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Much is left to be said about our present fee for service system. In order that everyone can have their say, we provide contrasting editorials, inviting comments on either point of view.

Fee for Service: Is it Dead?

Our present Health Care System pays most physicians on a fee for service basis. This method of payment, while giving physicians good incomes over the years, has been attacked by many developments and new concepts that deserve examination. The fee charged by physicians for professional services once was part of the basic contract between patient and doctor. As Dr. W. Vail, former CMA President has recently stated, this situation has changed drastically.

Our contract is now with the Government. If that is so, fee for services is outdated, impractical, and really only in the interest of the Government. Then they do not have to provide the clinics, buildings, offices, insurance, and fringe benefits to thousands of civil servants who cannot strike and, therefore, give little political back-talk to the bureaucratic decision makers.

In the Fee for Service System, the physician's primary concern is sometimes volume not quality of service, often made worse by a Fee Schedule that encourages procedures and visits that can be actually harmful to the patient. Incentive to refer is then not based on need but time saving, patient demand, (who can bother to explain) and need to guard against malpractice suits.

Insurance for all these individual medical acts is

On the Other Hand

Recently, the fee for service system of payment in this country has been under attack, both in obvious and subtle ways. Dr. William Vail, has stated that we no longer have a contract with individual patients but only with the Government, since they pay the fee. This, of course, is simplistic and cannot go unchallenged since our contract is much more than our fee. And until changed, it is still true that the Government is nothing more than a very powerful insurance company who happens to have a monopoly. It is still paying *for* the patient. The patient and doctor still have many rights and responsibilities inherent in the present fee for service system, that could and will be lost if salaried medicine is established. The patient can still choose his or her own doctor, change when unhappy, and sue for damages.

The doctor still owns the patient record (probably), can end a patient-doctor relationship under certain circumstances, and has an ethical and traditional role as his patients advocate in many circumstances.

Without this advocacy in occupational medicine, insurance claims, and court battles, the patient would be at a true disadvantage. Increasingly, with the scarcity of health care dollars, this advocacy for the individual patient will be come even more important

also becoming impractical and extremely inefficient. "Risk Management" medicine is often synonymous with bad or more expensive care, done to save money that would be at risk from a legal system that threatens to make physicians and hospitals pay for all the unfortunate and sometimes inevitable accidents of a less than perfect world.

Counting, differentiating, recording all the individual medical acts in our Society is about as useful as counting the grains of sand in a pillar of cement. Of course, those manic individuals that might desire to "be rich", that have a compulsion to work, that have an efficiency factor driving them to their first myocardial infarction (Type A), all use the fee for service to great advantage. But the virtues seen in these types of practices have long ago been identified as vices.

This "efficient billing" of large number of patients really does not serve the public well, least of all in the smaller rural areas of Canada. Underserviced areas are often a problem of the Billing System, although people give other reasons for not moving to rural Canada. A well paid position, in a job requiring less actual work in a system where all were on salary, would not long go begging. A fair system of salaries would not then penalize those working in isolated or sparsely populated areas. And no longer would experience be ignored under fee for service; the older more experienced physician could receive acknowledgment of his growth in his profession if salaries were the rule.

Fee for service is antiquated, inefficient, promotes bad care and unhealthy doctors, and does not allow for adequate planning or control of the medical system. Worse than this, it still leaves the public believing we make inordinate amounts of money from their suffering and are overpaid, with a primary interest in our fee rather than their welfare. Change has come upon us.

Many new graduates, especially female, seem much more prepared to accept a salary that would allow them to practice good preventive medicine as they have been taught in medical school. Dr. Robert Spasoff, in Community Medicine at the University of Ottawa, has stated strongly that it is very difficult to practise preventive medicine under fee for service.

Recognition of this change could benefit all. Cession of the fee for service system would allow us to centre our interest where it should be — on the patient and his/her welfare.

J.F. O'C.

as the patient tries to get his new artificial hip or his coronary artery bypass or other procedures or levels of care that will be increasingly rationed.

In fact, economics is probably the most pertinent argument for the retention of fee for service system. Rough calculations of the cost of placing all physicians on a decent salary with all the usual benefits, must frighten our politicians. Observing the costs of private clinics and outpatient facilities, along with our overhead costs might finally make them see the bargain that we currently are.

Duplication of the mistakes of Great Britain make no sense, and as the British go more and more to additional private hospitals and private service, the true cost of socializing the system has not yet been achieved.

The manpower problem caused by a 36 hour week for physicians, if salaried, is amusing to contemplate. The golf courses and the Continuing Medical Education facilities would love the business generated, and most of us would enjoy laughing up our sleeves.

But what of the patient?

Surely we are not that angry, miserable, impractical, or uncaring to wish on our patients a system in which they would become only one of a population making demands of a system that depended on politicians to keep their word.

Fee for service has its limitations, of course, but the enterprising nature of man and physicians helps to preserve much of the best of care and the dignity of both patient and physician.

J.F. O'C.

□

This issue contains two reports by Beth Rafuse written as a second year Medical Student just prior to her death in 1985. The first article was written in association with Dr. T.J. Murray, while the second was done while participating in an elective in Family Medicine with Dr. Heather Zitner. It is with great sadness, but also with satisfaction that we see these articles published.

Dr. Bill Acker
PRESIDENT
The Medical Society of Nova Scotia
1986 - 1987

The new President of The Medical Society of Nova Scotia says, "We must re-affirm the position of the physician in our health care system". Dr. W.C. (Bill) Acker added, "We must be pro-active, taking our case to the people, after all, it is the people we serve".

Dr. Acker says he wants The Society's role to become absolutely clear to everyone. "We must be the advocate of the patient to ensure the highest quality patient care." He emphasized, "Doctors must not only care for their patients, but we must also care for our patients' rights within the health care system."

The new President is counting on the active participation of his colleagues to carry the message. He wants to really open the lines of communication within the Society. "We must communicate effectively among ourselves before we can take a clear message to government or the general public," he said.

Dr. Acker has already started the process. At his first meeting as Chairman, he asked each of the Officers to bring their concerns forward at an open forum and he promised to make that a part of each agenda.

The President also chaired a session with all the Chairmen of the Society's Standing Committees. The brain storming session was designed to set goals and priorities not only for each Committee but also for the Society. "It's a matter of working together," said Dr. Acker. "We can do a more effective job if we all know where we are going and what we hope to achieve."

Dr. Acker has a history of working well with people and with producing results. Right out of medical school he set up his general practice in Pictou where he became President of the Pictou County Branch Society.

He returned to his native Halifax in 1970 for a year of post graduate surgical training before joining Dr. John Cox in a family practice.

By the mid 1970's Dr. Acker's involvement in the Medical Society had become a committment to his profession. He served on the Executive of the Halifax Branch Society and held several key positions with the Provincial organization including Treasurer and Chairman of the Economics Committee.

The President maintains a strong committment to groups associated with medicine but outside of the

professional association. He continues as a member of the Blood Program Committee of the Red Cross Society of Nova Scotia. And, he is likely to make his 100th blood donation in 1987.

Your President is also an intensely devoted family man. It is not uncommon to see his wife Penny and his four children at Society functions. Dr. Acker insists on quality time with his family and he has found it easy to blend family life with Society life during his years of service.

That sense of family dedication should come as no surprise as Dr. Acker is the son of a physician. His father, Dr. Tom Acker, practised for many years in Halifax as an orthopaedic surgeon.

Those who have had the pleasure of working with Bill Acker describe his as "even handed and fair minded" and his patients describe him as "dedicated". Add to these qualities his deep sense of committment to the profession and you'll likely agree that the reins of the Medical Society are in good hands for 1987. □

Standardizing the Indications for Tonsillectomy and Adenoidectomy

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In the past tonsillectomy, with or without adenoidectomy, has swung through a pendulum from widespread acceptance to condemnation. Many of the attitudes expressed were based more on emotion than on scientific thought. Now, relatively well proven indications for this type of surgery are emerging from controlled scientific trials. Application of these indications to both specialty and primary care practices should produce a relatively even standard of care in any given geographic area.

Tonsillectomy and/or adenoidectomy remains one of the most common operations performed on children in North America. In the past fifty years controversy over the efficacy of the procedure has polarized the medical community. Much of the problem has arisen from the lack of scientific information in the literature to guide in the selection of patients for surgery. Such information is now emerging and this paper will attempt to summarize these studies.

HISTORICAL INDICATIONS[1]

Tonsillectomy has been performed since at least AD 50 when described by Celsus. The operation of adenoidectomy was described in the 1870s by William Meyer of Copenhagen who felt that infection of this tissue was responsible for otitis media and nasal symptoms.

In the early twentieth century the two operations were popularly combined as a unit procedure. Advocates claimed that a "focus of infection" which caused various systemic disorders was removed with the lymphoid tissue. Rheumatism was most popular, but anorexia, mental retardation and eneuresis were felt to justify the procedure, as was the first hint of prophylactic surgery: "a general measure to promote good health". The zenith of popularity occurred in certain communities where public schools were used to perform surgery on entire segments of the school population.

The pendulum began to swing in the opposite direction beginning in the 1930s as authors began to point out the natural history of childhood respiratory infections.[2] Antibiotics became generally available and, correctly or incorrectly, the risk of polio was felt to be increased after tonsillectomy. Finally, scientific studies began to demonstrate the lack of efficacy of the procedure in the vast majority of the then-fashionable indications. Ultimately one segment of the medical population felt there was no indication for the procedure while another continued unchanged from the pre-1930 attitudes.

Today, the operations can be viewed on a relatively scientific basis in all instances. The absolute indications are clear cut and can be acted upon without prolonged observation or investigation. For the relative indications, the resulting complications of nonsurgical management are generally benign. Delay to allow demonstration of surgical efficacy of the intended procedure is entirely safe in these cases.

ACCEPTED INDICATIONS[3]

The indications for tonsillectomy are not identical to those for adenoidectomy. While the two procedures may be performed simultaneously, separate consideration should be given to each aspect of the procedure and the minimum amount of indicated surgery performed. Dr. Sylvan Stool is quoted, "One doesn't like three bleeding sites for the necessity of one."

As for all surgical procedures we divide our criteria for surgery into absolutely indicated, relatively indicated and contraindicated categories. Conflict arises when one patient falls into both the absolutely indicated and contraindicated categories. Alternate means of therapy or the correction of the cause of the contraindication (if possible) must be considered before undertaking surgery.

ABSOLUTE INDICATIONS FOR TONSILLECTOMY

1) Obstruction of the Airway

This is the most frequent absolute indication for tonsillectomy. The patient normally presents with sleep apnea, but acute obstruction (alveolar hypoventilation) or chronic obstruction (cor pulmonale) of the upper airway also occur. Immediate relief of the symptoms can be obtained with a nasopharyngeal airway and injectable steroids (dexamethasone 1.25 mg/Kg IM). Secondary tonsillectomy is then undertaken after adequate nutrition is restored and after the patient has had an opportunity to regain the arousal reflexes. These patients require monitoring for at least twenty-four hours post-operatively.

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2) Failure to Thrive

This indication is not uncommon and may be due either to obstruction of the upper aerodigestive tract or chronic sepsis. Primary care physicians can assist the decision making process by including a copy of their growth chart with the referral.

3) Associated with Other Surgical Procedures

Some procedures such as uvulopalatopharyngoplasty for snoring or apnea require removal of the tonsils as part of the procedure. Others, such as pharyngeal flap for hypernasality, may require prior removal of the tonsils to guarantee a safe oral airway after the indicated surgery. In such instances, the additional risk of the tonsillectomy must be considered in the overall risk-benefit analysis of the procedure considered.

RELATIVE INDICATIONS FOR TONSILLECTOMY

1) Recurrent Pharyngotonsillitis (RPT)[4 5]

This is the most common reason given for tonsillectomy. Controversy arises in both the frequency of the disease and in the definition of pharyngotonsillitis. If one is to examine the incidence of pharyngitis, it is apparent that most children will have three to six sore throats per year until the second grade. Most of these will be viral and self-limiting. The incidence will be higher in day care centers and in the early years of school. The usual history is that the child has at least one miserable year followed by steady improvement over the succeeding years.

Purulent tonsillitis (ie. fever, odynophagia, tonsillar exudate, cervical lymphadenitis) represents a relatively small subset of all children with pharyngitis. These patients are ill for more than a few days and most frequently grow streptococcus on culture of the throat. Many children have the same symptoms without the exudate requiring cultures to differentiate from viral pharyngitis. Tonsil hypertrophy alone or with a mild fever does not represent pharyngotonsillitis.

A significant number of patients are streptococcal carriers. Once these patients are identified, cultures are of little value as the bacteria will be present in disease or in health, and are less likely to be the responsible pathogen.

Before acting on a referral, the surgeon should have enough information available to determine whether the patient has RPT or merely occasional pharyngitis with reactive tonsil hypertrophy. Records of frequency of attacks, observations of the symptoms, duration of illness and the response to therapy along with the cultures are most helpful. Randomized trials have demonstrated efficacy of tonsillectomy for up to two years post-operatively in those patients with true RPT. This author requires a history of at least two winters of RPT to ensure surgery is not undertaken for one of the natural increases in frequency of respiratory infection which are unchanged by surgery.

2) Halitosis

In older children and adults, halitosis from debris in persistent crypts will require tonsillectomy for relief. This is relatively uncommon.

3) Peritonsillar Abscess with RPT

Tonsillectomy may be justified either acutely or after incision and drainage. Most abscesses are isolated incidents and after adequate drainage do not recur.

4) Voice Disorders

The "hot potato" or muffled voice is noted with tonsillar enlargement. In older children, tonsillectomy may be indicated when the tonsils do not appear to be regressing and the voice disorder persists. This condition is often associated with pedunculated tonsils that extend inferiorly occupying space in and immobilizing the hypopharynx.

5) Biopsy

Tonsillectomy may be indicated for biopsy purposes in certain malignant conditions. This procedure should only be considered diagnostic as tonsillectomy does not constitute definitive treatment for any malignancy. Likewise it does not constitute prophylaxis against malignancy.

ABSOLUTE INDICATIONS FOR ADENOIDECTOMY

1) Airway Obstruction

In younger children, obstructive apnea is often caused by adenoid obstruction alone while in older children the tonsils play a more significant role. Both procedures may be required to relieve the obstruction.

2) Failure to Thrive

Persistent sepsis is the usual cause although some children are unable to swallow properly when the nose is obstructed.

3) Associated with Other Surgery

As for tonsil surgery, this may be an intimate part of a procedure or required prior to undertaking the indicated procedure.

4) Complete Nasal Obstruction

This condition may be associated with apnea, anosmia, taste disturbance, hyponasality, growth disturbance, rhinosinusitis and otitis media. Complete obstruction can be demonstrated by the hyponasality for 'm', 'n', 'ng'. Pinching the nose will not alter the sound of the voice in the presence of complete nasal obstruction. Efficacy of adenoidectomy has been

demonstrationed when complete nasal obstruction is present. Surgery for any of the individual symptoms is not necessarily indicated in the absence of complete nasal obstruction.

RELATIVE INDICATIONS FOR ADENOIDECTOMY

1) Recurrent Adenoiditis

This indication is similar to that for RPT.

2) Hyponasal Voice Disorders

This condition should be persistent to recommend surgery. Nasal allergies must be eliminated as a cause of nasal obstruction before undertaking surgery.

3) Rhinosinusitis

Rhinosinusitis appears to improve with relief of nasal obstruction and stasis caused by adenoid hypertrophy.

4) Otitis Media (OME)

OME when associated with high opening pressure on eustachean tube function testing *and* demonstration of large adenoids may be improved with adenoidectomy.[6,7]

5) Biopsy

Removal of all or part of the adenoids is indicated when searching for a cause of a positive neck node or if a mass detected in the nasopharynx.

UNPROVEN INDICATIONS FOR TONSIL AND/OR ADENOID SURGERY

1) Otitis Media

There appears to be no association between tonsil disease and OME. The efficacy of adenoidectomy in the management of OME is not universal and should be approached with caution.

2) Snoring

Snoring associated with enlarged tonsils or adenoids in children is a transient condition and, in the absence of apnea, does not constitute disease. Many conditions other than tonsil or adenoid enlargement cause snoring and should be sought in evaluating these patients. Many patients are medically treatable.

3) Facial Growth Disturbances

Various dental subspecialties have in the past recommended tonsil or adenoid surgery to "normalize" facial growth or to relieve "tongue thrust". Efficacy has not been demonstrated.

4) Tonsil or Adenoid Hypertrophy

In the absence of the listed indications, this condition represents a "non-disease".

5) Sore Throat Prophylaxis

This is a remnant of pre-1930 thinking. There is no evidence that this type of surgery decreases the incidence of viral sore throats.

