Medical History In Newfoundland

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Dear Mr. Editor:

To ask, as you have kindly done, for a short History of Medicine in Newfoundland requires on my part research and study beyond what has yet been given to the subject. For the facts that follow I am indebted largely to papers prepared by the late Dr. L. E. Keegan, M.D.,C.B.E., (published in *The Book of Newfoundland*, 1936, edited by J. R. Smallwood) and an address by Surgeon-Commander John Cusson, R.N., given before the Newfoundland Historical Society.

Medical History in Newfoundland seems to have begun in 1662 when the French strongly fortified Placentia. As a small hospital was built, it is believed a doctor was attached to their forces.

1703 saw a permanent garrison established in St. John's, commanded by a Major Lloyd. In a petition to London for Major Lloyd's removal the the third of seventeen charges against him is a reference to "his Barbarity to the Surgeon."

From this date successive Regimental M.O.'s and Naval Surgeons gave medical aid to the fishermen.

1708 St. John's was taken by the French, and the Garrison *including the surgeon* were taken prisoners and marched to Placentia.

1765—Notes on the history of the town of Trinity state that a Dr. John Lane settled there in 1765. His is the first name of a doctor recorded. Of great historical interest is an entry in these notes on Trinity as follows: "One of the great blessings of the world—that of vaccine, was first used in Trinity by the Rev. John Clinch, who before he came to Newfoundland was a medical co-worker with Dr. Jenner."

It appears Jenner sent vaccination crusts to-Dr. Clinch who proceeded to vaccinate all willing to submit. Smallpox hit the settlement a year or two later, and not one of those vaccinated contracted it. It is said this evidence, laid before the Royal Commission, had a decisive influence in making their report favourable.

1794—There is record of Mr. M. Dingle, Missioner and Doctor, at Bay Bulls who also acted as Magistrate.

1796—he was taken prisoner by the French, and all his property destroyed.

1797—There is record of David Duggan and John McCurdy both practising in St. John's—the former is chronicled as Acting Surgeon to the Royal Newfoundland Regiment.

At this time several doctors were practising in outlying harbours: Dr. Francis Bradshaw (at Placentia), Mayde, and Moore. Many of these were also Justices of the Peace. In fact Prowse states that Dr. D'Ewes Coke of Trinity became in 1792 Chief Justice of the island.

In 1802 he was succeeded as Chief Justice by Dr. Jonathan Ogden. Ogden's name is the first authentic name recorded of a British doctor practising to St. John's. Ogden came to St. John's in 1784 from Halifax, N. S.,

where he had held a hospital position as Surgeon's Mate, R.N., to act as Surgeon to the Royal Newfoundland Regiment.

In 1795 Ogden wrote a Memorandum to his Colonel, who forwarded it promptly to the Governor, requesting "that some place should be provided for a *hospital* because of the over-crowding of the sick and healthy in the barrack room." Two Military Hospitals were built, one for general, the other for infectious diseases.

During all these years the clergy were looked to for physical as well as spiritual advice, and nobly did they rise to the occasion. In fact, in many outports far removed from a doctor, the clergy still are looked to for medical advice. When the Medical Act was enacted in 1893 at least one clergyman was registered as a medical practitioner.

Clergy and doctors were probably the only persons with education. The doctors, graduates as they were of Edinburgh, London, and Dublin acted frequently as magistrates—not always a pleasing combination of duties, as the writer knows from personal experience on the Labrador. There is a letter extant from Dr. Edgar, Greenspond, to Governor Keats, dated 1813, asking to be relieved from the unpleasant situation of magistrate stating "I have been censured by illiterate and unprincipled persons for discharging my duty as an upright and impartial man ought to do."

And so the record goes of heroic service under adverse conditions in all our larger bays and older settlements with little reward but that of a sense of work well done.

In 1805 there is mention of Dr. Stephenson in Burin—his Commission as Justice of the Peace is dated 1805. Practising with him was a Dr. Row, also an ex-Naval doctor. These men were succeeded by the Morans, Frank and James, one of whom practised at Brigus. Conception, Trinity and Placentia had resident surgeons too in these early days.

In 1808 Dr. William Carson arrived here after ten years practice in Birmingham. He was a strong, energetic crusading Scot, and was so appalled by conditions that he became the leader in every kind of reform. His outstanding ability and university training, his knowledge of the British Constitution, qualified him for the splendid patriotic work he performed. As one writer puts it "It was through Dr. Carson's efforts that the Floating Courts were abolished, and a proper system of British Justice brought in. It was through Carson's ability as a statesman, that Representative Government was secured for Newfoundland."

Dr. William Carson not only practised but taught medicine, for we have records that he and his son, Samuel, took as apprentices, H. H. Stabb and Charles F. Renouf who, after five years training proceeded abroad to University to qualify. The indenture of apprenticeship is an interesting document but space forbids quoting it here.

Shortly after Dr. Carson arrived, he started an agitation for a civilian hospital and in 1813 the Corner Stone was laid by the Governor, Sir R. G. Keats. This hospital cost £2,135 to erect and was subscribed by the public. Among the items of expenditure it is quaint to find £19 sterling to cover rum for the men who hauled the frame. Also, that one of the privileges of the surgeons was that, before proceeding to an operation, they finished a bottle of Port!

In 1852 one of the Military Hospitals was pulled down, and a new one

built on Forest Road; out of the latter grew the present General Hospital. Evidence of its military origin is still to be seen in some of the old fire places, which bear the Royal Monogram V.R.

From this we trace the medical history of St. John's in the work of its surgeons—Crowdy, Shea, Rendell, F. Stabb, Keegan, Fraser, Anderson, Cowperthwaite.

During Dr. Shea's Superintendency a Nurses' Training School was established 1901, under the late Miss Mary Southcott, Nursing Superintendent, a graduate of the London Hospital. During this period four large wards were added.

But to return to earlier days, in 1892 Dr. Smith at Burin successfully performed the first Caesarian section. He was one of the first in this country to adopt Lister's teaching.

Doctors Rendell, Stabb and Fraser, graduates of Edinburgh, arrived in the 80's imbued with the principles of antisepsis, and with Dr. H. E. Kendall (lately Lt. Governor of Nova Scotia) who came here after the 1892 fire, did a great deal to stimulate the practice of surgery

Later Dr. Fraser, at his own expense, opened a Children's Hospital with an operating room—a distinct step forward.

