak Walton Killam Hospital for Children, was recently elected president of the Canadian Association of Pathologists at its annual meeting in Toronto.

ADVERTISERS' INDEX

THE MEDICAL SOCIETY OF NOVA SCOTIA

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