CONTRAINDICATIONS TO TONSIL AND/OR ADENOID SURGERY

General Conditions

1. Anaesthetic Intolerance
2. Bleeding Disorders
3. Untreated Allergies

Local Conditions

1. Palate Malformation — adenoidectomy
   - — Submucous cleft palate
   - — Short palate
   - — Neuromuscular malformation
2. Acute Pharyngotonsillitis

COMPLICATIONS OF TONSIL AND/OR ADENOID SURGERY[8]

Death of the patient is the most severe complication of this surgery and receives the majority of the publicity. The mortality rate has been reported as high as 1:8,000 and as low as 1:24,000. In all probability the truth lies somewhere between these figures.[9]

Hemorrhage during and after surgery is the most frequent complication. The rate is between six and ten percent with most bleeding occurring in the first twenty-four hours after surgery. The risk of secondary hemorrhage lasts up to two weeks post-operatively. The distance of the patient's residence from secondary medical care must be noted before recommending surgery.

Speech problems in the form of hypernasality commonly occur after adenoidectomy. Most resolve spontaneously within three months, but the occasional child will have a persistent defect requiring speech therapy or further surgery.

CONCLUSIONS

Adequate documentation must be provided by the primary care physician to allow the surgeon to make a recommendation to the patient. Without that, the surgeon is obliged to gather such documentation on his own to determine whether or not indications for surgery exist. For the relative indications such delay is not harmful and in fact, most often demonstrates that the patient would not benefit from such surgery.

The risk of complications of tonsillectomy or adenoidectomy must be balanced against the expected benefit of such surgery. The type and severity of possible complications for both the medical and surgical management of the particular condition must

be presented to the patient or parent to allow rational decision making.

With competent medical, surgical and anaesthetic care, the complication rate will be relatively fixed as a percentage of the total procedures. The incidence of complication does not seem to be related to the indication for surgery. It would then seem that the overall numbers of patients having these complications would be reduced by restricting surgery to those patients in whom efficacy can be demonstrated by adequate pre-operative evaluation by both the primary care physician and the surgeon.

Such cooperation between generalist and surgeon to select and treat the appropriate patient surgically will gradually modify public expectations. The generalist will not feel forced to refer patients for "recurrent sore throats", but instead will have a scientific standard of referral which has gained public acceptance. The patient will derive the maximum benefit. He will be assured that the indications for surgery exist and will know the recommendation is made after scientific evaluation rather than the on the "hit or miss" traditional basis. □

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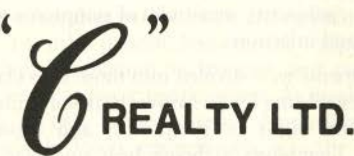

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Heat Sensitivity in Multiple Sclerosis Patients

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It is well established that the symptoms and signs of multiple sclerosis (MS) can be worsened with rises in body temperature.[1-3] On lowering the temperature conduction returns to normal.[3-4] This has led to the use of heat as a diagnostic tool (the 'hot bath test'). Its success as a diagnostic tool rests on the assumption that the vast majority of multiple sclerosis (MS) patients are sensitive to heat.

It was the purpose of this study to determine the prevalence of subjective heat sensitivity among an MS population of 280 patients. Also, an attempt was made to correlate the heat sensitivity and various features of the disease with disability.

STUDY

The study assessed data from 280 computerized patient files from the Dalhousie MS Research Unit. Only patients diagnosed as probable (36) or definite (244) MS were included. Data available included the degree of involvement (Kurtzke scale [0-10]); classification of MS (relapse and remitting, relapse and progressive, chronic progressive, benign or RBN only); level of MS (cord, brainstem, cerebellar, cerebral, and/or ocular); subjective sensitivity of symptoms to heat, exercise, and infection.

The patients were divided into those who classified themselves as being heat sensitive (heat worsening their neurological signs or symptoms) and those who classified themselves as being heat unaffected. The total number of patients who were heat affected was 172 of 280 (61.4%); and heat unaffected as 85 of the 280 (30.4%), while the remaining 8.0% were undecided. Two patients claimed improvement of symptoms with heat, and one of these patients was previously reported in detail.[3]

RESULTS

There were 172 patients heat affected and 85 heat unaffected. We used the detailed computerized data base on these cases in the Dalhousie MS Research Unit to determine one or more factors which were related to or perhaps would predispose an MS patient to heat sensitivity. Heat sensitivity was correlated with the pattern of MS progression (Table I). The two populations appeared similar with the exception that a greater proportion of heat effected patients had relapsing and remitting MS; whereas as many had benign as relapsing and remitting MS in the uneffected group. This difference was not statistically significant.

TABLE I

CLASSIFICATION OF DEFINITE AND PROBABLE MS PATIENTS

	Heat No.	Sensitive %	Heat No.	Sensitive %
Relapse and Remitting	70	40.7	27	31.8
Relapse and Progressive	38	21.2	20	23.5
Chronic Progressive	44	25.6	11	12.9
Benign	20	11.6	27	31.8
RBN only	0	—	0	—

Evidence on examination of areas of the nervous system involved by MS showed that heat sensitive MS patients have lesions in more areas of the nervous system, although this manner of judging levels of involvement is admittedly very crude (Table II). Most cases fell into patterns of pyramidal (corticospinal) or brainstem involvement, with no difference in heat sensitivity in these groups.

TABLE II

TYPES OF DEFINITE AND PROBABLE MS PATIENTS

	Heat No.	Sensitive %	Heat No.	Sensitive %
Cord	168	97.7	74	87.1
Brainstem	120	69.8	53	62.4
Cerebellar	79	46.0	24	28.2
Cerebral	39	22.7	12	14.1
Ocular	52	30.2	28	33.0

Heat sensitivity in those with clinical evidence of involvement in each area of the nervous system (Table III) but there seemed to be no significant increase in heat sensitivity with increasing disability (Table IV).

An individual in the range of 1 to 8 on the Kurtzke disability scale has approximately a 70% chance of being heat affected. When the entire scale from 0-10 is used in the calculations, an individual has a 63% chance of being affected by heat. The degree of disability appears to play no role on heat sensitivity as it is fairly uniform throughout the scale (Table IV).

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For instance, the two patients that had died of MS in recent years had not noted sensitivity to heat when they were previously assessed in the Unit.

TABLE III
PATIENTS WITH ANY KURTZKE INVOLVEMENT (1-10)

Parameter	Heat No.	Sensitive %	Heat No.	Sensitive %
Pyramidal	160	93.0	64	75.3
Sensory	138	80.2	53	62.4
Mental	67	39.0	27	31.8
Cerebellar	93	54.1	29	34.1
Bowel and Bladder	78	45.3	26	30.6
Brainstem	124	73.8	52	61.2
Visual	54	31.3	33	38.8
Other	14	81.4	4	4.7

TABLE IV
KURTZKE SCALE OF DISABILITY

Scale No.	Total No. patients	% of affected	% of unaffected
0	17	23.5	76.5
1	71	62	38
2	44	75	38
3	37	70.3	29.7
4	17	76.5	23.5
5	9	77.8	22.2
6	32	78.1	21.8
7	20	70	30
8	5	60	40
9	3	100	0
10	2	0	100

As would be expected, a greater percentage of the MS patients that were heat sensitive also noted worsening of symptoms during infection (30%) or exercise (20%) than did those who claimed insensitivity to heat (5.8% and 5.7%).

DISCUSSION

There is no doubt that the clinicopathological relationships of MS are very complex as there is great disparity between clinical abnormalities and pathological lesions. New structural lesions may be formed or existing structured lesions may change in the absence of apparent clinical worsening.[5, 6] On the other hand, clinical worsening may occur (such as with temperature increase) without the formation of new lesions or worsening of pre-existing lesions.[3, 7] Sensitivity to external conditions, including temperature change, is especially marked in demyelinating disorders, most profoundly in patients with MS.[7, 8] Increased body temperature may not only result in the worsening of pre-existing symptoms, but may also uncover signs that were not previously found in the patient.[7, 9, 10] These signs may include a decrease in visual acuity (in one or both eyes), paresis, nystagmus, dysarthria, paresthesiae, intranuclear ophthalmoplegia, and other signs associated with the disease. There is one report of persisting deficit following the hot bath test, suggesting the test may not be without risk but we have not seen any evidence of this.[19]

As noted in this study sensitivity to increased body temperature is not universal within the MS population. Other studies have shown somewhat similar results. Simons reported that 62% of patients with MS gave a history on becoming weak on exposure to heat.[1] Nelson *et al.* demonstrated the onset of new neurological signs in 60% or more patients during hot bath testing.[8] Malhota and Goren using a study population of 20 patients found that 85% of the patients showed changes in neurological status when given the hot bath test with new signs developing in 60% of patients.[7] Changes in neurological status did not occur in the control subjects which included normal subjects and subjects with varying neurological diseases other than MS. Brennais and associates, by way of questionnaire, found that 90% of 125 patients indicated worsening of neurological symptoms or of general feeling when taking a hot bath, higher than in our study.[12]

We can explain conduction defects in MS and other demyelinating diseases if we assume that the only abnormality present is in myelin. Demyelination results in defects in conduction along the axon which are exaggerated with increases in body temperature. Davis and Schawl demonstrated that the conduction velocity of normal nerve increases with increasing temperature over a broad range, reaches a maximum at about 40°C, and then decreases before there is complete conduction block.[13] Demyelinated fibres follow a similar pattern; however the temperature of maximum conduction is lowered and conduction block occurs at lower temperatures. As myelin is lost, thinner or new formed myelin, conduction fails at progressively lower temperatures, i.e. the blocking temperature is a function of the amount of myelin present. If the myelin sheath is reduced to one fourth of its normal thickness, the fibres become very sensitive to the effect of temperature, and the blocking temperature falls steeply from 40°C to 20°C.[14]

Therefore, at normal body temperature the more severely demyelinated fibres are already blocked. A slight increase in body temperature will result in the less severely demyelinated and remyelinated fibres becoming blocked. Rasminsky reported a 0.5°C increase in temperature resulted in conduction block at the internode of demyelinated ventral roots in the rat.[4]

This has been the explanation for the appearance of new signs during the hot bath test. Elevation of body temperature by 0.5 to 1.5°C will frequently cause conduction block in those fibres that were marginally functioning at body temperature.[10] Thus the hot bath test "uncovers" subclinical lesions by making those fibres that were capable of functioning at normal body temperature unable to conduct at the increased

temperature. The abnormalities are rapidly resolved on return to normal body temperature as the conduction block is reversible. Because MS is a disease of multiple lesions throughout the CNS, it is only when additional lesions are demonstrated that the test is of diagnostic value, although MS patients commonly show general worsening and most (61.4%) have noted this themselves.

A particular temperature elevation was necessary for the signs to occur, i.e. a patient who demonstrated changes in neurological function at an elevation of body temperature of 2.4°F would have no such changes in a hot bath even if he were to remain in it all day if his temperature was raised only 2°F above normal body temperature. There was much variation among the patients as one had neurological changes even before a change in temperature could be recorded; whereas another had no noticeable change until his body temperature (rectal) was raised 2.7°F above that at the onset of the experiment.[11] The study also indicated that increasing signs with increasing temperature is more likely if the disease process is active and patients in remission needed significantly greater temperature elevations and showed fewer new signs. Although the CNS has limited ability to remyelinate axons remissions do in fact reflect remyelination.[14] Also a relatively trivial degree of demyelination at cortically demyelinated internodes might cause dramatic changes in conduction, and might well alter the temperature of conduction block in patients in remission.[4]

Nelson and McDowell also demonstrated that all the signs which appeared during the induced hyperthermia disappeared when the patients were cooled, but often at a temperature above that which the signs appeared.[11] This last point, along with the knowledge that some patients appear insensitive to heat, casts some doubt on the argument that the amount or degree of myelin change alone is solely responsible for the neurological changes seen on elevation of body temperature. The disappearance of signs at a temperature higher than that at which signs first appeared strongly suggests some adaptation during heating.

In this study it was shown that about one-third of patients with severe MS deny sensitivity to heat. Although they might have some deterioration of abilities when core body temperature is significantly raised, under experimental testing conditions, their own lack of awareness of the effect of heat on their symptoms suggests that mild increases in body temperature do not bother them. On the other hand, other MS patients only mildly affected by the disease claim intense sensitivity to heat. It has even been noted that normal circadian temperature changes may dramatically effect some patients.[2]

Why would a patient with severe MS be less sensitive to heat than a patient with mild MS? Davis theorized that the effect of temperature would not be noticed if the lesions were too severe or extended too far along the length of the axon as there would be no conduction there even at body temperature.[15] In relatively small lesions in which there was a population of fibres with varying amounts of myelin, a small increase in temperature would substantially decrease the number of fibres whose blocking temperature exceeded the body temperature and this reduced the number of conducting fibres.[13] Patients with such lesions would be more likely to have additional signs with increased temperature plus worsening of pre-existing symptoms. However, this logic is limited in that some patients with severe MS are indeed sensitive to heat while other patients with mild MS are inaffected by heat. Although severity of disease need not be proportional to degree of demyelination (as seen on autopsy), it would seem that factors other than degrees of myelination would account for the lability of neurological function.

Varying thermosensitivity in patients may reflect differences in the membrane structure of demyelinated fibres in different plaques in that some fibres appear to retain or acquire more sodium channels than others.[16 17] David and Shawl demonstrated that by decreasing the maximum sodium permeability of a 90% demyelinated fibre by a 20%, a further 5°C lowering of the blocking temperature fiber could be calculated.[13] The electrolyte concentration bathing the nerve fibres has some importance as it was also demonstrated that reductions in calcium concentration would cause the blocking temperature to increase toward normal, and that this effect was most predominant in severely demyelinated fibres. Reductions of the maximum potassium permeability also improved conduction in demyelinated nerve by increasing the blocking temperature. Specific membrane structure, i.e. destruction or reorganization of ion channels, of demyelinated nerves may well play an important role in how conduction is lost as maintained with increased temperature — membrane structure varying between individuals.

Further explanations for the thermosensitivity among certain MS patients include edema[18] because the diameter of a demyelinated region of nerve is reduced 50% the blocking temperature is decreased by an additional 15°C for any particular amount of demyelination.[13] "Neuro-electric blocking factors" have been noted to occur in at least some patients with MS.[6] These 'factors' might include antibodies against sodium channels themselves. The effects of temperature in multiple sclerosis are associated with altered neurotransmission and tyrosine and tryptophan, precessors of neurotransmitters, can prevent deterioration in optic nerve function induced by hyperthermia.[12] It has even been speculated that hormonal changes related to the thermo-regulatory response be responsible for the neurological impairment that occurs during hyperthermia.[11]

All these theorized explanations can account for the variability of thermosensitivity among MS patients and possibly the adaptation to hyperthermia, but the degree of demyelination alone seems inadequate to explain the differences in symptoms with the MS population with hyperthermic conditions.

We have demonstrated that in two-thirds of MS patients characteristic heat sensitivity can be obtained from the history alone. This is similar to most reports of the hot bath test in published reports.[7] [11] There are many reasons for abandoning the hot bath test and relying on the history alone.[20] These include the uncertainty about the sensitivity and specificity of the test, and the inconvenience and awkwardness, discomfort, and expense of the test.

CONCLUSIONS

This study revealed that 61.4% of the sample MS population was aware of heat sensitivity with worsening of neurological symptoms or signs in a hot bath, warm room or hot day. Some noted worsening with exercise or infections. When correlating other specific characteristics of the disease to heat sensitivity, there appeared to be no significant difference between the sample population which was heat sensitive from that which was not. The most interesting finding was that increasing disability with the disease was not associated with an increasing incidence of the phenomenon of subjective heat sensitivity.

Although the hot bath test might uncover a higher percentage of heat sensitive patients, some patients are unresponsive to this test. In 60-80% of MS cases the test is positive but the heat response is noted by 60% of cases without doing the test, and the information can be obtained from the history. □

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Cervical Incompetence

Elizabeth J. Rafuse*,

Halifax, N.S.

INTRODUCTION

There are many factors known to underlie the occurence of spontaneous abortion: some fetal, some maternal, while others result from feto-materal interaction. Embryonic abnormality is obviously an important cause for abortion — it is estimated that chromosomal abnormalities are responsible for some 30% of early abortions.[3]

Following the thirteenth week of pregnancy the fetus is usually normal and fetal loss, therefore, is particularly traumatic for the potential mother. Incompetence of the cervix is recognized as an important etiological factor in mid-trimester abortion or premature delivery, being responsible for up to 20% of the mid-trimester losses.[13] Although this is an impressive and often quoted figure, it will be seen that due to difficult and often subjective diagnosis of this disorder it is very difficult, rather close to impossible, to put a number on its incidence (the literature varies greatly with the incidence reported to be between 1 per 125 pregnancies and 1 per 2,000 pregnancies).[21]

Cervical incompetence (CI) is defined as the inability of the uterine cervix to retain an intraunterine pregnancy until term. Although CI was first reported in the late 1800s, it was the pioneering work of Palmer and LaComme,[16] Lash and Lash,[11] Skirodkar,[20] and McDonald[14] who focused attention on CI and recommended effective therapy. Almost 40 years after these original papers, the subject of cercival incompetence and its treatment remain high on the list of controversy in obstetrical medicine. It is the purpose of this paper to present some of the facts and controversies of CI and to attempt to draw some conclusions about the treatment of this disorder.