In 1892 occurred the Great Fire. No hospitals were in the burnt area, but practically all the doctors' houses were burnt. While the town was still smoking a ketch-rigged North Sea trawler—the Albert—sailed through the Narrows. On her was Dr. Wilfred Grenfell, of the Royal National Mission to Deep Sea Fishermen, who had sailed from England because of what he had heard of the desperate need of the inhabitants of Labrador for medical attention. The following year Grenfell returned with another doctor and two nurses and opened two hospitals, one at Battle Harbour, open all the year; another at Indian Harbour, summer only and himself travelled up and down the coast, in a hospital ship. The aid rendered to the fishermen was immense. Your readers may be aware how greatly this work has grown. The work under the International Grenfell Association has now grown to one hospital, approved by A.C.S. at St. Anthony in Northern Newfoundland of 124 beds, and three in Labrador with two doctors—58 beds. There are Nursing Stations and Hospital Steamers also.

1893—Medical practice in Newfoundland was brought under legal control by the Medical Act of 1893, which set up the Medical Board of seven practitioners as the registering body. Vacancies on this Board are filled by vote of the licensed medical practitioners. The Board is in reciprocity with the General Medical Council of Great Britain and Ireland.

In 1920 a movement was started to provide specially trained District Nurses for the Outports. Gradually the Newfoundland Outport Nursing and Industrial Association (called Nonia) expanded along the Highland and Islands Association of Scotland, teaching the women to produce finely knitted and woven fabrics. This work resulted in the placing of some nineteen nurses who gave fine service.

In 1934, when the present Department of Public Health and Welfare was organized, it took over the nursing side of Nonia to start its District Nursing Service.

In 1922 the Sisters of Mercy established a small hospital in a large private house which was later expanded into a new 156 bed building of modern and scientific design, and a school of nursing started.

In 1923 a hospital—planned originally as a Maternity Hospital—was erected by the Salvation Army, largely by public subscription. This has now expanded into a general hospital of 165 beds and a school of nursing.

At present the student nurses of the three hospitals affiliate with the Sanatorium, the Mental Hospital and the Fever Hospital; those of the General Hospital affiliate with Grace Hospital for their maternity training.

Early in the century a Fever Hospital was built near the General Hospital, which in the thirties was renovated and modernized. It has 53 beds.

During World War II the General Hospital was added to on a large scale—indeed one could say a new hospital, complete in itself was built, with the pre-existing buildings now forming an annex. It is built to the most modern design and has 400 beds, with X-ray, Deep X-ray, Radium, Physio-Therapy, etc., Departments.

Tuberculosis. The general feeling was that open air treatment of tuberculosis was an impossibility in a climate so variable as Newfoundland's but led by Dr. Herbert Rendell and one or two others who were convinced by their experience with private patients, a start was made. The Newfoundland Chapter of the Daughters of Empire sponsored a small experimental sanatorium—wooden huts surrounding a slightly larger administration building—and so great was the improvement in the patients after a year, that our Government was convinced that Sanatorium treatment was not only feasible, but absolutely necessary. So the Government set about building our Tuberculosis Sanatorium, which now contains over 500 beds. Another is being built at Corner Brook.

Twillingate Hospital was the first to be started by the efforts of the people themselves. They were organized by Dr. Charles Parsons and have now an approved A.C.S. Hospital of 13 beds, with Dr. Olds as Superintendent.

Mental. As in most countries, the care of mental patients makes sad history. Their champion in Newfoundland was Dr. H. H. Stabb, Edinburgh, (one of Dr. Carson's apprentices) who in 1845 succeeded in having the insane removed from the General Hospital to a separate house, and in 1854 saw the central part of the present hospital built in the suburbs. This building has expanded and now holds 630 patients.

When War broke out in 1914 the only semblance of even semi-military medicine we then had was the lately established St. John Ambulance Brigade Overseas. When the officers of the various Boys' Brigades took on the formation of the Newfoundland Regiment, the St. John Ambulance Brigade undertook the Medical Department, organized the examining of recruits, performing vaccinations, and caring for the men in Camp, the Assistant Commissioner becoming Principal Medical Officer of the Regiment.

Newfoundland made her contribution to Medical History in World War I in connection with poison gas.

The Principal Medical Officer of the Newfoundland Regiment was in France when the Canadians were victims of the first German gas attack and it was he who invented the first gas helmet. He was sent back to London with it: placed on the first War Office Committee dealing with poison gas: and by them put in charge of producing the helmet in quantity. That quantity went to well over twenty million.

St. John's has a Clinical Society which meets monthly.

The Newfoundland Medical Association formed in 1923 arranges annual Conventions, lasting several days and is attended by a large proportion of the Island's medical men.

Our senior physician still in practice is Dr. N. S. Fraser, O.B.E., who took his M.B. from Edinburgh in 1886. He celebrated his medical jubilee by submitting a thesis to Edinburgh in 1936, on which he was granted his M.D.

I enclose a list of Newfoundland Hospitals as supplied last year to the American Medical Association which you may wish to publish.

One might add that at the Goose Airport in Labrador there is a Canadian Hospital capable of expanding to 200 beds and a United States Hospital capable of expanding to 300 beds.

NEWFOUNDLAND & LABRADOR

Population, Newfoundland 315,643
Population, Labrador 5,528
No. of Physicians, Newfoundland 135
No. of Physicians, Labrador 2
Area in Square Miles, Newfoundland 42,734
Area in Square Miles, Labrador 112,400

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Honourable H. W. Quinton, Commissioner, St. John's
L. G. Crummey, Secretary — Dr. L. A. Miller, Director of Medical Services

HOSPITALS AND SANATORIA—NEWFOUNDLAND

Location	Date Established	Category	Beds	Superintendent	Miscellaneous
St. John's:					
General Hospital	1834—D.P.H. and Welfare	General	400	E. Leo Sharpe, M.D.	School of Nursing X-ray Department Out-Patient Department
Grace Maternity Hospital	1923—Salvation Army	General	165	Major J. Janes, R.N.	School of Nursing X-ray Department Out-Patient Department
St. Clare's Mercy Hospital	1922—Sisters of Mercy	General	156	Sister Aloysius, R.N.	School of Nursing X-ray Department Out-Patient Department
Hospital for Mental and Nervous Diseases	1853—D.P.H. and Welfare	Psychiatric	630	C. A. Roberts, M.D.	Out-patient Department X-ray Department
Sanatorium	1918—D.P.H. and Welfare	Sanatorium	500	R. E. Bennett, M.D.	X-ray Department Out-Patient Department
Merchant Navy Hospital	1942—D.P.H. and W.	Ex-Service	60	E. F. Moores, M.D.	X-ray Department
Fever Hospital	—D.P.H. and W.	Communicable Diseases	53	M. Walker, R.N.	