ETIOLOGY AND DIAGNOSIS

When considering the etiology and diagnosis of CI, it is important to understand the normal anatomy and function of the cervix and the changes that occur in pregnancy. Danforth showed that the cervix is composeds almost entirely of connective tissue — not the smooth muscle of the uterus.[6] (Indeed, the fibromusclar junction represents the interal os of pregnancy). From his research he surmised that: a) The cervix did not have the slightest role in maintaining pregnancy prior to the fourth month; b) That after 14 to 16 weeks gestation the cervix is the primary factor in retaining the conceptus inside the uterus; and c) That it is the connective tissue nature of the cervix that permits it to carry out its function. Incompetency of the cervix is felt to be due to some impairment of this fibrous ring. Danforth categorizes the cervical defect to three major groups.[24]

In Group 1 are the cases of mechanical injury to the cervix, i.e. cervical trauma. In fact a history of cervical trauma can be elicited from 30 to 50% of patients and is the major cause of CI. The most frequent causes are: surgical history (D&C, D&E, conization, amputation, tracheoloplasty); spontaneous delivery (laceration, fistula); lacerations secondary to operative deliveries; and excessive cervical dilation for dysmenorrhea.[21] It should be noted however that the presence of these risk factors is not invariably associated with CI. Furthermore, a fairly recent cohort study of the relationship of induced abortion to later pregnancy complications failed to relate the two factors significantly.[10]

Group 2 includes the cases where there is no cervical injury and the cervical contours are normal, but the structure is defective, i.e., a congenital cervical incompetency. Danforth demonstrated that the histologic transition from the predominantly muscular isthmus to the predominantly fibrous cervic varied in women from an "abrupt change" (1-2 mm) to "extremely gradual" (over 5-10 mm) and that in several women with classical histories of cervical incompetency, the cervix was found to be strewn with heavy muscle bundles.[24]

Exposure to diethystilbestrol (DES) in utero has been associated with the incompetent cervix. However, it is difficult to determine whether this is due to a cervical or a uterine factor or both, as there is known to be an association between idiopathic uterine anomalies and CI.[16 21]

Danforth's etiological Group 3 includes those cases in which there is no prior injury and the cervical structure is normal, but the cervical barrier is rendered incompetent by premature triggering of the factors that normally result in the softening, effacement and increasing dilatability of the cervix at term. These changes result from the dissociation of the collagen bundles of the cervix into their component fibrils. This would explain why women with a past history of repeated late abortions may later carry a fetus to term

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with no treatment whatsoever.

Accurate diagnosis of the incompetent cervical os is difficult. Other causes of mid-trimester fetal loss, i.e. amnionitis, abnormal placentation, syphilis, uterine anomalies, and submucus myomas must be excluded.[21]

Classically, CI presents as a repetitive, acute, painless second trimester evacuation of the uterus without associated bleeding or uterine contractions. It is often associated with premature rupture of membranes or bulging of the fetal membranes into the vagina.[4] It should be noted however, that the spectrum of CI includes patients who do not present with this classic picture. Some carry pregnancies beyond 19 weeks gestation as it is not uncommon for cervical effacement and dilatation to occur silently over several weeks time. As well, fetal loss is not always painless; therefore the presence of uterine contractions is not mutually exclusive of the diagnosis.[4]

Regardless, the obstetrical history remains the most important factor in diagnosis. Unfortunately, there is no symptom complex that is diagnostic of an impending mid-trimester abortion due to CI. Only when the fetal membranes are seen protruding through a partially dilated cervix in the middle trimester of pregnancy can cervical incompetence be confidently diagnosed.[25] However, at this late stage treatment is difficult and less successful. Therefore, screening of high risk patients is often done between pregnancies. Passage without resistance of a Hegar No. 8 dilator into the cervical cannal is suggestive of CI as is passage of a Foley balloon. Hysteroscopy and or ultrasonography may also be useful in some cases.[2] In general, a nonpregnant cervical isthmus of 6 mm or more confirms the diagnosis.[13]

During pregnancy, any patient with a suspect history should be examined weekly beginning at 12 weeks so that cervical dilatation can be regularly assessed. Any patient with a previous mid-trimester loss should be taught the vague clinical symptoms such as heaviness or pressure in the upper vagina or pelvis, a blood-stained mucoid discharge, or a profuse watery discharge, and asked to report them to her physician.[21]

TREATMENT

The CI treatment regimen practised by physicians are: nonsurgical (bedrest, hydration; pessary; silicone plastic cuff; progesterone; electrocautery); and surgical (cerclage), using the vaginal approach (non-pregnant-Lash; pregnant-McDonald, Shirodkar, Wurm or modifications) or the abdominal approach. Cousins discussed the problems of comparing the efficacy of these treatment regimens as 1) diagnostic criteria are often omitted; 2) definitions of successful treatment vary; 3) treatment approaches are not detailed; 4) fetal outcome before treatment is often not stated; 5) cases are often categorized according to etiology; and 6) combination therapies are regularly used.[4] Therefore, one must appreciate the research treatment results with these inconsistencies in mind.

There has not been an adequately controlled study evaluating the effectiveness of hydration and prolonged bed rest in the Trendelenburg position versus other available treatment modalities.[21]

The Smith-Hodge pessary, a device which must be placed soon after conception and replaced with a larger one as the pregnancy progresses, has little popularity among physicians, although the fetal salvage rates are comparable to cerclage procedures.[21] Vitsky suggests that the pessary works by enhancing cervical resistance by changing the inclination of the cervical canal, by redistributing the weight of the growing ovum, and by compressing the cervix through tension exerted on the uterosacral ligaments.[22] His favourable fetal success results are enhanced by the fact that no infections, no sloughing, no cesarean sections, no ruptured uteri, no hospitalization, no operation occured or was needed. However, Yosowitz states that the pessary may be associated with discharge, discomfort, erosion and bleeding.[23]

Yosowitz's alternative, the silicone plastic cuff, is also not frequently used, as it, like the pessary, is only successful with minimal effacement and cervical dilatation. It also has the unattractive feature of slipping off. Its advantages are ease of application, lack of major complications and economy.[23]

Hormonal treatment with progestins is not advised due to possible teratogenic effects.[9]

Electrocautery must be done before pregnancy, and has a history of cervical stenosis and lacerations on delivery.[4]

Surgery has been the mainstay of the treatment of CI, although there are many factors which should determine the surgical approach including the presence of an identifiable anatomic defect, pregnancy, and the failure of other treatments. The most important determinant of the surgical technique utilized appears to be the obstetric surgeon's preference. The surgical objective is to enhance the resistance of the cervix to effacement and dilatation by the primary repair of an anatomic defect (Lash Procedure) or reinforcement with a circumferential suture or band (cerclage).[4]

Block and Rahhal suggested that researchers preoperatively score their patients using these five criteria:[1]

1. Previous premature delivery or mid-trimester abortion without obvious cause.
2. Visual evidence of previous surgical or obstetric trauma to the cervix.
3. History of painless premature labor and rapid delivery.

4. Progressive dilatation or dilatation greater than 2 cm on initial examination during mid-trimester.
5. Previous diagnosis of cervical incompetence with previous cerclage.

as a useful guide for selection of appropriate patients for surgery, for more meaningful comparison of treatment results, and prognostic value. It was shown that scores of three or more had statistically better pregnancy outcomes. This is not surprising as an accurate diagnosis of CI wth these higher scores was more likely. However, to date, such scoring has met with little enthusiasm.

The Lash procedure is used for patients with CI secondary to a traumatic isthmic or cervical defect and must be done in the nonpregnant state. This procedure includes a wedge-shaped resection of part of the cervix, anterior cervix being the most common site of defects (the incision extending up to the interal os), with suitable resuturing.[26] Lash and Lash reported a 79.2% success rate.[11] Unfortunately, this procedure had been associated with a rather ominous record of post-operative infertility which is still in dispute.

By far, the most common surgical procedures are the Shirodkar[20] and the McDonald[14] which are performed during pregnancy. The difference of opinion among physicians concerning whether to perform a surgical procedure during pregnancy or in the non-pregnant state arises primarily from varying experiences with complications in the pregnant group, such as excessive blood loss, onset of premature labor, and infection.[1] Proponents of cerclage stress that it allows active intervention as soon as the diagnosis is made.

The Shirodkar operative procedure is conducted under general anesthesia, with the patient in the lithotomy position and with a Trendelenburg tilt. The cervix is drawn down and a small incision made in the vesicocervical angle of the anterior vaginal fornix, following which the bladder is reflected above the level of the internal cervical os. An aneurysm needle is then inserted from the anterior incision around the cervix to the posterior incision on each side. A mersilene tape is then drawn around the cervix and tied securely on the ectocervix in the anterior vaginal fornix. The cerclage is tied anteriorly in order to allow easy removal at a later date.[25]

The McDonald procedure is a simpler cerclage technique that involves no dissection of the cervical vaginal epithelium. The stitches should encircle the cervix in a purse-string manner at the highest level of access. Each bite should penetrate deeply enough to gain anchorage in the collagenous "core" of the cervix.[26] The advantages of this type of cerclage is its simplicity and ease of removal at term or when necessary. When comparing the two techniques, Harger demonstrated equivalent success rates and morbidity although at the time of initial suture the Shirodkar procedure had an average 14 ml greater blood loss and was associated with a slightly higher Cesarean section rate.[8] Recent studies consistently show survival rates of 70 to 90% with the two procedures — fetal survival prior to any surgical procedure being 20 to 50%.[15 10 18]

It would seem that the ease of procedure, minimal blood loss, and liklihood of vaginal delivery favour the McDonald suture. Indeed, a prominent Halifax ob/gyn surgeon using only the McDonald technique has a personal success rate of 91% with few major complications.

The suggested optimal time of gestation for either cerclage is from 12 to 16 weeks. Suturing at this time would prevent the risk of retaining a first trimester abortion; allows for fetal heart recordings; and results in a technically easier operation as cervical effacement and dilation are less likely before 14 weeks.[8] Robboy demonstrated that more failures occur when the procedures were performed later in the second trimester.[18] Contrastly, in patients with past history of CI, the earlier the procedures were performed in the second trimester the better the fetal survival rate. This fact has been confirmed by other researchers.[8 10 17]

Cervical cerclage via the transabdominal route is the most satisfactory approach when cervices are extremely short or so deeply scarred that the vaginal approach is technically impossible.[12] This approach also avoids the necessity to dissect through infected tissue planes as is sometime the case with vaginal approach. It is best done in the gravid state at about 10 weeks gestation. Mahran reported a salvage rate of 87.5%. Delivery by cesarean section and exposure to two episodes of anesthesia are the major drawbacks of procedures using the abdominal route.

During the immediate postsurgical period the patient must be monitored closely for uterine irritability since labor necessitates removal. Bedrest in the Trendelenburg position for 24 to 48 hours after surgery is followed by in-hospital ambulation before discharge. There has been no evaluation of the risks of intercourse, orgasm or both on survival rates after operative intervention. Limitation of other physical activity is unnecessary.[21]

The complications of cerclage are suture displacement, infection (chorioamnionitis, suture-line infection sepsis), cervical laceration during labor, dystocia, rupture of membranes, bleeding, labor, uterine rupture, vesico vaginal fistula, leukorrhea and premature delivery.[21]

Suture replacement is becoming less frequent since the practice of placing the cerclage at an earlier time in the second trimester makes the procedure technically easier.

Patients who experience uterine contractions before 36 weeks gestation can be treated with tocolytics, such as isoxsuprine and magnesium sulfate, with close

PROCEEDINGS OF

22nd MEETING OF COUNCIL

and

133rd ANNUAL MEETING

of

THE MEDICAL SOCIETY OF NOVA SCOTIA

HALIFAX

November 28-29, 1986

THE MEDICAL SOCIETY OF NOVA SCOTIA
PROCEEDINGS OF
22nd MEETING OF COUNCIL
AND
133rd ANNUAL MEETING
November 27-29, 1986

The 22nd Meeting of Council began as the Medical Society Officers, accompanied by Dr. Jacob Dyck, President of The Canadian Medical Association, paraded through Council Chambers to the head table. Following call to order by Dr. Rob Stokes, Chairman of the Executive Committee and General Council, the Officers and Dr. Dyck, were introduced.

Mr. Peacocke, Executive Director, read the names of Society members deceased since October 1, 1985 as follows: Dr. Robert L. Alexander of River John; Dr. Eleonore Bergmann-Porter of Yarmouth; Dr. Laverne E. Cogswell of Berwick; Dr. William S. Cole of Dartmouth; Dr. Horace B. Colford of Halifax; Dr. Herbert R. Corbett of Sydney; Dr. William A. Hewat of Lunenburg; Dr. Mary Kernohan of Goose Bay, Labrador and Parrsboro, Nova Scotia; Dr. Herbert L. Knodell of Halifax; Dr. Edward MacArthur of Berwick; Dr. Francis B. MacDonald of Sydney; Dr. Daniel A. MacDougall of Antigonish; Dr. Olding C. MacIntosh of Antigonish; Dr. Robert Mair of Yarmouth; Dr. Neville Mason-Browne of Louisbourg; Dr. Robert Mattey of Berwick; Dr. David S. Moore of Truro; Dr. Arthur L. Murphy of Halifax; Dr. Angus E. Murray of Halifax; Dr. C. Henry Reardon of Annapolis Royal; Dr. Ronald M. Ritchie of Halifax; Dr. Arthur G. Shane of Halifax; Dr. Gordon Smith of Hantsport; Dr. Lewellyn T. Stead of New Glasgow; and Dr. Bentley R. Wilson of Middleton.

The Transactions of the 21st Meeting of Council and 132nd Annual Meeting (1985) as printed in the December 1985 issue of The Nova Scotia Medical Bulletin were approved.

The Transactions of the 22nd Meeting of Council and the 133rd Annual Meeting of the Society which follow are a concise record of reports which were presented and the decisions arising therefrom. In the interests of economy and to encourage interest in the transactions they are brief. It may be necessary for the reader to refer to Reports To Council (1986) for detailed background information. The Reports are available through the Society office, all Branch Societies and members of Council. In addition, detailed notes, and tape recordings of the proceedings are held in the Society office. All information is available for viewing at the office on reasonable notice.

Council approved a motion that the narrative of all reports and supplementary reports be received for information.

EXECUTIVE DIRECTOR'S REPORT

Mr. Peacocke's report provided Council with information on action taken by the Society relative to decisions made at Council (1985). Also highlighted was the great improvement in overall communications as a result of Mr. Martin's presence.

EXECUTIVE COMMITEE CHAIRMAN'S REPORT

Dr. Stokes' report provided Council with a concise resume of business conducted by the Executive Committee during the past year.

In 1986 the Executive considered an application to form a Section of Emergency Medicine. The By-Laws Committee was asked to review the approval process for forming Sections. It was proposed that applications to form a Section be approved at an Annual Meeting.

RESOLUTION 1

"THAT SECTION 5.1.1 of the By-Laws of the Medical Society be amended to read: Any group of ten or more members of the Society who are primarily interested in any aspect of the science and/or practice of medicine may be recognized as a Section of the Society by making formal application to the Annual Meeting of the Society, providing such application is endorsed by the Executive Committee." *CARRIED*

RESOLUTION 2

"THAT the Section of Emergency Medicine be recognized." *CARRIED*

The Executive Committee, anticipating that Council might approve relocation of the Society's head office, agreed that the By-Laws should be appropriately amended.

RESOLUTION 3

"THAT Section 15.1 of the By-Laws of The Medical Society of Nova Scotia be amended to read: 'Until changed by resolution at an Annual Meeting of the Society the office of the Society shall be located at Halifax-Dartmouth as defined in the Halifax-Dartmouth Regional Development Plan." *CARRIED*

During 1986 the Chairman of the Executive Committee was authorized to strike a Search Committee for Committee Chairmen of the Society and Representatives to Other Organizations. Arising from the Report of that Search Committee were:

RESOLUTION 4

"THAT the appointment of Committee Chairmen and Representatives to Other Organizations, as read and as set out at the end of the 1986 Transactions be approved." *CARRIED*

RESOLUTION 5

"THAT a Society Past President be appointed to chair an ad hoc committee to undertake a review of committee terms of reference, reporting to the Executive Committee at its January 17, 1987 meeting, and

THAT Committee Chairmen be asked to consider, when adding members to their committee, the potential and availability of individuals to serve as the chairman in the year (s) ahead." *CARRIED*

RESOLUTION 6

"THAT the Officers strike a Search Committee to recommend for appointment by the Officers, the Chairman for the Professionals' Support Program Committee." *CARRIED*

PRESIDENT'S REPORT

Dr. Judy Kazimirski reported a very busy year for the President, Officers, Staff and Executive Committee. Her report provided a total comprehensive overview of all activities of the Society during the past year. Highlighted in her report were improved communications, improved relations between the Society and Branch Societies and much improved media relations.

Relations with Government and other organizations such as the RNANS, the Provincial Medical Board, Workers' Compensation Board, the Faculty of Medicine, other Divisions, and the C.M.A. appeared to improve markedly during the year.

Late in the year the Medical Society dealt with a request to produce an up-to-date audio visual aid for Province- wide Prenatal classes.

RESOLUTION 7

"THAT Council endorse the proposal of Dr. D.W. Johnston to produce an up-to-date audio visual aid for province-wide prenatal classes, and

THAT the Society authorize the expenditure of up to $3000.00 to co-produce the film with the Department of Health and Dalhousie Faculty of Medicine." *CARRIED*

(The Economics Committee Report was considered in camera at a later time, however the details follow here since the Economics Committee is a committee of the Officers, responsible to the Officers thus the unique reporting arrangement.)