Location	Date Established	Category	Beds	Superintendent	Miscellaneous
Outports:					
Brookfield, B. B.	1944—D.P.H. and W.	Cottage Hospital	24	L. Lawton, M.D.	X-ray Dept. & Out-Patient Dept.
Markland, Whitbourne	1936—D.P.H. and W.	Cottage Hospital	18	W. H. Newhook, M.D.	Out-patient Department
Placentia	1942—D.P.H. and W.	Cottage Hospital	24	W. P. Collingwood, M.D.	X-ray Dept. & Out-Patient Dept.
Burin, P. B.	1936—D.P.H. and W.	Cottage Hospital	22	J. W. Heath, M.D.	X-ray Dept & Out-Patient Dept.
Grand Bank, F. B.	1941—D.P.H. and W.	Cottage Hospital	22	J. Burke, M.D.	X-ray Dept. & Out-Patient Dept.
Harbour Breton, F. B.	1936—D.P.H. and W.	Cottage Hospital	22	M. Twomey, M.D.	X-ray Dept. & Out-Patient Dept.
Burgeo, S. W. Coast	1936—D.P.H. and W.	Cottage Hospital	12	M. G. Jacoby, M.D.	X-ray Dept. & Out-Patient Dept.
Stephenville Crossing	1937—D.P.H. and W.	Cottage Hospital	22	D. Cant, M.D.	X-ray Dept. & Out-Patient Dept.
Norris Pt., Bonne Bay	1940—D.P.H. and W.	Cottage Hospital	22	N. Murphy, M.D.	X-ray Dept. & Out-Patient Dept.
Bonavista	1940—D.P.H. and W.	Cottage Hospital	22	C. A. Forbes, M.D.	X-ray Dept. & Out-Patient Dept.
Come-By-Chance	1936—D.P.H. and W.	Cottage Hospital	28	M. G. Coxon, M.D.	X-ray Dept. & Out-Patient Dept.
Old Perlican, T. B.	1936—D.P.H. and W.	Cottage Hospital	12	A. A. Wilkinson, M.D.	Out-Patient Department
Gander	1946—D.P.H. and W.	General	50	J. G. Paton, M.D.	X-ray Dept. & Out-Patient Dept.
Botwood	1946—D.P.H. and W.	General	40	W. D. Rowe, M.D.	X-ray Dept. & Out-Patient Dept.
Corner Brook	—Company	General	32	R. F. Dove, M.D.	X-ray Dept. & Out-Patient Dept.
Grand Falls	—Company	General	18	J. F. Brown, M.D.	X-ray Dept. & Out-Patient Dept.
Buchans	—Company	General	6	A. M. Guy, M.D.	X-ray Department
N.D.B. Memorial, Twillingate	1924—Private Assoc.	General	130	J. M. Olds, M.D.	X-ray Dept. & Out-Patient Dept.
St. Anthony	1900—Grenfell	General	124	C. S. Curtis, M.D.	X-ray Dept. & Out-Patient Dept. School of Nursing
Labrador:					
Cartwright	1937—Grenfell	General	25	C. H. Forsyth, M.D.	X-ray Dept.
North West River	—Grenfell	General	9	W. A. Paddon, M.D.	Portable X-ray
St. Mary's River	1930—Grenfell	General	24	Miss Jupp, R.N.	Out-Patient Dept.

Behind The Front*

ARTHUR L. MURPHY, M.D.,F.A.C.S.

IT is not inappropriate that this talk should be coupled with that of a distinguished gynecologist—or any gynecologist. Backache, as a complaint rings in his ears with as great frequency as does dysmenorrhoea, and far more often than does sterility. Yet I feel that I am not being too radical in stating that fully abreast of uterine retroversion, chronic cervicitis and endometritis as causes of backache are conditions of the back itself.

Nor does backache enter the field of the gynecologist alone. Pathological conditions, pancreatic, colonic, cholecystic, cardiac, neurologic, renal, adrenal and above all, psychiatric, may manifest themselves as backache. Yet so great is the attraction of the face, and the anterior surface of the human anatomy to the interne, medical student, and, alas, sometimes his senior brother, that he will carry out the most painstaking, laborious physical examination, replete with minute auscultation, sensory responses to touch, pin prick, heat and cold, an opthalmic impression of the fundi, a fanciful measurement of cardiac dullness expressed in fractions of a centimeter, and yet not accord one fleeting, cursory inspection to the site that stimulates the wailing of hundreds of milllons of human voices annually—the back.

An examination that does not include a study of the patient *standing* barefooted, with back fully exposed, is not a complete physical examination.

The baby in utero has, through environmental necessity, a uniformly flexed spine. Comes delivery, with room to stretch a bit and he soon loses this. The spine becomes straight from occiput to sacrum, and so it remains until the urge to walk possesses him. To do this means getting his legs stretched out and tilting his pelvis forward to put them in a usable position. To permit this the spine must hyper-extend which it does at the nearest point, that is, the lumbo-sacral joint and the lower lumbar area. It gives slowly and he spends some weeks in a state of precarious balance. At last hyperextension, or lordosis, becomes ample to allow him to strut which he does proudly, head high and straight. Admiring parents and friends put down the little potbelly he has acquired through his lordosis, to fat, and are gratified at the fine figure he presents from the waist up. His straight dorsal and cervical spine and exaggerated lordosis serve him well while his bones are partly cartilaginous, and elastic. With his flexible hip joints and short legs he can stand with his knees extended and touch hands to the floor without effort and almost without spinal flexion. But as the bones toughen toward their maturity and joints become firmer, in adolescence, modifications of alignment are necessary. Lumbar lordosis is reduced partly by the development of the abdominal muscles which flatten the belly contour as they pull from costal margins to pubes, tilting the anterior part of the pelvis up. This throws the dorsal and cervical area back. The dorsal spine brings the torso erect again by flexing, and the cervical spine returns the head to its necessary vertical position by hyperextending.

In late adolescence the spine reaches normal maturity, (although it still grows for five to seven years). The young adult standing erect, with the three curves in his spine, is straight from head to toe, his arms falling relaxed by his sides just forward of the apex of the lumbar curve. His erector spinae

*Delivered at the staff meeting, Victoria General Hospital, November 26, 1948.

muscles are thick and elastic, his belly muscles beneath the light abdominal fat pad, form almost a straight line from costal margin to pubes. His breathing is produced by combined movements of his intercostal muscles and diaphragm, the chest rising easily and the abdomen protruding slightly with each inspiration.

His weight is balanced evenly on his feet. With the anterior arch, the lateral border of the foot and the heel bearing almost equal amounts, he gives the impression of being able to break into motion at a split second's notice, which, indeed, he is.

His spine has lost the universal flexibility of babyhood but has become adapted to the new rigidity of its components by regional development. Thus the cervical area, its most mobile section, possesses flexion, extension, lateral flexion and rotation. The dorsal area, fixed somewhat by the bony thorax, is limited in flexion and extension. It gives only slightly in lateral flexion but permits of rotation to turn the whole trunk. The lumbar area, limited in lateral flexion and rotation, has freedom of movement in extension and flexion.

Every physician knows this happy normalto be the exception rather than the rule. More often good posture is found in the female rather than the male. Commonly woman has a more acute angle at her lumbo-sacral articulation than man. This gives her a more marked lordosis and a slightly fuller abdomen. Perhaps the extra forward tilt of the pelvis is to permit the urteus in pregnancy to grow forward without cramping too greatly the abdominal viscera. Despite the increased lordosis the female spine is more erect and if we may postulate a reason this is due to the less rapid growth of the female during adolescence. Because it is during this period that the human frame seems to run its greatest developmental risks.

It is a common observation that persons of short stature are better posturally than the tall who almost always gain the height of their six and more feet by "string bean-like" growth in their early and middle teens. This period of frantic metabolic activity would seem to demand fuel which the gastro-intestinal tract and the sunshine of our northern climes, at least, have difficulty in supplying. Lack of bone building minerals and vitamin D results in a softening of bones at a period when the general development demands greater stability. The result, of course, is rickets—not necessarily the beaded ribs and bowed legs of the grossly deformed. These happily are becoming much less frequent in recent years. But the spine is even more vulnerable than the long bones, and rickets, if insidiously, still works its evil way sowing there the seed of a pathological harvest which may not be reaped for another twenty or even forty years.

It is an old surgical maxim that an articulation with great range of movement is a weak articulation, and it is probably in the upper dorsal and cervical area that adolescent rickets first appear. The firm elastic pads of the intervertebral disks gradually cushion their way into the softened vertebral bodies. The result is that the gentle dorsal curve becomes a marked kyphosis. The neck is thrown forward, the head goes down. The spirit of youth will not permit of head and eyes being cast down. To raise the head by hyperextending the cervical spine is fatiguing so he goes to the next mobile area, throws his lumbar lordosis into a marked exaggeration, relaxes his belly muscles and gets

his nose in the air again. In a very few years his faulty posture becomes fixed and he has started on the road to its pathological sequelae.

The first, most immediate change to appear is in his balance. Weight distribution on the feet is altered so that the great part now is borne by the heels. This not only, in truly vicious cycle, produces further back strain, it may result in relaxation of the tibial and peroneal muscles, and the short muscles of the foot, leading to flattening of the longitudinal arches. At best it takes much of the elasticity from the step and changes the young man from a forward springing to a backward leaning individual. A close relationship to physical and mental, particularly in these growing years, may thus work changes in his whole pattern of life. Perhaps most important is the alteration in his breathing habits. The dorsal kyphosis, coupled with the lumbar lordosis, tend to produce a flattening of the thoracic cage, with a forward descent of the shoulder girdles. The use of the intercostal muscles is discouraged. Breathing becomes largely diaphragmatic. As a result aeration of the lungs is decreased. This applies particularly to the apical area. Immediate effect is a slight general reduction in the body metabolism with an attempt on the part of the heart to compensate for the diminished supply of oxygen by speeding up the circulation of blood through the lungs. It is difficult to see how this can be other than harmful over a long period. The other long-term effect is, of course, the increased susceptibility of the apices to disease.

The relaxation of the abdominal muscles concomitant with the lordosis produces, in its early stages, no more than a full belly. However, as omental and abdominal wall fat deposits increase, the musculature tends still further to lose its tone and the way is open for other pathological processes. Visceroptosis, and chronic constipation, from its many causes, may be hastened. Hernial orifices, perhaps congenitally weak, pouch out with peritoneum as their enfolding musculature relaxes.

As adolescence merges into the late teens and early twenties, other sequelae of the faulty posture begin to appear in the back itself. Most common is the simple lumbago, the acutely painful, spastic protest of the erector spinae muscles against the constant strain of attempting to hold the sagging lumbar area in position. In later years, with the early degeneration of the muscles setting in as a result of this constant strain, they become calcareous and lose their elasticity. Stiffness of the back and low grade pain on movement is then chronic. The lumbago of earlier years attains a new dignity of title as fibrositis and myositis.

The sacro-iliac strains which appear through this same period are another natural mechanical effect of the lordosis. The lumbar vertebrae having hyperextended as much as possible, the strain of hyperextension is thrown on the two sacro-iliac joints which normally have a very limited range of to-and-fro movement in the antero-posterior plane.

Next to give way before the stress of faulty mechanics and time, is the intervertebral disk. This firm elastic cushion functions well while the pressure upon it is equally distributed. With alterations in the normal pressure, so that the posterior edges are being constantly pinched while the centre of the cushion, which should receive and distribute the main pressure, is relatively unused, damage is inevitable and degeneration of a part or the whole disk frequently occurs. This manifests itself most often in the form of pres-

sure on adjacent nerves. The erector spinae muscles go into spasm in a desperate effort to flatten the exaggerated cervical or lumbar lordosis and the whole clinical picture of the ruptured intervertebral disk takes form. That this happens so often in the cervical and lumbar areas, so rarely in the dorsal, is due to the greater range of movement in the upper and lower parts of the spine, and the fact that it is here deformities of posture are most often seen.