Dr. A.G. Cameron began his report with a resume of the distribution of the 1986 settlement. Following discussion of various aspects of that item Dr. Cameron introduced Dr. Kempton Hayes, Chairman of the Task Force on Tariff Distribution Formula which is a sub-committee of the Economics Committee. Dr. Cameron reminded Council that the Task Force recommendations are recommendations to the Economics Committee and not to Council. He noted that in some instances a number of them had already been dealt with, others are under active consideration and the remainder would be dealt with in due course. He went on to say however that he hoped Council would discuss the content of the Task Force Report to ensure complete understanding of it and to convey opinions on the work of the people involved in Economic matters on behalf of the Society.

Following extensive consideration of Dr. Hayes' Task Force Report several decisions were made:

RESOLUTION 8

"THAT the relativity of consultation fees between Sections be unlocked." *CARRIED*

RESOLUTION 9

"THAT the April 1, 1987 Tariff increase be distributed so as to begin to achieve the 1:1.3 average net hourly income ratio between General Practitioners and Specialists." *CARRIED*

RESOLUTION 10

"THAT the Society strike a Task Force under the direction of and reporting to the Economics Committee to investigate the average net hourly income ratio between Specialists Sections." *CARRIED*

RESOLUTION 11

"THAT Council approve in principle a single consultation fee for each Section/Sub-Section." *CARRIED*

RESOLUTION 12

"THAT the 1:1.3 average net hourly income ratio in AR 797 (2) be the permanent section ratio or policy of this Society and

THAT decreasing disparity between Sections is a high priority objective of this Society."

DEFEATED

Following consideration of the Task Force on Tariff Distribution, Council then received brief reports on

activities relating to the Economics Committee Fee Schedule Sub-Committee chaired by Dr. Aquino, the Economics Committee Task Force on New Procedure Fees chaired by Dr. Jollymore and the Economics Committee New Procedures Fee Review Sub-Committee chaired by Dr. John Clark.

Following completion of the President's Report including the Economics Committee presentations, Dr. Kazimirski stated that "there are many uncertainties at both the Federal and Provincial levels of Government related to health care. The Society is moving away from the doctor being free to practice professionally and more to Government determining how medicine is practiced. To affect the direction of future health care all physicians need to be involved in the affairs of the Association." She thanked all those who had contributed to the achievement of Society goals during the past year.

REPORTS OF STANDING COMMITTEES

ALLIED HEALTH DISCLIPINES

Dr. J.H. Quigley's committee contines to work closely with the C.M.A. Committee on Allied Health dealing with the continuing development of perspectives on health occupations. Additionally the Task Force on development of a Health Personnel Standards Act chaired by Dr. A.H. Shears presses for interest in this activity on the part of the Provinicial Minister of Health. The Society supports continued interest in this matter.

RESOLUTION 13

"THAT the Medical Society endorse continued negotiations with the Department of Health for the development of a Health Personnel Standards Act." *CARRIED*

ARCHIVES COMMITTEE

Dr. Ian Cameron's report pointed to the need to properly manage the archival collections located in a variety of places. The need for an archivist was addressed.

RESOLUTION 14

"THAT The Medical Society of Nova Scotia through its Archives Committee contribute $5000.00 toward hiring a part-time archivist in conjunction with the Joint Medical History Committee. The subsequent funding for the position will be subject to review." *CARRIED*

BY-LAWS COMITTEE

Dr. P.W. Littlejohn reporting on a request to his Commitee to review the mechanisms for forming Sections divided the issue into two parts. The first, interpretation of By-Laws, has been eased by the passage of Resolution 1. The second involved policy thus being beyond the scope of the By-Laws Committee.

RESOLUTION 15

"THAT a Special Committee be formed to develop a Protócol for the formation of Sections of the Society." *CARRIED*

Action to be taken when the numbers of Branch members goes above or below the 100 member threshold relative to membership on the Executive Commitee requires clairfication.

RESOLUTION 16

"THAT the By-Laws of the Medical Society be amended to clearly define the terms under which a member of the Society sits on the Executive Committee." *CARRIED*

The By-Laws Committee review of the By-Laws during the past year revealed inconsistencies and difficulties in interpretation.

RESOLUTION 17

"THAT a major review of the By-Laws be undertaken in order to ensure consistency and ease of interpretation." *CARRIED*

CHILD HEALTH COMMITTEE

Dr. G.H. Nickerson reported that the mandate of this Committee is to study and make recommendations regarding all matters which will be of benefit to the welfare of infants and children. His report to Council concerned itself mainly with the family and school system and their apparent contributions to childhood misery. Six motions were introduced by the Committee.

RESOLUTION 18

"THAT the teaching of health with all its personal and social ramifications be elevated to a major subject of instruction in all schools of Nova Scotia." *CARRIED*

RESOLUTION 19

"WHEREAS learning disabilities among our school children, often unrecognized and unremedied, are contributing to a national illiteracy of alarming proportions, many such students eventually ending up in a Young Offender's Court ,

BE IT RESOLVED THAT this serious medical and educational problem with its personal and anti-social sequalae again be brought forcefully to the attention of the Nova Scotia Ministries of Health and Education, and to the Attorney General to bring about remedial action." *CARRIED*

RESOLUTION 20

"THAT it be imperative for judges, appointed to the Provincial Courts dealing with young offenders, to have formal training in the psycho-dynamics of childhood and learning disabilities." *CARRIED*

RESOLUTION 21

"THAT young mothers under 16 years of age, show competency for mothering to the Social Services Department of Children's Aid Society regardless of support given by grandparents or the Provincial Government." *DEFEATED*

RESOLUTION 22

"THAT the Child Health Committee in 1987 consider the feasibility of the establishment of Regional Child Health Centres, where Regional Hospitals exist, staffed and supervised by a paediatrician." *DEFEATED*

RESOLUTION 23

"THAT the Child Health Committee in 1987 consider the feasibility of the establishment of a first class School Health Program in all schools throughout Nova Scotia." *CARRIED*

EDITORIAL BOARD

Dr. J.F. O'Connor reported another successful year for the Bulletin.

RESOLUTION 24

"THAT the Nova Scotia Medical Bulletin continue to be published by The Medical Society of Nova Scotia." *CARRIED*

FINANCE COMMITTEE

Dr. V.P. Audain presented Financial Statements for Fiscal Year 1986. These, together with the Society's budget for Fiscal Year 1987 were reviewed. *ATTACHED*

RESOLUTION 25

"THAT the Financial Statements of The Medical Society of Nova Scotia for Fiscal Year 1986 be approved." *CARRIED*

RESOLUTION 26

"THAT Doane Raymond be retained as the Medical Society's Auditors for Fiscal Year 1987." *CARRIED*

HORIZONS COMMITTEE

Dr. E.V. Rafuse's report, presented for information only, included numerous concepts that his Committee had been considering during the course of the past year. He expressed the hope that during the year ahead they would serve as the basis for wide discussion within the Society.

RESOLUTION 27

"THAT the Report of the Horizons Committee be received for information, and

THAT the recommendations contained therein be referred to the Executive Committee." *CARRIED*

CONJOINT COMMITTEE ON OBSTETRICAL SERVICES

Dr. Steve Owen opened his report by observing that official response to his report had been minimal, and that it was the opinion of the Committee that portions of it should be circulated or referred to different points within the Society for continuing discussions and comment.

RESOLUTION 28

"THAT the Conjoint Committee's recommendations regarding training and maintenance of competence (ref CC97-102, CC104-105) be referred to a committee of the Medical Society for further discussion/negotiation with Dalhousie University and the Provincial Medical Board." *CARRIED*

RESOLUTION 29

"THAT the recommendations of the Conjoint Committee regarding Family Practice Organizations (CC103,CC108-110) be referred to a committee of the Section of General Practice." *CARRIED*

RESOLUTION 30

"THAT the recommendations regarding consumer concerns (CC112-114) be referred to the Medical Society for consideration of professional public awareness programs." *CARRIED*

RESOLUTION 31

"THAT the Conjoint Committee's recommendations regarding fee code changes be referred to the Economics Committee with the exclusion of references to transferred care fees." *CARRIED*

RESOLUTION 32

"THAT the Medical Society refer the Conjoint Committee's recommendations on Midwives (CC115-117) to the Committee on Allied Health Disciplines for inclusion in their consideration for the development of a Health Personnel Standards Act." *DEFEATED*

Following consideration of Dr. Owen's recommendations, the subject of midwifery was raised again.

RESOLUTION 33

"THAT The Medical Society of Nova Scotia oppose the legalization of non-institutionalized practice of midwifery in the Province of Nova Scotia." DEFEATED

Council then discussed a proposal to set up a central registry of family physicians practicing Obstetrics, and who are willing to accept referrals from other family physicians who do not. Council debated the pros and cons of this proposal following which:

RESOLUTION 34

"WHEREAS it is recognized that some family practitioners may be opting out of obstetrical care, and

WHEREAS the Medical Society encourages the delivery of primary obstetrical care by family physicians,

BE IT RESOLVED THAT The Medical Society of Nova Scotia publish and distribute Guidelines designed to encourage the transfer of patients for obstetrical care from a family physician not practicing obstetrics, to another family physician who does practice obstetrics, and

THAT the Nova Scotia Chapter of the College of Family Physicians and The Medical Society of Nova Scotia establish a Central Registry of family physicians practicing obstetrics who are willing to accept referrals from other family physicians." CARRIED

OCCUPATIONAL HEALTH COMMITTEE

Dr. J.D. Prentice's report raised the issue of Arbitration for work refusal cases involving health related matters, pointing to the lack of arbitrators with medical experience.

RESOLUTION 35

"THAT the Medical Society advocate the formation of an Arbitration Committee with medical involvement for the resolution of health related right to refuse cases." CARRIED

PHARMACY COMMITTEE

Dr. J.P. Anderson reported on a variety of topics with which his Committee had dealt during the year, in particular the use/availability of hemophilus influenze type B vaccine.

RESOLUTION 36

"THAT once the hemophilus influenzae type B vaccine becomes readily available, the Medical Society urge its members to protect all patients between the ages of 2 and 5 against this serious bacterial organism, and

THAT the Department of Health be asked to provide this vaccine at no cost to physicians to be available for their patients in this age group." CARRIED

PHYSICAL FITNESS COMMITTEE

Dr. M.R. Banks reported on the success of the Professional Challenge and noted the absence of funds allocated for continued support of the Program. It was his understanding that a three-year commitment had been made two years ago.

RESOLUTION 37

"BE IT RESOLVED THAT The Medical Society of Nova Scotia continue its co-sponsorship of the Professional Challenge for 1987 with a financial contribution of up to $2000.00, and

THAT a review of the program be held by the Officers and the Physical Fitness Committee prior to further sponsorship." CARRIED

RELOCATION COMMITTEE

Dr. J.F. Hamm presented Council with a comprehensive review of the issue which his Committee has been working on for several years and which has been reported on to the membership on frequent occasions. Discussion was lengthy and exhaustive, at the same time providing the Committee with many important considerations with which it should deal as the detailed planning for this exercise continues. Rising out of the debate and discussions were a sequence of motions as follows:

RESOLUTION 38

"THAT The Medical Society of Nova Scotia purchase the property in the City of Lakes Business Park on the site indicated in Appendix "A" to the Report of the Relocation Committee." CARRIED

RESOLUTION 39

"THAT Scenario "D1" of the Report of the Relocation Committee be the preferred financing approach." DEFEATED

RESOLUTION 40

"THAT prior to construction of any building a referendum of the entire membership be conducted, and

THAT the results be binding on the Executive Committee." DEFEATED

RESOLUTION 41

"THAT the membership dues for Ordinary Member be increased by $100.00 commencing October 1,

1987, such increase to remain in place for five successive years, with the revenue from said increases to be applied to the Relocation Project." *CARRIED*

RESOLUTION 42
"THAT the Relocation Committee be redesignated the Building Committee." *CARRIED*

RESOLUTION 43
"THAT the Building Committee be authorized to proceed with the proposal to build a Society Office in the City of Lakes Business Park,
"THAT for fiscal year l987 this authorization pertain soley to preparation of an architectural concept and design, and
THAT the amount of money for this purpose be restricted to $40,000.00. *CARRIED*

The following Committees of the Society reported to Council without presenting motions. It is recommended that their reports be reviewed using the Reports to Council as a reference.

Awards
Cancer
Community Health
Discipline
Drug & Alcohol Abuse
Ethics
Faculty of Medicine/Medical Society Liaison
Maternal & Perinatal Health, including Reproductive Care Program
Mediation
Medical Education
Membership Services
Professionals' Support Program
Workers' Compensation Board/Medical Society Liaison

REPORTS OF NOVA SCOTIA REPRESENTATIVES TO C.M.A.

BOARD OF DIRECTORS

In August l986 Dr. J.C. Kazimirski assumed the responsibilities of Nova Scotia Representative to the C.M.A. Board of Directors from Dr. R.D. Saxon. Their combined report summarized the activities of the C.M.A. Board for the past year.

COUNCIL ON HEALTH CARE

Dr. D.S. Reid summarized an extremely busy year for the Council on Health Care. His report highlighted the many recommendations approved at C.M.A. General Council in Winnipeg, August l986. Specific items were presented for Society approval.

RESOLUTION 44
"THAT The Medical Society of Nova Scotia support the introduction of legislation in Nova Scotia to introduce daytime running lights on all vehicles." *CARRIED*

RESOLUTION 45
"THAT The Medical Society of Nova Scotia recommend to the Government of Nova Scotia that it introduce legislation that will:
(a) require licensing of All-Terrain-Vehicles
(b) mandate the wearing of safety helmets for all users of All-Terrain Vehicles, and
(c) impose a minimum age of l4 for the operation of All-Terrain Vehicles." *CARRIED*

RESOLUTION 46
"THAT The Medical Society of Nova Scotia urge the provincial Department of Health to develop educational programs for the public regarding the consequences of sexually transmitted diseases." *CARRIED*

RESOLUTION 47
"THAT The Medical Society of Nova Scotia put in place a committee of its Executive to meet jointly with the Registered Nurses' Association on a yearly basis to further explore our mutual areas of interest in health care and delivery of same." WITHDRAWN (because these meetings are already on-going)

COUNCIL ON MEDICAL ECONOMICS

Dr. P.D. Muirhead's report summarized the issues dealt with by his Council with during the past year. There were no recommendations.

COUNCIL ON MEDICAL EDUCATION

Dr. J.D.A. Henshaw informed Council that his report was an attempt to keep the Medical Society abreast of his Council's activities during the past year. His report was wide-ranging covering all related matters and concluding with:

RESOLUTION 48
"THAT The Medical Society of Nova Scotia recommends to the Faculty of Medicine of Dalhousie University that it maintain and, where necessary, expand the Preceptorship Program in rural areas so that students who wish to do so may experience practice outside major urban areas." *CARRIED*

RESOLTION 49

"THAT The Medical Society of Nova Scotia recommends that postgraduate training programs should provide opportunities for senior residents to undertake periods of practice in rural areas as part of the educational component of their residency training program. The degree of supervision required should be determined on the basis of the experience and level of competence of the individual resident." CARRIED

MD MANGEMENT LIMITED

Dr. G.A. Sapp took the opportunity to remind his colleagues that MD Mangement has a Branch Office located in Halifax in the Society's office suite and that it is managed by Mr. John Klaas, a very accommodating individual skilled in counselling members in financial matters. He suggested in the strongest terms that all physicians should take advantage of this excellent opportunity to better arrange their financial affairs.

REPORTS OF SECTIONS

ANAESTHESIA (including Anaesthesia Mortality Review Committee)

The Section expressed continuing concern regarding the absence of protection for health personnel involved in the Peer Review Process. Mr. Peacocke reported that mandatory reporting of anaesthetic deaths has been provided for and that the Minister has agreed to introduce legislation in the next sitting of the House to satisfy the profession's requirements.

RESOLUTION 50

"THAT The Medical Society of Nova Scotia support government action to make reporting Anaesthetic related deaths compulsory, as well as enactment of legislation to protect the review process from Subpoena." CARRIED

GENERAL PRACTICE

Dr. J.P.T. Graham provided Council with information on the National Conference of Sections of General Practice which has been developed during the past year, expressing the view this could be an important step forward for Family Physicians. He also reported briefly on the membership survey taken recently on General Practice Fee Codes. He expected to report to the Society soon on this matter.

OPHTHALMOLOGY

Dr. D. M. Andrews spoke to the need of development of a program which would facilitate the harvesting of eyes for corneal transplant.

RESOLUTION 51

"THAT the Section of Ophthalmology in association with the Section of General Practice develop an enucleation and corneal harvesting policy." CARRIED

PAEDIATRICS

Dr. A.F. Pyesmany provided Council with interesting information regarding the Summary Report, Canada Health Attitudes and Behaviours Survey. Arising out of the Section's discussions during the year were several resolutions:

RESOLUTION 52

"THAT the Medical Society recommend to the pertinent provincial government departments, evaluation of, and possible improvements in, the programmes for physical education, dental, nutritional, and mental health in the public school system." CARRIED

RESOLUTION 53

"THAT the Medical Society support the increase in the legal age for purchase and consumption of alcohol to 21 years." CARRIED

Council received, for information, reports from Sections of the Society listed below which did not include recommendations. These are included in Reports to Council and where there is interest they are recommended for your consideration.