Last stage in the pathological march is arthritis. The post-traumatic arthritis, usually of osteoarthritc type, that so commonly follows bone and joint injury in the later years, the occupational arthritis that develops in the right hand of the skilled craftsman and the shoulder or back of the laborer, are physiological cousins of the spinal arthritis in the middle aged, sway back, the result of minute intrinsic traumata, one upon the other, through the years.

The increase of weight that often accompanies the middle years is another factor in spine disability. In an individual with good posture loss of the support of the abdominal muscles through great omental fat deposits seems to matter little. Presumably, by middle age the spine has become sufficiently fixed to get along without this aid. However, the arches of the feet are not as rigid, and the waddling gait of the obese and flat-footed will in its turn take a toll upon the spine.

To attribute all the ills of the human back to faulty posture would be wrong. Intervertebral disks can break down and protrude, osteoarthritis can throw out its spurs in spines as erect as the two year old's, but their morbidity approaches that of malaria in the Eskimo.

To label rickets as the whole cause of faulty adolescent development is perhaps equally wrong. The physiology and metabolism of adolescence are too complex, too broad to be explained either in their strength or their weakness by one word. But if the great prophylactic to the adolescent problems of mind as well as body, be fresh air, sunshine and exercise, then it matters little what name we put to the underlying pathological process. Every high school and college medical examiner has had the unhappy experience of seeing fine, young examples of boyhood entering their freshman term, to graduate three or four years later bespectacled, stooped, round-shouldered, asthenic, and learned in a dozen divergent branches of the arts and sciences. If this be the triumph of mind over matter then the old saw takes on a new meaning that "a little learning is a dangerous thing."

It is a popular saying among psychologists that if you give them a child in his first seven years no great harm can come to his mind thereafter. With equal truth it could be said that if the second seven were turned over to a physical director his bodily future would be assured.

In conclusion, may I refer you again to the title of this paper and stress that behind the front is the back.

MEDICAL ECONOMICS

The Health Grants—The Health Survey
A Review of Our Position

NORMAN H. GOSSE

THE profession in Nova Scotia will remember that at our last Annual Meeting, a committee was appointed to be the Advisory Committee on the subject of the Health Grants. It was expected that that committee would be the actual advisors to the government of the province, but it hasn't in fact worked out quite that way. In effect it has.

The Advisory Committee

The government decided that it would set up an advisory committee that would have representation from the various institutions, organizations and sections of society, which would include one representative from the Medical Society of Nova Scotia. In addition to that committee, there was also to be a department committee of advisors to the Minister of Health.

Members who attended the last meeting of the executive will remember with what concern we accepted that situation. It didn't look right; but finally we accepted the assurance that the committee upon which we were to have representation was to be *the working committee*, and with such grace as we could command, we bowed ourselves in, with your Chairman of the Committee on Economics as your representative on that mixed Advisory Committee. It is now reasonable to expect that members will want to know what the present state of affairs is, and it is to bring you up to date, and for another reason which will later emerge that this statement is being made. (Much of what is contained herein has already been sent to the Secretaries of the Branches).

We met first with the Minister, Hon. L. D. Currie presiding, (later with Dr. Stewart in the Chair) and probably the main thing to come out of that preliminary canter was that we were to go back to our respective principals and set up any sub-committees we wished, under any or all of the grants.

The committee set up at Ingonish by the Medical Society of Nova Scotia as *its* Advisory Committee was made to function as a sort of steering committee which hereafter it will be called. It will be remembered that in its formation it was kept small for direct dealing with the government, but since that function was still-born, it was no longer necessary to keep the group so small. Furthermore, since it was not always possible for some of its members to get in to Halifax, and since it was important that authority for certain decisions should be spread over more people, the committee was enlarged, and it now stands:

Original Group.....	Dr. Malcolm MacAulay, Sydney Dr. A. E. Blackett, New Glasgow Dr. J. W. Reid, Halifax Dr. N. H. Gosse, Halifax

Added Personnel.....
- Dr. H. D. O'Brien, President, Halifax Medical Society
- Dr. H. G. Grant, Secretary, Medical Society of Nova Scotia
- Dr. D. F. MacDonald, Yarmouth
- Dr. E. W. MacDonald, Glace Bay
- Dr. J. P. McGrath, Kentville
- Dr. H. A. Fraser, our president, who is member ex officio was early made a very active member from his district.

In all this while the aim of the committee was the selection of capable men who have indicated interest and willingness to be inconvenienced, consideration was given also to geography, so that a representative group could always be gotten together from that list to make decisions that had to be made.

The first decision was on the extent to which we should go in making studies and recommendations under the grants, and it was decided that our organization being interested in every phase of health must study them all.

The Sub-Committees

Your representative to the government's Advisory Committee then asked our committee to name the Chairmen of the sub-committees which he had been authorized to set up for the different grants, and then to give consideration to the membership of those sub-committees. It had been suggested to us that as wide a provincial representation as possible, to secure the provincial viewpoint rather than a sectional one, was important. The following sub-committees being named, (in some instances the personnel of the committee was left to its chairman to select) the chairmen nominated were requested by your representative, to act on the assigned sub-committee.

The grants, their amounts and the sub-committees as we have them are:

Crippled Children's Grant..... $ 26,945.00
- Dr. T. B. Acker
- Dr. W. T. McKeough, Sydney Mines
- Dr. R. A. Moreash, Berwick

Hospital Construction..... 642,857.00
- Dr. H. A. Fraser

Venereal Diseases..... 13,599.00
- Dr. D. F. MacDonald

Mental Health..... 211,676.00
- Dr. R. O. Jones, Halifax
- Dr. J. R. MacNeil, Glace Bay
- Dr. James Muir, Truro

Tuberculosis..... 182,585.00
- Dr. C. J. V. Beckwith
- Dr. G. R. Forbes
- Dr. W. A. Hewat

Health Survey
(a) Medical Care
Dr. J. A. Noble

General Public Health 217,350.00
Dr. A. E. Blackett

Cancer Control 172,077.00
Dr. N. H. Gosse
Dr. E. W. MacDonald
Dr. H. R. Corbett
Dr. J. C. Wickwire

Two grants were not covered by us—the Professional Training Grant $26,945.00 and the Public Health Research Grant—$100,000.00 for all Canada —but it would appear that we have "made" the working committee! (For completeness it should be re-stated that the Hospital Construction Grant and the Cancer Control Grant are grants to be matched by the province).