Emergency Medicine
Internal Medicine
Internes/Residents
Laboratory Medicine
Obstetrics & Gynecology
Orthopaedic Surgery
Otolaryngology
Psychiatry
Radiology

REPORTS OF REPRESENTATIVES TO OTHER ORGANIZATIONS

COMMUNICABLE DISEASE CONTROL ADVISORY COMMITTTEE

Dr. T.J. Marrie's Report suggested that the public would benefit from periodic upgrading of physician information on Communicable Diseases, such as AIDS, Rubella, Needlestick Injuries etc.

RESOLUTION 54

"THAT The Medical Society of Nova Scotia encourage the Department of Health to institute a

quarterly newsletter on the subject of communicable diseases to be issued to all physicians in the Province." *CARRIED*

RESOLUTION 55

"THAT the editorial board set up to produce the quarterly newsletter on the subject of communicable diseases include the Society's representative to the Department of Health Communicable Disease Control Advisory Committee." *CARRIED*

PROVINCIAL MEDICAL BOARD

Dr. G. McK. Saunders provided Council with a summary of principal activities of the Board during 1986 noting in particular the retirement of Dr. M.R. Macdonald effective January 1, 1987. Complimentary remarks regarding Dr. M.R. Macdonald's contribution to medicine and society over his life time were numerous.

Council discussed Board reference in its Annual Report to the subject of the presence of a third person when female patients are being examined and continuity of care. Arising out of these discussions was:

RESOLUTION 56

"BE IT RESOLVED THAT The Medical Society of Nova Scotia produce Guidelines for physicians working in remote and isolated areas respecting
(a) continuity of care, and
(b) 3rd person presence while patients are being examined." *CARRIED*

RESOLUTION 57

"THAT a sincere vote of thanks be extended to Dr. M.R. Macdonald for his years of devoted service to the medical profession."
CARRIED UNANIMOUSLY

Numerous other Representatives to Other Organizations listed below reported to Council without making specific recommendations. Their reports deserve your interest and consideration. They are contained in Reports to Council.

Abilities Foundation of Nova Scotia
Canadian Cancer Society
Diagnostic Imaging Committee
Driver Licensing (Medical Advisory Committee)
Drug Information Advisory Committee
Health Professionals for Social Responsibility
Laboratory Services Committee (Joint)
Lung Association (Nova Scotia)
Maritime Medical Care Inc. - President's Report
Nursing Assistants (Board of Registration)
Nursing Liaison Committee
Occupational Health Association
Pharmacy Review Committee
Physician Manpower (Provincial Advisory Committee)
RH Committee
Refresher Course Commitee (Dalhousie - Div. of C.M.E.)
St. John Ambulance Association
Safety Council (Nova Scotia)
Smoking & Health (Council on)
V.O.N.

NEW BUSINESS OF COUNCIL

COMMUNICATIONS

The view was expressed by some that the Medical Society must give increased attention to communications both within the Society and externally.

RESOLUTION 58

"THAT the Pictou County Branch Society moves that the incoming Officers of The Medical Society of Nova Scotia be instructed to make every possible effort to improve communications WITH and feedback FROM the Branch Societies regarding any important matters." *CARRIED*

Dr. Shaw reported that at a meeting of the Past Presidents of the Medical Society, the view was once again expressed that a great deal of expertise and experience was available within the ranks of the Past Presidents but it is not being utilized. A motion was presented.

RESOLUTION 59

"THAT a Standing Committee be formed known as the Senior Advisory Committee which will be composed of Past Presidents only, and
THAT an ad hoc committee of Past Presidents be formed to prepare terms of reference for the above Committee." *CARRIED*

MEETING WITH CABINET

Dr. D.S. Reid pointed out that in spite of the Medical Society's understanding, Cabinet does hear from a fairly wide range of groups and organizations. He pressed again for action in this regard.

RESOLUTION 60

"THAT The Medical Society of Nova Scotia OFFICIALLY request by formal letter of the Chairman of the Executive Council of the Province of Nova Scotia namely the Premier - that an annual presentation to the Cabinet of the Government of Nova Scotia be set up to discuss matters concerning health care and the delivery of same to Nova Scotia's citizens." *CARRIED*

PARLIAMENTARY PROCEDURE

Dr. H.J.Bland expressed his concerns regarding the conduct of business at Council noting that some organizations with which he is familiar make it a practice to have legal counsel available at meetings.

RESOLUTION 61

"THAT The Medical Society of Nova Scotia engage the services of legal counsel or other suitably qualified persons being expert in parliamentary procedure to assist in the framing of motions and to be available at Council to advise on procedural problems." *DEFEATED*

ELECTION OF OFFICERS

President	Dr. W.C. Acker
President-Elect	Dr. J.D.A.Henshaw (Berwick)
Chairman of the Executive Committee	Dr. Rob Stokes (Baddeck)
Vice-Chairman	Dr. B.S. Ignacio (Sydney Mines)
Treasurer	Dr. V.P. Audain (Halifax)
Honorary Secretary	Dr. J.H. Gold (Halifax)

ELECTION OF BRANCH REPRESENTATIVES TO THE 1987 EXECUTIVE COMMITTEE

Antigonish-Guysborough	Dr. D.P. Cudmore
Bedford-Sackville	Dr. G.L. Myatt
Cape Breton	Dr. P.K. Cadegan
Colchester East Hants	Dr. F.E. Slipp
Cumberland	Dr. W.G. Gill
Dartmouth	Dr. W.D. Canham Dr. W.R.Lee
Eastern Shore	Dr. D.P. Sinha
Halifax	Dr. R. Brewer Auld Dr. W.G.C. Phillips
Inverness-Victoria	Dr. J.O. Belen
Lunenburg-Queens	Dr. D.V. Wright
Pictou	Dr. E.R. Sperker
Shelburne	Dr. M.E. Riley
Sydney	Dr. P.F. Murphy
Valley	Dr. W.M. Enright Dr. J.R. MacEachern
Western	Dr. P.L. Loveridge

The 133rd Annual Meeting of The Medical Society of Nova Scotia adjourned at 3:00 p.m. on Saturday, November 29, 1986.

The 134th Annual Meeting will take place November 26-28, 1987 in the World Trade & Convention Centre and Prince George Hotel, Halifax.

APPOINTMENT OF COMMITTEE CHAIRMEN

Allied Health Disciplines	Dr. J.H. Quigley
Task Force Health/Personnel Standards Act	Dr. A.H. Shears
Anaesthesia Mortality Review	Dr. K.W. Fairhurst
Annual Meeting	President
Archives	Dr. I.A. Cameron
Awards	Dr. P.E. Kinsman
By-Laws	Dr. P.W. Littlejohn
Cancer	Dr. A.J. Bodurtha
Child Health	Dr. P.C. Bagnell
Community Health	Dr. Mark Kazimirski
Discipline	President
Drug & Alcohol Abuse	Dr. E.L. Reid
Ethics	Dr. D.P. Rippey
Faculty of Medicine/Medical Society Liaison	President
Finance (Treasurer)	Dr. V.P. Audain
Horizons	Dr. E.V. Rafuse
Hospitals & Emergency Services	Dr. D.F. Craswell
Maternal&Perinatal Health (Reproductive Care Program)	Dr. E.R. Luther
Mediation	President
Medical Education	Dr. V.M. Hayes
Membership Services	Dr. K.R. Langille
Minister of Health/Medical Society Liaison	President
Nutrition	Dr. Meng Hee Tan
Occupational Health	Dr. J.D. Prentice
Pharmacy	Dr. J.P. Anderson
Physical Fitness	Dr. Kent Pottle
Professionals' Support Program	T.B.A.
Relocation Committee	Dr. J.F. Hamm
W.C.B./Medical Society Liaison	President
Editorial Board	Dr. J.F. O'Connor

APPOINTMENT OF REPRESENTATIVES TO OTHER ORGANIZATIONS

Abilities Foundation NS Chapter	Dr. J.J. P. Patil
Anaesthesia Care Program	Section Chairman
Board of Registration of Nursing Assistants	T.B.A.
Camp Hill Drug Information Committee	Dr. Jean Gray
Canadian Cancer Society	Dr. A.J. Bodurtha
Canadian Physicians for Prevention of Nuclear War	Dr. D.F. Fay
Communicable Disease Control Advisory Committee	Dr. T.J. Marrie

Committee	Representative
Diagnostic Imaging Committee	Dr. J.A. Chadwick Dr. H.R. Roby
Drugs & Therapeutics Committee	Dr. C.R.T. Dean Dr. G.C. Jollymore
Joint Laboratory Services Committee	Dr. K.G. Kini Dr. S.E. York
Kellogg Health Services Library	Dr. M.B. Bergin Dr. R. McI. Washburn
Maritime Medical Inc.	Mr. D.D. Peacocke Dr. R. Stokes
Medical Advisory Comm. on Driver Licensing	Dr. C.C. Giffen Dr. A. Purdy
NS Council on Smoking and Health	Dr. D.F. Fay
NS Lung Association	Dr. R.T. Michael
NS Safety Council	Dr. R.A. Perry
Nursing Liaison Committee	Dr. M.B. Murphy
Occupational Health & Safety Advisory Committee	Dr. J.C. Kazimirski
Occupational Medical Association of Canada	Dr. J.D. Prentice
Pharmacy Review Committee	Dr. A.S. Dill Dr. E.V. Rafuse
Physician Manpower Co-Ordinating Committee	Dr. T.J. Marrie Mr. D.D. Peacocke
Provincial Medical Board	Dr. G. McK. Saunders
Provincial Organ Procurement Committee	Mr. Bill Martin
Refresher Course Committee	Dr. A.G. Cameron Dr. G.W. Thomas
Reproductive Care Action Group	Dr. C. Folinsbee Dr. J.C. Kazimirski
Rh Committee	Dr. T.F. Baskett
St. John Ambulance Association	Dr. J.D.A. Henshaw
School Health Education (Assoc. for the Advancement of)	Dr. G.H. Nickerson
Undergraduate Medical Education Committee (Dalhousie)	Dr. D.R. MacLean
V.O.N. For Nova Scotia	Dr. Mark Kazimirski

THE MEDICAL SOCIETY OF NOVA SCOTIA

FINANCIAL STATEMENTS

SEPTEMBER 30, 1986

AUDITORS' REPORT

To the Members of
The Medical Society of Nova Scotia

We have examined the balance sheet of The Medical Society of Nova Scotia as at September 30, 1986 and the statements of income and surplus, and related statements of the Cogswell Library Fund for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests and other procedures as we considered necessary in the circumstances.

In our opinion, these financial statements present fairly the financial position of the Society and its related funds as at September 30, 1986 and the results of its operations for the year then ended in accordance with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Halifax, Nova Scotia

October 27, 1986

Doane Raymond

Chartered Accountants

Doane Raymond

THE MEDICAL SOCIETY OF NOVA SCOTIA

BALANCE SHEET

SEPTEMBER 30, 1986

ASSETS	1986	1985
Current		
Cash and short term investments	$ 572,558	$ 391,902
Receivables		
Members	1,120	8,677
Other	3,672	1,260
Accrued interest	5,346	4,372
Prepaid expenses	10,972	4,628
	593,668	410,839
Investments (Note 1)	665,979	608,670
Equipment and leasehold improvements (Note 2)	42,296	31,762
	$1,301,943	$1,051,271
LIABILITIES		
Current		
Payables and accruals		
Trade	$ 16,425	$ 25,589
Honoraria		37,405
Cogswell Library Fund	3,615	181
Deferred revenue (Note 3)	659,486	475,250
Unexpended project funds		2,843
	679,526	541,268
CAPITAL		
Contingency Fund (Note 9)	111,250	101,650
Surplus	511,167	408,353
	622,417	510,003
	$1,301,943	$1,051,271

Contingent liability (Note 4)
Commitments (Note 5)

ON BEHALF OF THE EXECUTIVE

_______________ Treasurer

_______________ Executive Director

Doane Raymond

THE MEDICAL SOCIETY OF NOVA SCOTIA

STATEMENT OF INCOME AND SURPLUS

YEAR ENDED SEPTEMBER 30, 1986

	1986	1985
Revenue		
Annual membership dues		
The Medical Society of Nova Scotia	$ 759,158	$718,745
The Canadian Medical Association	177,499	169,194
Post Graduate levy	20,010	21,510
Student memberships	768	770
Intern and Resident memberships	5,115	5,160
	962,550	915,379
Bulletin (net)	652	4,648
Gain on sale of investments (Note 6)	3,320	
Investment income (Note 7)	79,111	69,365
Other income (Note 8)	2,525	6,929
	1,048,158	996,321
Expenses	945,344	803,618
Excess of revenue over expenses	102,814	192,703
Surplus, beginning of year	408,353	215,650
Surplus, end of year	$ 511,167	$408,353

Doane Raymond

THE MEDICAL SOCIETY OF NOVA SCOTIA
NOTES TO FINANCIAL STATEMENTS
SEPTEMBER 30, 1986

1. Investments

Operating Fund, at cost

Bonds, Debentures and Term Deposits	Interest Rate	Maturity Date	Par Value	Cost	Approximate Market Value
Bell Canada	11%	2004	$ 10,000	$ 10,000	$ 10,425
District of Guysborough	9.75%	1988	10,000	10,000	9,700
District of Guysborough	9.75%	1990	15,000	15,000	14,250
Government of Canada	13.75%	1990	10,000	10,000	11,230
Government of Canada	9.50%	1994	25,000	25,938	25,475
Government of Canada	8.75%	2002	8,000	7,711	7,848
Province of Nova Scotia	9.25%	2000	20,000	19,700	18,282
Continental Bank	8.3%	1986	300,000	300,000	300,000
Nova Scotia Power Corporation	10%	1991	50,000	50,000	50,250
			448,000	448,349	447,460

Shares	No. of Shares	Cost	Approximate Market Value
Bank of Nova Scotia	750 common shares	4,658	19,688
Canada Development Corp.	200 preferred shares - 7.6%	4,000	2,800
Maritime Tel & Tel Co. Ltd.	600 common shares	4,585	6,600
Nova, An Alberta Corp.	200 convertible 2nd preferred shares - 6.5%	5,000	3,775
Royal Bank of Canada	200 common shares	2,469	6,426
Stelco Inc.	200 convertible, preferred shares	4,964	4,826
Toronto Dominion Bank	500 common shares	8,254	11,250
MD Growth Fund	4,462,787 units	42,450	63,640
MD Realty Fund	319.66 units	30,000	33,600
		106,380	152,605
		554,729	600,065

Contingency Fund, at cost plus accrued interest

	Interest Rate	Maturity Date	Cost	Approximate Market Value
Credit Foncier - G.I.C.	8.875%	1986	55,598	55,598
HFC Trust - G.I.C.	9%	1986	55,652	55,652
			111,250	111,250
			$ 665,979	$ 711,315

Doane Raymond

THE MEDICAL SOCIETY OF NOVA SCOTIA

NOTES TO FINANCIAL STATEMENTS

SEPTEMBER 30, 1986

2. Equipment and leasehold improvements

	1986			1985
	Cost	Accumulated Depreciation	Net Book Value	Net Book Value
Office furniture and equipment	$ 57,069	$ 50,176	$ 6,893	$ 7,535
Leasehold improvements	30,927	30,927		6,050
Computer	55,096	19,693	35,403	18,177
	$143,092	$100,796	$42,296	$31,762

The Society records depreciation at a rate of 20% annually on a straight line basis on all fixed assets.

3. Deferred revenue

Annual membership dues for the next fiscal year received by the Medical Society before September 30, 1986 are recorded as deferred revenue.

4. Contingent liability

The Medical Society of Nova Scotia has guaranteed the bank loans of Nova Scotia Medical Society students with the Bank of Montreal totalling $34,300 (1985 - $22,800).

5. Commitments

The future minimum lease payments on the operating lease for office space is $51,750 per year until 1989 and $47,438 in 1990. These payments do not include a provision for operating costs which are presently $4.11 per square foot annually.