Aims and Objects of the Survey

The immediate aim and object appears to be, to undertake a real survey of the position of the province in matters of health, and, with as much data in hand as possible to construct a master-plan for the repair of such defects as may be found to exist.

In this view, every sub committee working on its particular grant examines the situation in that particular field, (a) with a view to determining the best way in which the particular grant can now be dispersed and (b) with a view to gathering data within that field which will assist in the making of the master plan. In some of the grants it is possible and indeed desirable, to make immediate interim recommendations to cover current or immediate needs, and later to make additional recommendations as more information becomes available. This has been done in several of the grants. Some thought may also be given to the fact that the grants are annual with a limit, and that most of them cannot have their balance carried over into the next year. They are offered to be spent, in each year, and if they aren't spent they die.

There is one grant however, under which the sub committee has the spending of no special grant to consider, but whose duties are the accumulation of data and the formulating of recommendations. That is *The Health Survey Grant.*

Director of Survey

Doctor C. B. Stewart was appointed Director of the Survey. He is by virtue of that, Chairman of the government's Advisory Committee. And your reporter would like to record here his full confidence in Doctor Stewart's ability and integrity. He would hasten to add however that that would be no compliment to Dr. Stewart among those who know him, but may be welcome information to those of our members who do not. He has sat in on our committee meetings and has been most helpful. **He is ex officio, a member of every sub-committee,** and Chairman of sub-committees will find it most advantageous to consult him with any questions. They should inform him of any meetings that they propose to hold.

Medical Care Survey—A Big Job

The Survey includes, among a'l the other things the question of Medical Care. This is the biggest problem of our profession. The problem of the Hospital Survey is one of considerable magnitude but from our point of view the problem of Medical Care—covering as it must every kind of practice or the lack of it in our province—looks larger still.

We have been fortunate in having Dr. Arnold Noble head up the sub-committee on Medical Care and he has been asked to select a committee under the general principles here suggested. The details for the making of this survey have not yet been worked out, but if it is going to be as good as we want it to be, it will require the very widest cooperation of our profession and especially of the officers of our branch societies. It should be repeated that this is of great concern to us, and when the facts of the survey have been arranged, it will almost certainly require more than a meeting of the sub-committee, or the main committee, to formulate and agree upon the recommendations which our Society may wish to adopt with respect to them.

It will, of course, be asked "How about the cost of all this?" The whole survey grant for the province is $33,399.00, and as the full survey is expected to take two years, that figure must be divided by two to get the figure per year. When the expenses are estimated, it is found that there will be a sum equal to about $100.00 per sub-committee for travelling expenses made necessary by them. *The representative on the Central Committee is responsible for seeing that his sub-committees do not in the aggregate spend more than that, but he is empowered to allot varying amounts to each sub-committee*—a sort of "robbing Peter to pay Paul", if Paul should appear to have the greater need. Some sub-committees are getting along very well through local conversations and provincial correspondence and will use little or none. Some of them will require the odd meeting, and that is to be provided for within the close restrictions here outlined. Our "Steering Committee" in spite of the very important part it will play is not really part of the system and we are informed cannot qualify for its expenses.

Reports of Sub-Committees

The reports of the various sub committees are sent to the representative on the Government's Advisory Committee and he in turn to the Director or to the Minister. But because our Society should be in as full knowledge as possible of what is being done, and should have some body to review everything, before anything is submitted in its name, your representative on the government's Advisory Committee is having our steering committee act as a reviewing body to ensure to the society that what is sent in is in conformity with our principles, and that what is of major importance shall be held for review by our Executive.

It becomes clearer to some of us that much of the factual material which will be derived from the Health Survey—whether collected by governmental agencies directly, as is planned, or by our profession as is going to be necessary in some of the details—will be material that will be of the greatest importance to us as a medical organization when the time comes that we shall have to consider more seriously than we have ever done, the question of adequate medical care for all our people. For this we must have facts, and all of them.

To this end the sub-committee on medical care will probably be making demands on all our members—heavy demands upon some of them.

It has been most interesting and most heartening to meet the pleasant willingness with which the different men who have been assigned tasks have slipped under and assumed a share of the burden, a willingness that has somewhat surprised us, and as we have gone along we have been disposed to analyse it. As with so many things it appears to be a composite of several elements:

(a) The desire to serve our medical organization. Nova Scotia may well boast of this; it is sound, good, and at this time, necessary.

(b) The desire to keep ourselves in close contact with all developments in Medicine—especially in its social implications and having in mind the errors of other countries. This is a constant element and one of continuing importance.

(c) The knowledge that as a profession we are anxious to make our contribution to the development of better medical care for our people. This is a most important element in our thinking and in the minds of a growing number of our profession, the most important single one.

In the aggregate these express a social consciousness on the part of our profession coupled with a determination that no one will play fast and loose with medical care in this province. In this regard, in spite of the fact that there are those who do not agree, this writer would here venture to record the view that at this time we have less to fear of that in Nova Scotia than in any province of Canada. He would predict that we are on the way towards a system of medical care for Nova Scotia which will be alike satisfactory to those who give and those who receive the service. He believes that this will materialize if all doctors will back what their medical organization has done and is attempting to do, but sees disaster sooner or later if through selfish disregard for our obligation to Society, any significant number refuse to accept some modification of present methods of practice.

Though for the better performing of our present task small sub-committees have been formed, it is not the view of anyone that only the committees' own ideas shall go forward. *The effort must be made to have every committee's report represent as fully as possible* the views of our whole profession. The Committees will therefore seek views and opinions from outside their own spheres and you will help greatly if you will write any of the Chairmen named and present your views on his subject. Some have already done that and it was welcomed.

In conclusion it should be stated that while, as is reasonable, differing views will be expressed in meetings of the government's Advisory Committee including possibly some criticism from labour, to the effect that Medicine has not measured up as well as it could have in the matter of the spread of medical care, nevertheless moving as we are in this matter, it is the writer's view that this represents a great opportunity for Medicine, which if properly seized upon will enhance its prestige and significance not only with our government, but also with the people of this province in whose interest we work, and with no adverse effect upon ourselves as individuals.

Medical Care of Welfare Groups

Since the foregoing was written an announcement was made by the Premier of Nova Scotia that the government would assume direct responsibility for medical care of the welfare groups—old age pensioners, mother's allowance groups, etc. So far no appraisal has been made of the matter to your committee on economics regarding its details, so that at the moment we have no knowledge to convey as to the extent of the service that will be offered, and how the cost will be met. Fortunately we have had some experience in Canada in the field of medical service to such groups, and we shall all be interested in learning of the details of our province's plan.

This is a step which we have visualized for years. The next in natural order would be care of the indigent in similar manner. Then, if Maritime Medical Care can take care of those of our employed and other people who can pay premiums, we would have—except for the rich who perhaps may be left to take care of themselves—an all-embracing system of medical care. Such a system would leave open the way to advancement in medical knowledge along which we have progressed so well in recent years, and which fully socialized systems in other places would seem to have effectively closed.

Though the action of our province now reported confirms our faith in the final development of a good system of medical care for Nova Scotia which will preserve the way to scientific advances in medicine and the further consequent lengthening of the life span, yet we shall want to "keep our powder dry" until the powers of darkness are forever frustrated. There is undoubtedly enough distrust among us to ensure that that will be done.

Medical Economics—Health Insurance

FIVE years ago the General Council of the Canadian Medical Association approved certain principles relating to Health Insurance, and they are reproduced hereunder.

It is now felt that the time has come for a re-examination of our policy and as Doctor Kelly has it "in the light of our present knowledge to provide the spokesmen of our profession with a version applicable to 1949."

The Committee on Economics of this province is now called upon to give serious study to this matter so that our representatives to General Council may at its forthcoming meeting be able to express the considered views of our division, and so make any decision then arrived at to be representative of our whole profession of Canada.

So that your Committee on Economics may be guided to formulate a true expression of the thinking of our province, it is requested that these principles be studied by every member of our Society, and that they communicate their views—individually or as branches—to the Committee, before 20th of April if possible. The Committee will meet then and consider the suggestions received before assembling them as an expression of our views.

It is a matter of great importance at this time, and any member who has ideas is earnestly requested to communicate them to us forthwith.

Norman H. Gosse, Chairman
Committee on Economics

PRINCIPLES RELATING TO HEALTH INSURANCE
Approved by the General Council of the Canadian Medical Association May, 1944

1. The Canadian Medical Association approves the adoption of the principle of contributory Health Insurance, and favours a plan which will secure the development and provision of the highest standards of health services, preventive and curative, provided the plan be fair both to the insured and to all those rendering the services.
2. Inasmuch as the health of the people depends to a great extent upon envionmental conditions under which they live and work, upon security against fear and want, upon adequate nutrition, upon educational facilities, and upon the opportunities for exercise and leisure, the improvement and extension of measures to satisfy these needs should precede or accompany any future organization of medical service. Failure to provide these measures will seriously jeopardize the success of any Health Insurance plan.
3. It is not in the national interest that the State convert the whole medical profession into a salaried service.
4. It is not in the patient's interest that the State invade the professional aspects of the patient-doctor relationship. Subject to geographical and ethical restrictions this relationship includes free choice of doctor by patient and free choice of patient by doctor; it implies also maintenance of the confidential nature of medical practice.

5. While leaving to each province the decision as to persons to be included, the plan must be compulsory for persons having an annual income insufficient to meet the costs of adequate medical care.
6. The dependents of insured persons should be included in the health benefits.
7. Medical care for resident and transient indigents should be provided under the plan, the Government to pay the premiums.
8. Health benefits should be organized as follows:
   (a) Every regularly qualified, duly licensed medical practitioner, in good standing in the province, should be eligible to practise under the plan.
   (b) The benefits conferred should be such as to provide for the prevention of disease and for the application of all necessary and adequate diagnostic and curative procedures and treatment. Specialist and consultant medical services should be available.
   (c) The following additional services should be available through the medical practitioner:
      1. Nursing service;
      2. Hospital care;
      3. Auxiliary services, usually in hospital;
      4. Pharmaceutical service, subject to regulation.
   (d) Dental service.
9. Cash benefits, if provided, should not be taken from the Health Insurance fund.
10. Health Insurance should be administered by an independent non-political Commission representative of those giving and those receiving the services. Matters of professional detail should be administered by committees representative of the professional groups concerned.
11. Under Health Insurance the Chief Executive Officer to the Commission and the Regional Executive Officers should be physicians appointed by the Commission from a list submitted by organized medicine in the province.
12. Each province should be served by an adequate Department of Public Health, organized on the basis of the practising physician taking an active part in the prevention of disease.
13. The granting of a license to practise medicine was designed primarily to protect the public. Therefore it is in the interests of the patient that all who desire licensure to practise a healing art should be required to conform to a uniformly high standard of preliminary education and of training in the recognized basic sciences as well as to furnish proof of adequate preparation in the clinical and technical subjects.
14. The method, or methods, of remuneration of the medical practitioners and the rate thereof, should be as agreed upon by the medical profession and the Commission of the province.
15. Every effort should be made to maintain health services at the highest possible level. This requires:
   (a) Adequate facilities for clinical teaching in the medical colleges and hospitals;

(b) Post-graduate training of all medical practitioners at frequent intervals;

(c) Necessary facilities for and support of research.

16. The principle of insured persons being required to contribute to the insurance fund is strongly endorsed.

17. Any Health Insurance plan should be studied and approved actuarially before adoption and thereafter at periodic intervals.

18. In the provision of health services, cognizance should be taken of the fact that well over a third of Canadian doctors are now in the Armed Forces. If Health Insurance should be implemented in any province before demobilization, the interests of the medical officers in the Services should be fully protected.

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The Committee on Economics of The Medical Society of Nova Scotia: Doctors Norman H. Gosse, (Chairman), W. G. Colwell, D. M. MacRae, F. J. Barton, H. A. Creighton, P. S. Cochrane, A. E. Blackett, D. F. Macdonald, J. V. Graham, J. R. Corston, H. G. Grant and H. D. O'Brien.

Editorials

For many years the warmest sentiments of friendship have existed between the medical profession of Nova Scotia and Newfoundland. We welcome the Union of Britain's oldest colony to Canada as permitting closer fellowship in future. Elsewhere in this issue is an historical outline of medicine in Newfoundland which will be read with interest and enlightenment by every physician in Nova Scotia. We, too, have an old and honourable tradition in the field of healing, and in common with our new associate province, a forward and progressive policy to promote the standards and the service of healing.