6. Gain on sale of investments

Shares	No. of Shares			Proceeds	Cost	Gain (Loss)
Denison Mines	100 common shares - Class A			$ 778	$ 2,276	$(1,498)
Denison Mines	100 common shares - Class B			802	2,275	(1,473)
Hiram Walker Resources	400 common shares			14,206	10,190	4,016
				15,786	14,741	1,045
Bonds	Interest Rate	Maturity Date	Par Value			
Bank of Nova Scotia	10%	2001	10,000	12,275	10,000	2,275
				$28,061	$24,741	$ 3,320

Doane Raymond

THE MEDICAL SOCIETY OF NOVA SCOTIA

NOTES TO FINANCIAL STATEMENTS

SEPTEMBER 30, 1986

7. Investment income

	1986	1985
Short-term interest	$64,158	$55,606
Long-term interest on investments	11,429	10,150
Dividends	3,524	3,609
	$79,111	$69,365

8. Other income

	1986	1985
Grant from CMA	$ 2,225	$2,092
Donations		100
Miscellaneous	300	4,737
	$ 2,525	$6,929

9. Contingency Fund

	1986	1985
Balance, beginning of year	$101,650	$ 89,705
Interest earned on investments	9,600	11,945
Balance, end of year	$111,250	$101,650

Doane Raymond

THE MEDICAL SOCIETY OF NOVA SCOTIA

EXPENSES

YEAR ENDED SEPTEMBER 30, 1986

	1986	1985
Administration		
Audit fees	$ 5,800	$ 9,735
Insurance, travel, bonding and property	818	728
Investment trustee fees	1,644	1,369
Legal fees	11,091	1,527
Office rent	61,158	35,229
Office services	22,722	35,563
Petty cash and miscellaneous	614	814
Postage	10,774	6,468
Repairs and maintenance	1,050	767
Taxes	2,461	2,356
Telephone and telegraph	14,458	11,147
Travel - secretariat	15,079	8,540
Unforseen expenses	13,741	10,385
Salaries and benefits		
Salaries	298,152	266,066
Canada pension plan	3,142	2,626
C.M.A. pension plan and insurance	40,905	34,052
Unemployment insurance	5,508	4,896
Vehicle leasing	7,790	12,628
Communication department	24,502	23,419
Economics department	16,311	2,487
Committee expenses including travel		
Branch meetings	68	
Executive meetings	14,415	13,391
Horizon committee	1,556	
Officers and branch meetings	12,108	10,301
Specialty sections	83	38
Membership services committee	74	1,803
Nominating committee	987	611
Other committees	4,662	4,142
Professional challenge	2,000	3,764
Annual meeting	18,259	14,347
Bad debts		5,000
Canadian Medical Association membership	179,569	167,989
C.M.A. general council - travel	11,978	9,931
C.M.E. grant	25,813	28,647
Depreciation	22,187	15,986
Drugs and therapeutics bulletin	3,610	3,610
Eastern division conference	1,952	
Honoraria	83,817	49,494
Staff development	923	
Student assistance loan plan	3,063	3,087
Unpaid student loans	500	675
	$945,344	$803,618

Doane Raymond

THE MEDICAL SOCIETY OF NOVA SCOTIA

COGSWELL LIBRARY FUND

BALANCE SHEET

SEPTEMBER 30, 1986

ASSETS	1986	1985
Receivables		
The Medical Society of Nova Scotia	$ 3,615	$ 181
Atlantic Trust		496
Accrued bond interest		16
	3,615	693
Investments		
Province of Nova Scotia	2,000	2,000
Continental Bank		3,000
	$ 5,615	$ 5,693
SURPLUS		
Reserve for Cogswell Library Fund	$ 5,615	$ 5,693

COGSWELL LIBRARY FUND

STATEMENT OF REVENUE, EXPENSE AND RESERVE

YEAR ENDED SEPTEMBER 30, 1986

	1986	1985
Income from investments	$ 418	$ 489
Contributions to Dalhousie University	496	427
Excess (deficiency) of revenue over expense	(78)	62
Reserve, beginning of year	5,693	5,631
Reserve, end of year	$ 5,615	$ 5,693

Doane Raymond

1987 PROPOSED BUDGET

	EXPENSES	BUDGET 1986 Oct. 1/85 to Sept. 30/86	FORCAST YEAR END to Sept. 30/86	PROPOSED BUDGET Oct. 1/86 to Sept. 30/87
	Administration:			
400	Audit Fees	$ 9,000.	$ 9,000.	$ 10,000.
401	Insurance — Travel, Bonding & Property	550.	818.	1,000.
402	Investment Trustee Fees	1,250.	1,700.	1,700.
403	Legal Fees	5,000.	7,000.	5,000.
404	Office Rent	63,461.	63,461.	71,572.
405	Office Services	30,000.	30,000.	30,000.
406	Petty Cash and Miscellaneous	1,000.	1,000.	1,000.
407	Postage	10,000.	11,000.	11,000.
408	Repairs and Maintenance	1,000.	2,800.	3,000.
409	Taxes — Business Occupancy	2,500.	2,489.	2,650.
410	Telephone	12,000.	13,000.	13,000.
411	Travel — Secretariat	12,000.	12,000.	12,000.
412	Unforeseen Expenses	2,500.	20,517.	5,000.
	Salaries and Benefits:			
430	Salaries	295,000.	298,531.	366,463.
431	Canada Pension Plan	3,000.	3,143.	3,736.
432	Pension Plan (CMA) and Insurance	40,000.	40,284.	55,860.
433	Unemployment Insurance	5,000.	5,509.	6,875.
434	Vehicle Leasing	13,355.	7,790.	—
440	Communications Department	20,000.	35,000.	16,550.
445	Economics Department	39,000.	13,000.	5,000.
446	Professionals Support Program	—	—	22,345.
	Committee Expenses — including travel:			
450	Executive Meetings	11,500.	11,500.	12,500.
451	Officers and Branch Meetings	10,000.	12,000.	12,000.
452	Branch Secretaries	1,000.	68.	500.
453	President's Meeting	1,000.	—	500.
454	Specialty Sections	1,000.	83.	500.
455	Membership Services Committee	3,000.	74.	1,500.
456	Nominating Committee	750.	987.	1,000.
457	Other Committees	6,000.	5,000.	6,000.
458	Archives Committee	7,000.	—	5,000.
459	Professional Challenge	—	3,500.	—
460	Horizons Committee	3,000.	2,000.	1,500.
461	Health Care Task Force	—	—	22,000.
480	Annual Meeting	15,000.	18,259.	15,000.
481	Bad Debts	—	—	—
482	Canadian Medical Association Membership	172,785.	172,181.	210,210.
483	C.M.A. General Council	12,000.	12,000.	8,000.
484	C.M.E. (Dalhousie) Grant	30,880.	25,813.	30,937.
485	Depreciation	12,000.	12,000.	12,000.
486	Drugs and Therapeutics Bulletin	4,000.	3,610.	4,000.
487	Honoraria	55,000.	49,000.	55,000.
488	Staff Development	1,000.	780.	1,000.
489	Student Assistance Loan Plan	7,000.	3,200.	5,000.
490	Unpaid Student Loans	—	—	—
491	Eastern Divisions Annual Conference	3,000.	3,000.	2,000.
		$922,531.	$913,097.	$1,049,898.

	REVENUE			
	Annual Membership Dues:			
300	The Medical Society of Nova Scotia	$724,425.	$745,204	$ 762,700.
301	The Canadian Medical Association	172,785.	174,619.	210,210.
302	C.M.E. (Dalhousie) Levy	20,280.	20,010.	—
303	Student Memberships	700.	768.	700.
304	Interne/Resident Memberships	5,000.	5,115.	5,000.
340	InforMed (net)	—	—	3,300.
350	Bulletin — Editorial Board (net)	3,000.	—	—
360	Investment Income	40,000.	50,000.	50,000.
380	Other Income	1,000.	2,225.	2,000.
		$967,190.	$997,941.	$1,033,910.

external electronic monitoring. Peters reports several successes of contraction cessation using these drugs which allowed for suture retention and prolongation of gestation past 38 weeks.[17] (The patients were maintained on oral isoxsuprine). However, most investigators agree that active uterine contractions or rupture of membranes after cerclage are indications for removal of the suture.

Infectious morbidity can be substantial and does not appear to be preventable by antibiotic therapy. Kuhn and Pepperall reported a high incidence of sepsis if the membranes are ruptured at the time of surgery.[10] When fetal membranes rupture, the amniotic fluid often is contaminated by the resident microflora of the cervix, but despite this, septic complications are low. However, during manipulation of the cervix and insertion of a mersilene band, tissue devitalization can occur and the incidence of choromanionitis increases greatly. Therefore, before surgery not only must the membranes be intact but vaginal and cervical cultures should be obtained as well. Similarly, any vaginal infection must be treated and operative intervention negated if there is any evidence of herpes genitalis.[25] A lower risk of infection was associated with cerclage between the 14th and 18th week of gestation than when the operation was performed after the 20th week.[10]

Robboy reported that cervical dystocia may result in mechanical obstruction to delivery after removal of the suture and necessitate cesarean section.[18] Kuhn and Pepperall reported a cesarean section rate of 16.2%, with cervical dystocia being the indication in about one-third of the cases. Since maternal mortality is five times greater after cesarean section than after vaginal deliveries and since fever occurs in about one third of women after section, the cerclage procedures thereby increase maternal morbidity and potential mortality.[8]

The major postoperative complication rate of cerclage procedures is only 2%. There has been one reported maternal fatality due to a gangrenous uterus.[8]

The contraindications to cerclage include uterine bleeding or activity, ruptured membranes, an almost fully dilated cervix, fetal anomalies and polyphydramnios. A preoperative ultrasound should be used to establish gestational age and to help rule out some congenital anomalies.[21]

The cervical suture reinforces the resistance of the cervix to dilatation — it can not increase the accomodative capacity of the uterus. Therefore, it should not be used indiscriminately, such as in multiple pregnancies.

CONCLUSION

Cervical incompetence is a condition which is often difficult to diagnose until repetitive mid-trimester fetal loss has occurred. Mercifully, the surgical treatment of CI has proven to be very successful. The procedure of choice is the McDonald cerclage technique but it is not without risk. The surgeon who ligates the patient's cervix must monitor her closely with follow-up examinations and ensure she is counseled regarding symptoms so that immediate medical attention is sought. □

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Current Topics in Community Health

Prepared by: Dr. Frank M.M. White
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HEALTH PROMOTION IN ACTION

An International Conference on Health Promotion was held in Ottawa, November 17-21, 1986. Participants were invited from almost 40 countries, co-sponsored by the World Health Organization, Health and Welfare Canada and the Canadian Public Health Association. During the week the Minister of Health, the Honorable Jake Epp, released a discussion paper entitled *"Achieving Health for All: A Framework for Health Promotion"*, copies of which are now being distributed by his department, and are available on request.

During the conference, a morning was set aside for exhibitors of 38 different health promotion projects, considered to be representative of such activities throughout Canada. The following 14 selected projects illustrate the range of activities presented. More information may be obtained from individuals listed below each project.

York Centre for Health

An innovative health promotion demonstration project, where six public health nurses provide a direct health promotion service to clients through a storefront drop-in centre. A community development approach is used to assist a multicultural neighbourhood to identify and address its health needs. Strategies include self-help action and individual counselling. Services to clients are provided free of charge as the centre is jointly funded by a local municipality (City of York, Metropolitan Toronto), and the Province of Ontario. This exciting centre is being closely observed to determine the feasibility of implementing the approach in other areas.

Ms. Elaine Polett, Director of Health Promotion and Health Education, York Centre for Health, 504 Oakwood Avenue, Toronto, Ontario, M6E 2X1

Mental Health and the Workplace Project

This project has been a major health promotion activity for the Canadian Mental Health Association (CMHA) since 1982. Funded until June 1987 by Health and Welfare Canada, the project is a national strategy to stimulate greater awareness and community action on issues on mental health related to employment. The CMHA sees the workplace as a critical arena for mental health promotion.

Peter Clutterback, Associate Program Director, Canadian Mental Health Association, 2160 Yonge Street, Toronto, Ontario, M4S 2Z3

Health Education for Indo-Canadian Women

An eight-week health education program, designed to increase the health-related knowledge and skills of immigrant women. The program has also resulted in two publications. *Health Education for Immigrant Women* is a publication developed for use by various agency workers in counselling women from a variety of cultural backgrounds. *The Women's Self-Help Handbook* is a guide suitable for day-to-day use, containing much of the information immigrant women need to address their health concerns. These publications are available in both English and Punjabi. A third publication, *A Guidebook for Problem Drinkers* will soon be available.

Sheila Mannulal, Orientation Adjustment Services for Indo-Canadian Women (O.A.S.I.S.), 8165 Main Street, Vancouver, B.C. V5X 3C2

The Prevention and Amelioration of Mental Retardation

Preventing mental handicaps from occurring or from becoming more significant is the issue dealt with in a series of publications from the G. Allan Roeher Institute (formerly the National Institute on Mental Retardation). *Making a Difference* emphasizes the importance of providing support to people with handicaps, in order for them to participate in the community and so prevent further handicaps rather than looking for a "cure" for handicaps. The publications emphasize, however, that any prevention approach must be reinforced with the promotion of lives of quality.

Diane Richler, Director, G. Allan Roeher Institute, York University, Kinsmen Bldg., 4700 Keele Street, Downsview, Ontario M3J 1P3

Adolescent Alcohol and Drug Abuse Prevention Campaign

Since 1981, AADAC has been delivering a highly-successful prevention program to 12-71 year-old Albertans. The approach involves using mass media to persuade and motivate adolescents to "make the most of you" in combination with strong face-to-face commuity programs to provide competence develop-

ment opportunities.

The program is continuously monitored and evaluated with a control group design. Results indicate 100% awareness penetration; 66% as believing they have personally benefited from the program; 7% reduction in teenage drinking; 8% reduction in smoking; 10% reduction in marijuana use.

Brian Kearns, Assistant Executive Director, Program Services, Alberta Alcoholism and Drug Abuse Commission, 10909 Jasper Avenue, Edmonton, Alberta T5J 3M9

Action on Health Barriers

A 3-year demonstration project funded by Health and Welfare Canada, the goal is to reduce the barriers that prevent sole support mothers on government assistance from taking effective action on their health problems. The association between structural factors and individual health problems is highlighted. Activities include a "Mother's Health Action Group", an awareness program for health care providers and advocacy. Individual and collective action on identified issues is promoted.

Jane Bremner, Beth Mairs, Program Coordinators, Opportunity for Advancement, 3101 Bathurst Street, Suite 401, Toronto, Ontario M6A 2A6

Alzheimer Family Resource Centre (AFRC)

The AFRC offers information, education and emotional support to families and friends of victims of Alzheimer's disease. A "Family Information Kit" has been developed with extensive information about the disease, management issues and community resources. Regular public information meetings and workshops are held with presentations on various topics of interest to family members, such as legal issues and personal care home placement. Family members can gain emotional support by joining a Family Support Group or being matched with a volunteer visitor. Written and audio-visual materials from the centre's library are available on loan to community or professional groups. The centre is sponsored by the Alzheimer Society of Manitoba and funded by Health and Welfare Canada.

Barbara Wiktorowicz, Program Director, Alzheimer Soc. of Manitoba, 170 Hargraves Street, Suite B, Winnipeg, Manitoba R3C 3H4

Immigrant Seniors' Project

A three-year initiative, funded mainly by Health and Welfare Canada to study problems and difficulties experienced by older immigrants as they attempt to gain access to the health care system. A model program of an ethnically sensitive 'Community Health Centre' has been designed specifically to address these needs. This Community Health Centre Model with its translated information materials, culturally-based programming and multicultural primary health care team focuses primarily on preventive care and health promotion as crucial to the well-being of the immigrant senior populations.

Marina Lundigran, Co-ordinator, London Cross Cultural Learners Centre, 388 Dundas Street, London, Ontario N6B 1V7

D.E.S. Action Canada

A national, non-profit consumer organization working to ensure that the 400,000 Canadian women who were prescribed the hormone drug D.E.S. (diethylstilbestrol) during pregnancy between 1941-1971, and their children, seek and receive proper medical care. Available are posters, detailed pamphlets, a *Fertility and Pregnancy Guide* for D.E.S. daughters and sons, and copies of the Canadian and American newsletters. All Canadian materials available in English and French.

Harriet Simand, Julie Vandevar, DES ACTION/CANADA, 5890 Monkland Ave., Suite 104, Montreal, Quebec H4A 1G2

Women's Health Education Project of Newfoundland and Labrador

A model of prevention based on the belief that shared problems and experiences will lead to shared solutions and motivation, this project operated in 57 communities from 1980 to 1984. The approach used centered around popular education methods and the program was designed to address the expressed needs of women in the province, encourage their active participation, and provide a means whereby they could share and validate experiences and together work towards solutions.

Francis Ennis, Labrador Women's Institutes and Nfld. Status of Women Council, Box 37, Tors Cove, Southern Shore, Nfld. A0A 4A0

Nobody's Perfect

An educational program designed for young, low-income, single or isolated parents with children under 5 years of age. The intent of the program is to give parents access to accurate, up-to-date information on their children's health, safety, development and behaviour and to encourage them to have confidence in their own ability to be good parents. Five books form the core of the program materials for parents. They are colorfully illustrated and simply written. To assist in the planning and facilitating of a "Nobody's Perfect" parenting group or one-to-one program, a Leader's Guide, flipchart and film have been developed.

Beth Sherwood, Health Promotion Directorate, National Health and Welfare, 5409 Rainnie Drive, Halifax, N.S. B3J 1P8

Stand Up and Be Counted

This national voluntary program was developed jointly by Health and Welfare Canada and the Canadian Pharmaceutical Association to encourage

pharmacists to discontinue the promotion and sale of tobacco products in their pharmacies. Since the program began in 1984, over 65% of all pharmacies have pledged support at one of the three levels of participation. The program continues to gain support among pharmacists who are faced with the dilemma of being a medical professional on the one hand and selling the leading preventable cause of death and illness on the other.

Ernest Stefanson, Canadian Pharmaceutical Association, 1785 Alta Vista Drive, Ottawa, Ontario, K1G 3Y6

The PAL Smoking Prevention Program

PAL is part of Break Free, the youth theme of the National Program to Reduce Smoking. PAL is a school-based program for 11-13 year-olds. Teachers use "peer-assisted learning" to help young people resist pressures to smoke, pressures that become particularly powerful at this age. During the six 40-minute lessons, students explore reasons why young people start to smoke, simulate pressure situations, practise saying "no thanks", and create their own advertisements promoting "not smoking".

The Canadian Home and School and Parent-Teacher Federation collaborated on the development of a parent component to be implemented through its affiliates. The program was developed and field-tested in consultation with provincial/territorial Departments of Education and of Health.

Susan Swanson, Health Promotion Directorate, National Health and Welfare, Ottawa, Ontario, K1A 1B4

Semons La Prudence, Récoltons La Santé

Well aware that children are exposed to the dangers of work on the farm, the Sécurité Agricole of Richmond, Québec, has developed a school curriculum on farm safety, for teachers of the elementary grades. This program produced specifically for young people living in a rural environment, makes children aware of farm accidents and the necessity of avoiding them. Farm Safety is the main tool of the program and consists of 33 lesson themes accompanied by school activities requiring the students participation.

Joseph Bavota, Centre Hospitalier Universitaire de Sherbrooke, 3001-13e avenue nord, Sherbrooke, Quebec, G1H 5N4

Source: Adapted from: *Health Promotion in Action; Exhibitors Guide*. International Conference on Health Promotion. Ottawa, November, 1986. □

Join the Majority
Be a Non-Smoker

Ⓝ CoActifed*

Tablets/Syrup/Expectorant
Antitussive—Expectorant—Decongestant

Indications: CoActifed Expectorant: *To facilitate expectoration and control cough associated with inflamed mucosa and tenacious sputum.*

CoActifed Syrup and Tablets: *The treatment of cough associated with inflamed mucosa.*

Precautions: *Before prescribing medication to suppress or modify cough, it is important to ascertain that the underlying cause of the cough is identified, that modification of the cough does not increase the risk of clinical or physiologic complications, and that appropriate therapy for the primary disease is provided.*

In young children the respiratory centre is especially susceptible to the depressant action of narcotic cough suppressants. Benefit to risk ratio should be carefully considered especially in children with respiratory embarrassment, e.g., croup. Estimation of dosage relative to the child's age and weight is of great importance.

Since codeine crosses the placental barrier, its use in pregnancy is not recommended.

As codeine may inhibit peristalsis, patients with chronic constipation should be given CoActifed preparations only after weighing the potential therapeutic benefit against the hazards involved.

CoActifed contains codeine: may be habit forming.

Use with caution in patients with hypertension and in patients receiving MAO inhibitors.

Patients should be cautioned not to operate vehicles or hazardous machinery until their response to the drug has been determined. Since the depressant effects of antihistamines are additive to those of other drugs affecting the CNS, patients should be cautioned against drinking alcoholic beverages or taking hypnotics, sedatives, psychotherapeutic agents or other drugs with CNS depressant effects during antihistaminic therapy.

Adverse Effects: *In some patients, drowsiness, dizziness, dry mouth, nausea and vomiting or mild stimulation may occur.*

Overdose: Symptoms: *Narcosis is usually present, sometimes associated with convulsions. Tachycardia, pupillary constriction, nausea, vomiting and respiratory depression can occur.*

Treatment: *If respiration is severely depressed, administer the narcotic antagonist, naloxone. Adults: 400 µg by i.v., i.m. or s.c. routes and repeated at 2 to 3 minute intervals if necessary. Children: 10 µg/kg by i.v., i.m. or s.c. routes. Dosage may be repeated as for the adult administration. Failure to obtain significant improvement after 2 to 3 doses suggests that causes other than narcotic overdosage may be responsible for the patient's condition.*

If naloxone is unsuccessful, institute intubation and respiratory support or conduct gastric lavage in the unconscious patient.

Dosage: Children 2 to under 6 years: 2.5 mL 4 times a day. Children 6 to under 12 years: 5 mL or ½ tablet 4 times a day. Adults and children 12 years and older: 10 mL or 1 tablet 4 times a day.

Supplied: Expectorant: *Each 5 mL of clear, orange, syrupy liquid with a mixed fruit odor contains: triprolidine HCl 2 mg, pseudoephedrine HCl 30 mg, guaifenesin 100 mg, codeine phosphate 10 mg. Available in 100 mL and 2 L bottles.*

Syrup: *Each 5 mL of clear, dark red, syrupy liquid with a pineapple odor and a sweet black currant flavor contains: triprolidine HCl 2 mg, pseudoephedrine HCl 30 mg and codeine phosphate 10 mg. Available in 100 mL and 2 L bottles.*

Tablets: *Each white to off-white, biconvex tablet, code number WELLCOME P4B on same side as diagonal score mark, contains: triprolidine HCl 4 mg, pseudoephedrine HCl 60 mg and codeine phosphate 20 mg. Each tablet is equivalent to 10 mL of syrup. If tablet is broken in half, it reveals a yellow core. Bottles of 10 and 50 tablets.*

Additional prescribing information available on request.

**Trade Mark W-610*

PAAB
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WELLCOME MEDICAL DIVISION
BURROUGHS WELLCOME INC.
KIRKLAND, QUÉ.

Presidential Valedictory Address — 1986

Judith Kazimirski, M.D.,

Windsor, N.S.

This evening I will turn over the Prsidency to Dr. W. C. Acker. I would like to share a few observations with you that I have made over the past year, and to predict areas of concern for the profession in the future. A look back, and a step forward, so to speak.

It has been a privilege to serve as your 133rd President. My term began with immediate immersion in media prominence. There were no early days of peaceful anonymity.

1986 has been a "public year". Two of the stated objectives of our Society have been my directing force this year:

1. The promotion of health and the prevention of disease.
2. The maintenance of the integrity and honour of the medical profession.

On many occasions it was these stated objectives that prompted me to speak out on behalf of our Society.

Last year as I accepted the Presidency, I said that too often the profession is seen as having its heart in its wallet. I said further that I thought our hearts were in the right place, that physicians have not lost sight of the patient as the prime person in our health care system. My efforts this year were geared to promoting the physician and the profession as the patient advocate.

I predicted that in 1986 The Medical Society of Nova Scotia would emerge as a strong and effective voice for patients as well as physicians. I believe we have succeeded. As I look back over the year, I realize that many major milestones were reached.

- the government accepted our Home Care Program for Nova Scotia and agreed to continue to work with the Society to make a comprehensive co-ordinated Home Care Plan a reality for Nova Scotians.
- legislation to protect those involved in the peer review process is being put forward by our Minister of Health on our behalf.
- M.S.I. direct crediting to our accounts will be a reality in early 1987.
- we are recognized as an effective voice for organized medicine in Nova Scotia and an "approachable" body by the media and other health professionals.
- we have gained respect and recognition as a province to be dealt with at the national level.
- we have maintained a high provincial and national profile.

These milestones that were obtained represent not only my efforts but the efforts and work on the part of many Past Presidents and Officers of your Society.

There is a necessary skill in dealing with government — "patience, time, lobby, lobby, and lobby again" are the key words.

I sense a new "mood" in all the Society. Council has never seen as many well prepared and well thought out reports come before it. People are becoming more involved. Why is this happening? Is it because of compulsory membership?" I've paid for this and I am going to be sure my money is used wisely and well!" Whatever the reason, I hope the trend continues!

In looking to the future, we have the experience and research data to be able to predict the future health care trends and needs. If this is so, we can exert influence, change or affect that future, or do the bare minimum, prepare ourselves to function effectively in that future health care environment.

Health professionals must be futurists — we must be involved in long range planning. At the CMA Policy Conference this year, Nova Scotia suggested that CMA address itself to a long range plan.

At the provincial level, we ourselves through our Horizons Committee are actively attempting to "look to our own future".

We as patient advocates, must take an ongoing active role in future health care planning for all Nova Scotians.

If we are ever to become more than a body that reacts to government decisions, we must have our own plans and objectives in relation to the organization of health care services for the people of Nova Scotia. We need to "go to bat" for the long term benefit of our patients, our health care systems and our profession.

Too often decisions that affect health care are based on political will and financial considerations only. We as a profession have a unique expertise to offer and must be prepared not only to consult with government but to initiate action that will ensure decisions affecting health are done so with the background of medical necessity and availabale technology.

Our present medical care system is geared to "acute care". It pays lip service only to preventive medicine and its major role in health maintenance.

Our Federal Minister of Health has suggested

strategies directed toward health promotion and disease prevention. "Health maintenance models" and approaches such as this must be looked at in an organized and comprehensive fashion if preventive approaches are to have an effect on the entire system. We all do preventive counselling in our offices but there has been no attempt to date to insure this service, nor take it beyond the individual patient/doctor contract. The challenge of the future is that preventive medical approaches must be an integral part of future health care planning.

I would suggest that the traditional roles and inter-relationships of those working in health care will change. Some are obvious, e.g. nureses are pursuing active roles in home care, administration and primary care. Physicians are taking active roles in hospital management. The future role of midwives in our changing medical environment is being addressed.

In 1981, Dr. A. MacLeod said that "medical care, in whatever form it may take must remain the responsibility of physicians. It may be delegated but it can never be abandoned!"

My concern is that the medical profession is allowing major changes to occur by default — not by design, planning or delegation. We are giving up obstetrics. New graduates are reluctant to cover senior citizens' homes, make house calls, or cover emergency. Physicians are neglecting some of the fundamental duties of the practitioner. This leads to "open spaces" and others are waiting, anxious and eager to take our places.

The effect on quality patient care, accessibility, and personal satisfaction from our career choices, is frightening. As a profession we must act responsibly to ensure availability of quality medical care.

We have a unique system in Nova Scotia that allows us access to our political leaders almost as needed. We speak out and are heard. This relationship like all good relationships must be constantly prodded, stimulated and challenged in order to reach its full potential. This is not to suggest confrontation, but aggressive consultation. It must go one step further. We must be prepared to initiate action in order to protect and develop our health care system. This is our responsibility and our challenge.

Government is not a leader, it is a follower. Government action follows change in public opinion polls and responds to the public perceived need. We must constantly prod and urge government to *lead*.

We all observe with dismay as hospital budgets are placed under increasing restraints. We sense frustration, questioning the wisdom of those making these major decisions. Our provincial deficit is astronomical! Is government performing a delicate balancing act which really has nothing to do with the number of beds or X-rays or dollars in a budget, but has everything to do with how much reduction the voting public will tolerate? The public at this point in time is nowhere near as upset by these restraints as we are and therefore I see in our future continued and increasing fiscal restraint. We find ourselves applying pressure on admitting departments, phoning ourselves to back "urgent" lab work — all done as part of our role as patient advoates, but the patient never realizes the restrictions in service imposed by financial restraint. Unless we can somehow show the voting public that there is not universal accessibility and that their health is at stake, the situation will continue to escalate.

Our Society has entered into a three-year agreement with government. This settlement acknowledged the reality of economic times in Nova Scotia. We cannot rest with past achievements. We must realize where the path we have chosen leads us — we must prepare for the future. The medical profession has a responsibility to do its fair share in finding a solution to the problem of health care funding. We as a Society are looking at possible solutions through our Utilization Project.

I predict the major crisis affecting the profession now and in the future is the "liability crisis". Doctors are struggling to maintain their practices in the face of rapidly escalating insurance premiums and an increasing incidence of lawsuits. What is the future of the liability problem? I predict that left unchallenged by the medical profession, left uncontrolled without government legislative action what is affected is quality health care.

Costs are driving physicians out of high risk specialties. Public accessibility is affected. We practise in fear of jeopardizing our career and families. As a Society we recognize that a re-appraisal of the Statute of Limitations, and the introduction of tax free awards, are but two of the list of solutions to the liability problem. A good MD/patient relationship is one of the best ways to avoid a lawsuit.

Dr. Roberts addressing the New Brunswick Medical Society on Medical Malpractice, Medical Liability Insurance said, "An abandoned patient is an angry patient, and an angry patient sues. It is often not the injury, but the patient's anger that involves physicians in malpractice suits. The only sure kind of defensive medicine is to be conscientious, kind, and caring to one's patients."

Tuesday evening, speaking to the Nova Scotia Association of Allied Health Organizations, Dr. V. Goldbloom said that the prime purpose of the physician is "to relieve patient anxiety". All the technology in the world, the best treatment, accurate diagnosis, and clinical management is of no use if we do not relieve anxiety. Both of these gentlemen are stressing the importance of improved communication as our major tool against the threat of litigation.

Now, what have I said? What does it mean today? Let me remind you what Merv Shaw said last year. He said get involved and be pro-active. He also said nobody would remember what he said — he obviously underestimated us. I want to add to Merv's thought by saying — get your colleagues involved. I recognize by your very presence in this room that you are involved. You are the physicians who care about our future and the future of our health care system.

However, you are only a small number of Nova Scotia's licenced physicians. You are the ones carrying the load in the Medical Society. I urge you to go back to your communities and carry our message to your colleagues who could not attend our Annual Meeting. Tell them to get involved. Tell them the importance of being pro-active. Tell them the Medical Society and indeed the Medical Profession must lead rather than follow.

Above all, tell them that quality care for our patients must be protected at all costs. Decisions about our health care system must have input from doctors. Let the politicians and administrators talk about timing and money while we talk about patient care.

The freedom of the profession to act professionally, to act as a patient advocate, to negotiate with government and promote health, is at stake. Our personal involvement will affect the outcome.

Thank you. □

Appreciations

DR. HERBERT CORBETT

Dr. Herbert (Bert) Corbett passed away on November 7, 1986 at St. Rita's Hospital, Sydney after a lengthly illness. He was 86 years of age.

Bert was born in Mulgrave. He graduated from St. Mary's University, Halifax in 1918 and Dalhousie Medical School in 1923. He did post-graduate studies in diagnostic radiology at University of Michigan.

In 1938 he joined the staff at St. Joseph's Hospital, Glace Bay, City of Sydney Hospital and St. Rita's Hospital. He was a consultant with Radiological Services, Nova Scotia Hospital Insurance Commission, from 1959 to 1962. In 1964 he was appointed to Head of the Radiology Department at St. Rita's Hospital where he remained until his retirement. In 1983 the Department of Radiology at St. Rita's Hospital was dedicated in his honour.

He was a Fellow with Canadian Association of Radiology and was honored as a senior member of the Canadian Medical Association in 1971 and The Medical Society of Nova Scotia in 1974.

Bert spent his retirement years compiling a history of Radiology in Nova Scotia and Cape Breton, which is in the Nova Scotia Archives.

Bert was a very dedicated physician and radiologist who always enjoyed any medical, political or social event. He was a man of very strong opinions which he did not hesitate to express — and his dislike of snow was legendary. He had a quick wit and a ready story, he will be sadly missed by his colleagues in Cape Breton.

He was predeceased by his wife, the former Vony Chisholm; a daughter, Shirley Anne; and a son, Bill. He is survived by five grandchildren, Darlene, Bill, Sheryl, Vernica and Aloyoise Dixon, all of Halifax.

M.A.S.

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DR. MARY KERNOHAN

Dr. Mary Kernohan, age 32, of Parrsboro, Nova Scotia and Goose Bay, Labrador died in hospital in St. John's, Newfoundland November 21, 1986.

Born in Halifax, she was the daughter of Dr. David and Molly Kernohan, Parrsboro. She graduated from the Parrsboro Regional High School in 1972, attended Dalhousie University where she obtained a Bachelor of Science degree, and graduated from Dalhousie Medical School in 1981. After graduation, she interned in Winnipeg and then went to the north coast of Labrador where she practised. Subsequent to that, she returned to Digby, Nova Scotia, to do a locum tenens for a few months. She then returned to Labrador as a "flying doctor" with the Grenfell Mission in Happy Valley, Labrador, where she was responsible for three small communities.

In addition to her parents, she is survived by a sister, Ann, London, England; a brother, Andrew, Parrsboro; and her fiancé, Dr. David Beach, Goose Bay.

D.M.R.

Pictorial Highlights
133rd Annual Meeting

Dr. C.E. Van Rooyen was awarded Senior Membership in the Medical Society this year. Unable to attend the Awards Banquet at the Annual Meeting, the Award was presented at the Society office by the President, Dr. Judy Kazimirski.

All the Presidents gathered around Dr. Arno Elmik of Parsboro after he was awarded Senior Membership in the Medical Society at the Awards Banquet of the 133rd Annual Meeting, Left to Right President, Dr. Bill Acker, Dr. Elmik, Past President, Judy Kazimirski and President-Elect, Dr. Doug Henshaw.

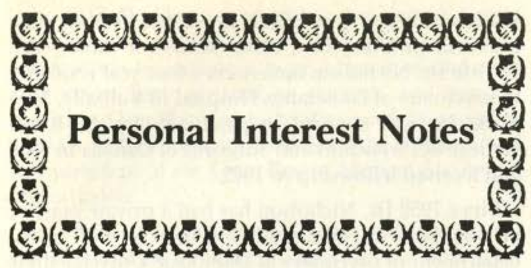
Dr. Winston Sodero (left) accepted his CMA Senior Membership Citation from the Association's President, Dr. Jacob Dyck.

Dr. Fraser Nicholson (centre) receives his CMA Senior Membership Citation from CMA President Dr. Jacob Dyck. He was assisted by CMA Secretary General Dr. Paul Landry.

Plan now to attend the

1987 Annual Meeting
November 26 - 28

World Trade & Convention Centre
and Prince George Hotel, Halifax



SENIOR MEMBERSHIP CITATIONS
THE CANADIAN MEDICAL ASSOCIATION

Dr. Arno Elmik

On behalf of the Cumberland Branch of this Society, I am pleased to present Dr. Arno Elmik, a candidate for Senior Membership in The Medical Society of Nova Scotia. Dr. Elmik was born in 1919 and graduated in medicine from the University of Tartu in 1944. During the years 1945-1947, he was employed by the United Nations Relief and Rehabilitations Administration. Following a period of practice in the United Kingdom, he arrived in Canada in 1951, and practised family medicine in Advocate Harbour, Canso, and Bass River. For the last eighteen years, he has resided in the town of Parrsboro, and conducted a solo practice there.

Arno has been a member of the Nova Scotia Medical Society since the early 1950s. He has been active at both the branch and provincial levels, serving as a member of Council, participating in committees, and representing the Cumberland Branch on the Board of Directors of Maritime Medical Care. He has served as President of both the Antigonish-Guysborough and Cumberland Branches.

Arno and his wife,Maret, reside in Parrsboro and have two sons, both students at Acadia University. In the community, Arno has received citations for devoted community health services.

Arno has been an active participant in continuing medical education programs. He has served several years as Chief of Medical Staff at the South Cumberland Memorial Hospital, Parrsboro, and is at the present time, a member of the active staff of the same hospital; he played an instrumental role in developing the Adult Day Care Centre in Parrsboro, one of the first geriatric day cares in the province.

Arno is known to all of us in Cumberland County as a model for other physicians. He is an enthusiastic supporter of this Society and an active participant at all our meetings. His counsel is sought and respected. He is known to us all as being forward-looking; he has no fear of change; he is known as a very active promoter of preventive medicine and of the individual's responsibility for his or her own health care. Above all, he has gained the respect and affection of his patients because of the selfless, dedicated efforts he has made on their behalf, following the time honored traditions of our profession.

I take great pleasure, Madame President, in presenting Dr. Arno Elmik to you as a candidate for Senior Membership in this Society.

David M. Rippey, M.D.,
President, Cumberland Branch Society

Dr. Clennel B. van Rooyen

It is a privilege to present for your recognition and honor, and for Senior Membership in The Medical Society of Nova Scotia, Clennel Evelyn van Rooyen, MB, ChB, MD, DSc, FRCP(Lond), FRCP(C), FRC(Path), FRS(Can) — distinguished scholar, scientist, author, physician and soldier — and friend and colleague of many here assembled — Van!

We do not have time to relate his impressive curriculum vitae and extensive bibliography — indeed, they combine to provide a survey of modern microbiology. Also, Van is modest, never having rested on his accomplishments, but using each as a stepping stone to a new idea or adventure in 20th century medical science. Rather, I will review the highlights of his brilliant career.

Van's formative years were at Edinburgh in the 1930s. From there he studied and worked with such masters of microbiology as Mackie, Gordon, Paaschen, and Castellani. They inspired the pursuit of excellence, and ordained the long hours in the laboratory, library, classroom and hospital ward. Van has always honored his teachers and schools of learning, not only for their science and methods, but also for the great intangibles that they exemplified — a code of behavior, conscience, respect for oneself and one's fellows — science to advance human knowledge, and science to serve mankind.

In the 1940s and 50s he lived in the exciting adolescence of virology and made fundamental contributions, interrupted only by service in World War II. These were some of his greatest years, and his close and mutually rewarding associations with such eminent peers as Andrew Rhodes, John Paul, Herald Cox, and Albert Sabin. His name will stand forever in the annals of poliomyelitis and hepatitis research, and his textbook, *Virus Diseases of Man,* with Andrew Rhodes, remains a classic in the libraries of medicine.

When he came to Dalhousie in 1956 I was his first research fellow. Fresh from six years in an isolated

rural practice, it was a unique and thrilling privilege to work with a master scientist and to try to learn the right questions and the methods to study and treat infectious illnesses. His growing and ever loyal staff respected and admired him immensely as he led them to their highest potential. He developed the Nova Scotia Virus Laboratory, critically examined the flu pandemic of 1957, studied in depth the new enteric and respiratory viruses, conducted the critical live polio vaccine trials and performed clinical trials with many new antibiotics. He gave untiring consultation to Eastern Canada's physicians and medical officers of health, and many lives were saved by Van's midnight efforts to identify a microbe and find the best antibiotic. All physicians may indeed save lives, but only a select few contribute to the scientific base we all use. Van is one of these!

Many of you know his outstanding characteristics — the great intellect, the curiosity, enthusiasm and dedication to duty — and above all, his spirit of compassion and concern.

To Hilda, John and Jennifer, we acknowledge with gratitude your loving support throughout his distinguished career.

Madame President, I present for senior membership in The Medical Society of Nova Scotia, Dr. C.E. van Rooyen.

Alan J. MacLeod, M.D.,
Representing Halifax Branch Society

SENIOR MEMBERSHIP CITATIONS
THE CANADIAN MEDICAL ASSOCIATION

Dr. John Fraser Nicholson

For 35 years John Fraser Nicholson has paractised and taught psychiatry in Nova Scotia. Generations of patients will attest to is excellence as a clinician. And as a teacher, Dr. Nicholson has twice won one of the most coveted awards in the university. In 1971 and in 1980, he was named Professor of the Year by the Dalhousie Medical Students Society.

Fraser Nicholson was born in Springhill, Nova Scotia, in 1913. After early education there and in New Waterford and Glace Bay, he entered Dalhousie University where he graduated in science in 1933 and then in medicine in 1937. Dr. Nicholson practised general medicine in Sherbrooke, Nova Scotia, for a year before attending the British Postgraduate Medical School in London for four months and then doing six months of surgery practice. During the subsequent war years he served with the Royal Canadian Army Medical Corps in England, Africa, Italy, Germany and Holland. He was demobilized in August 1945. He then practised in Glace Bay, Nova Scotia for three years. In 1948 Dr. Nicholson undertook a four year residency in psychiatry at Grasslands Hospital in Valhalle, New York. He was certified in psychiatry by the Royal College of Physicians and Surgeons of Canada in 1952 and received fellowship in 1972.

Since 1952 Dr. Nicholson has had a private practice of psychiatry in Halifax and has been on staff in the department of psychiatry at Dalhousie University. He rose from assistant professor to associate professor in 1964 and was made a full professor in 1968. Between 1972 and 1979 he was assistant dean of medicine for admissions and student affairs. In 1981 he was named professor emeritus. Dr. Nicholson is also currently a consultant to Camp Hill Hospital, Victoria General Hospital and Nova Scotia Hospital. He is a member of several medical review committees and medical advisor to the hospice program at Victoria General.

Dr. Nicholson is a member of the Canadian Psychiatric Association, the Nova Scotia Psychiatric Association and, until recently, the American Psychiatric Association.

Dr. Nicholson lists gardening and sailing among his pastimes.

Dr. George Watson Sodero

George Watson Sodero's career as a general practitioner and gerneral surgeon has spanned more than 50 years. He is one of the last of a disappearing breed of physicians. He not only managed a large general practice but also was able to do most of the major and minor surgery in that practice. Surgeons of his era were expected to be competent in all types of major abdominal surgery and orthopedics and on occasion it would be necessary for them to venture into the chest cavity or to make burr holes in the skull. Dr. Sodero is respected by both his patients and his colleagues as an empathetic counsellor and a dependable, conservative surgeon.

Watson Sodero was born in Sydney Mines in 1907 and received his early education there before moving with his family to the city of Sydney in 1923. He graduated from Sydney Academy in 1925 and entered Dalhousie Medical School the following year. A bout of tuberculosis forced him to take two years away from his medical studies. He graduated in 1934 and then practised general medicine in Guysborough, Nova Scotia, for two and a half years. Postgraudate studies followed at the British Postgraduate Medical School in London. He spent a year in London and a year in Edinburgh, Scotland, studying surgery. Subsequently he received certification in surgery from the Royal College of Physicians and Surgeons of Canada and fellowship with the American College of Surgeons.

In 1938 Dr. Sodero opened a practice in family medicine and general surgery in Sydney, a practice which came to include a large amount of obstetrics and gynecology as well as surgery and general medicine. Over the years he held a variety of positions at both Sydney Hospital and St. Rita Hospital and was president of the Cape Breton Medical Society on one occasion.

Dr. Sodero is now semi-retired and spends the summer months at Whycocomagh in the Bras D'Or Lakes area of Cape breton. He continues to see patients in both Sydney and Whycocomagh.

His wife, the former Isabel Floyd of Guysborough, died in 1985. He has three children and six grandchildren.

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Correspondence

To the Editor:

I was fascinated with your very thoughtful editorial in *The Nova Scotia Medical Bulletin* October 1986 entitled 'The Physician in a Narcissistic World". I would like to draw to your attention a book by Wilson Bryan Key entitled *Subliminal Seducation* with an introduction by Marshall McLuhan, First Signet Printing, December 1974. Dr. Key presents a great deal of evidence that magazines in particular select a target population and prey upon their narcissism.

It should be pointed out that there is a mental form of narcissism as well as the more familiar physical narcissism. These magazines recognize that a certain sector of the population has been educated, pressured or otherwise molded into a certain mind-set by our social institutions. When this occurs, that sector of the population becomes vulnerable to the presentation of misinformation that panders to and strokes their particular self-image. Flattered by such stroking, it is very easy for the magazine by way of its articles and the complementary advertising to gain insidious access to the mind of anyone in the target population. For example, once a person in a particular social class selects the magazine that appeals to his prejudices, he becomes the victim of advertisers who tell him that he will not continue to be acceptable unless he drives a certain kind of car, smokes a certain kind of cigarette, and offers his friends a certain type of alcoholic drink. I have referred here to the male and the advertising approach is exactly parallel for the female. It is certainly time that we examined the media very carefully to determine just what their purpose is.

With regard to medicine, there seems to have been a tradition of rejection of what was called hypochondriasis in favor of "real illness". Actually, the distinction between these is much less clear than it used to be. For example, we now recognize that some of the complaints that were once considered hypochondriacal were based upon sensitivity to changes in the body that are of significance. In fact, it may be that many psychosomatic conditions could be easily treated if they were reported early enough when the complaint sounds "hypochondriacal". That is to say the patient who is sensitive to his own body and able to describe minimal physiologic changes, can become available for treatment before serious pathology develops.

In psychiatry, this is a particularly significant problem. If a condition develops to a certain point, it usually requires chemotherapy, such as tranquilizers or antidepressants. These procedures are palliative and we now realize that they often have to be continued life-long. Moreover the mental functioning of the patient is impaired by these chemicals but their use is justified by the fact that a modified sort of social functioning becomes possible. Increasing numbers of the population are now being treated as if they had serious mental illness because psychiatrists often avoid the troublesome and painstaking operation of psychotherapy and family therapy.

Drugs can suppress the signal value of the symptom, for example pain, and worsen the communication aspect of a problem. Sexual function is frequently impaired. Spouses and other family members have in some cases been frustrated by an obstacle to communication and have even requested drugs for themselves. One husband began using alcohol to suppress his sexual interest in his spouse because she was on a tranquilizer.

We may ask: "How can physicians help our society escape from an exclusively chemical framework in its attempt to diagnose and treat its ills? How can we increase rather than suppress our sensitivity to our own bodies and to the communications of others?" Inappropriate prescription of drugs can amount to malpractise.

Yours sincerely,

Eric J. Cleveland, M.D.,
Hebron,
Yarmouth Co., N.S.

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ERRATUM

Dr. R. S. Dunn M.D., F.R.C.S.(C), F.A.C.S. and Dr. M. A. Naqvi, M.D., F.R.C.S.(C), F.A.C.S., authors of the article "A Five Year Review of Ruptured Abdominal Aortic Aneurysm at a Regional Referral Centre" which appeared in the October 1986 issue of the *Bulletin*, are both General and Vascular Surgeons, Sydney City Hospital and St. Rita Hospital in Sydney, N.S., not the New Waterford Consolidated Hospital.

OBITUARIES

Dr. Herbert L. Knodell, (77) of Halifax, N.S. died on September 23, 1986. Born in Halifax he received his medical degree from Dalhousie Medical School in 1937. He practised in Nova Scotia until his retirement in 1980, and was a member of The Medical Society of Nova Scotia and The Canadian Medical Association. He is survived by a sister and two brothers, to whom we extend sincere sympathy.

Dr. Robert P Mattey, (32) of Berwick, N.S. died on October 14, 1986. Born in Montreal he received his medical degree from McGill University in 1978, and completed a residency in orthopedics at Montreal General in 1985. He was a member of The Medical Society of Nova Scotia and The Canadian Medical Association. He is survived by his wife and four children. The *Bulletin* extends sincere sympathy to his wife and family.

Dr. William A. Hewat, (82) of Lunenburg, N.S. died on October 23, 1986. Born in Ontario he received his medical degree from Dalhousie Medical School in 1928. He practised for 33 active years in Nova Scotia before ill health forced him to retire. He was a member of The Medical Society of Nova Scotia and The Canadian Medical Association. He is survived by his wife and two daughters. Our sympathy is extended to his family.

Dr. Gordon K. Smith, (90) of Hantsport, N.S. died on November 4, 1986. Born in Windsor he graduated from Dalhousie Medical School in 1922. He was past president of the Valley Medical Society and a senior member of The Medical Society of Nova Scotia. He was active in the community as mayor of Hantsport and honorary president of the Payzant Memorial Hospital. His is survived by his son, a sister and two grandchildren, to whom the *Bulletin* extends sincere sympathy.

Dr. David S. Moore, (64) of Truro, N.S. died on November 17, 1986. Born in Moncton, N.B. he received his medical degree from the University of Ottawa in 1955. He had been practising in Truro as an obstetrician and gynecologist for 25 years. He was a member of The Medical Society of Nova Scotia and The Canadian Medical Association until his retirement. He is survived by his wife, two daughters, and a son. The *Bulletin* extends sincere sympathy to his family.

Dr. Mary Kernohan, (32) died on November 21, 1986. Born in Halifax she received her medical degree from Dalhousie Medical School in 1981. She practised medicine as a flying doctor in northern Labrador before she started working at the Grenfell Regional Health Service in Goose Bay. She is survived by her parents, a sister, and a brother. We extend sincere sympathy to her family.

Dr. Horace B. Colford, (76) of Halifax, N.S. died on November 25, 1986. Born in Chezzetcook, N.S. he received his medical degree from Dalhousie Medical School in 1950. He served with the City of Halifax and the Province of Nova Scotia Health Departments as director of communicable diseases and maternal and child health. He was very active in the Canadian Association for the Mentally Retarded and the Canadian Red Cross. He is survived by his wife and two sons. The *Bulletin* extends sincere sympathy to his family.

Dr. Bentley R. Wilson, (69) of Middleton, N.S. died on November 26, 1986. Born in Fredericton, N.B. he received his medical degree from Dalhousie Medical School in 1943. He practised in the Middleton area for 38 years and served on the board of the Soldier's Memorial Hospital for 22 years. He was a member of The Medical Society of Nova Scotia and the Canadian Medical Association. He is survived by his wife and three daughters, to whom we extend sincere sympathy.

Dr. Robert W. Napier, (55) of Halifax, N.S. died on November 30, 1986. Born in Halifax he graduated from Dalhousie Medical School in 1962. He practised medicine in Newfoundland before returning to Halifax in 1963, and was a member of The Medical Society of Nova Scotia. He is survived by his wife, three sons, and one daughter, to whom the *Bulletin* extends sincere sympathy.

Dr. Herbert Corbett, (86) of Sydney, N.S. died on November 7, 1986. Born in Mulgrave he received his medical degree from Dalhousie Medical School in 1923. He did post graduate studies in diagnostic radiology and tuberculosis medicine, and was appointed Head of the Department of Radiology in 1964. He was senior member of the Canadian Medical Association and The Medical Society of Nova Scotia. He is survived by five grandchildren. The *Bulletin* extends sincere sympathy to his family. □

GROWTH HORMONE THERAPY AND CREUTZFELDT—JACOB DISEASE

In April 1985 four cases of Creutzfeldt-Jakob disease were reported from the USA and Great Britain in young male adults who had previously received human pituitary derived growth hormone. To date, no further cases have occurred in the world. Longterm surveillance is critical to effective counselling of persons who have previously received growth hormone and to further our understanding of the association between Creutzfeldt-Jacob Disease and growth hormone therapy.

All physicians are requested to report any death or unexplained serious neurological disease in a person who has previously received GH therapy. Please contact Dr. Heather Dean or Dr. Henry Friesen at the growth hormone registry in Winnipeg (204-788-6698).

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