Since 1867 the Maritime Provinces of Canada have felt the influence of a common bond. The origin of their peoples, their kindred sources of livelihood and their external relations with the rest of the world bind them closely. Where there have been Three, we now rejoice to see Four. Let us face our destiny together.

H. L. S.

The April campaign for funds and membership of the Canadian Cancer Society deserves the whole-hearted support of the medical profession of this province. During the past year a letter was sent by the provincial division to all doctors practising in Nova Scotia, describing the educational and welfare work of the Society, and seeking the help of the doctors in bringing those in need of welfare services within the reach of these aids. So all should have some idea of the purposes for which the Society exists. These purposes cannot be carried out without money. The sum asked for is not large and the Cancer Society would be best pleased if the $35,000 came from 35,000 individual subscribers. This represents an ideal, however, and does not mean that donations of more than one dollar would be refused.

Of its welfare work, carried out with very slender resources, the Cancer Society has every reason to be proud. Ministering to those who are cared for by no other organization the welfare workers carry comfort, order and cheer to the cancer sufferer who would otherwise be left to misery and despair. Medical readers need no elaboration of the details. These are all too familiar, but perhaps the work of the Cancer Society is too little known.

Since the announcement of the Federal grants by which cancer diagnostic and treatment facilitities will be expanded, the role of the Cancer Society as the body primarily responsible for Cancer Education has on more than one occasion been emphasized. It is obvious that such increased diagnostic and treatment facilities can be of little benefit unless the people are sufficiently well-informed to avail themselves of what is offered. Even with existing facilities, a great deal more could be done in the fight against cancer, if the patients were reached early enough. Of its heavy responsibility in respect to education the Cancer Society is fully aware. It also realizes that it cannot "compel them to come in," and up to the present there has been no way to assess the effectiveness of its inducements.

But from time to time one hears it said that cancer education is creating cancerphobia. This seems a little far-fetched and it would be interesting to

learn of specific instances. Certainly the production of cancerphobia has no place in the thoughts of those charged with planning an education programme, either in this province and dominion or on this continent. It is true that, in the past, literature and propaganda were heavily overlaid with the motif of fear. But the error of this has for some time been realized and the emphasis is now placed on the note of Hope rather than that of Fear. But there are those who quarrel with this too. They say the Cancer Society teaches that *all* cancer is curable, if taken in time, thus misleading those with cancers whose first signs appear late in the disease. It would seem that the simplest way to lay one's doubts in either direction would be to read some of the easily obtainable literature put out by the Cancer Society, and see how accurate, how carefully worded and how little calculated to produce either over-optimism or fearful anxiety are the statements contained therein.

And even if in the minds of our weaker brothers and sisters some "cancerphobia" does arise, what matter? Is it not far more profitable and pleasant to reassure the victim of cancerphobia than to break bad news to the victim of cancer? In short—which is the more dread disease—cancer or cancerphobia?

M. E. B. G.

Federal Health Grants

Some of our members have been voluntarily sending in suggestions and recommendations for the Advisory Committee under the Health Grants. These suggestions are most welcome and are passed to the respective sub-committees as they come in where they are fully considered. This is a very important matter just now and if any of our members have any ideas as to how any of those grants should be spent they should express them where they can do most good—namely, to our own Advisory Committee.

Norman H. Gosse, Chairman

Pride's Penalty

Transgression of nature's requirements in the use of the feet usually carries a penalty and so it is that the feet are subject to many disabilities.

Probably the most common of these is foot-strain, the condition generally known as fallen arches. In most cases a course of foot drill will bring about a cure but in advanced cases it may be necessary for the patient to remain in bed for a week or two before beginning foot drills. Frequently excessive body-weight is a potent factor in producing foot strain.

Keep Them Small

Parents often pay little attention to the food they serve their pre-school age children. Nutritionists suggest that if the parents eat properly, the youngsters can have the same foods *but* they need it in smaller servings.

In some cases this may mean a child should have five meals a day instead of three, especially if he is under weight. Most children like new foods but they require time to get used to them so it is best to introduce new foods gradually. Pre-school agers still need cod liver oil regularly.

Fingertip Infections

Biting the finger nails is not only a bad habit that irritates others but it is also a danger to the health, according to national health authorities. In the same category are the habits of fingering the face with such objects as money, paper, pens and pencils.

Many contagious diseases enter the body through the mouth and many of these are carried on such objects. Washing the hands thoroughly before eating—using plenty of soap—helps prevent such infections. Personal cleanliness is essential to good health.

Income Tax Information

THE practice of making quarterly installment payments on income tax may be new to certain of our members, and the rule in this connection is as follows:

Individuals whose income—(a) is derived from carrying on a business or profession (other than farming); (b) is derived from investments; (c) is more than 25% derived from sources other than salary or wages, are required to pay their estimated tax by quarterly installments during such year. Each payment must be sent in with Installment Remittance Form T. 7-B Individuals. Any balance of tax is payable with interest with the T-1 General return which is due to be filed on or before April 30 of the succeeding year.

The following timetable indicates the returns required during 1949.

A. Doctors NOT receiving salaries amounting to ¾ of income:

Date Due	Forms to Be Used
March 31, 1949	T. 7-B Individuals, 1949
April 30, 1949	T. 1-General, 1948 (Note: Doctors should not use T.-1 Short regardless of income)
June 30, 1949	T. 7-B Individuals, 1949
September 30, 1949	T. 7-B Individuals, 1949
December 31, 1949	T. 7-B Individuals, 1949

B. Doctors receiving salaries amounting to ¾ or more of income:

Date Due	Forms to Be Used
April 30, 1949	T. 1-General, 1948 (In cases of salary with Investment Income below $1,800 T-1 Short is the form)
Whenever Status is changed*	T.D.-1

Doctors who pay salaries to their own employees should send in Form T.-4 by the end of February of each year.

For income tax purposes all salaries are net. Therefore doctors must pay tax on the total amount they receive as salary.

Dominion Income Tax Returns by Members of the Medical Profession

As a matter of guidance to the medical profession and to bring about a greater uniformity in the data to be furnished to the Income Tax Division of the Department of National Revenue in the annual Income Tax Returns to be filed, the following matters are set out:

Income:

1. There should be maintained by the doctor an accurate record of income received, both as fees from his profession and by way of investment income. The record should be clear and capable of being readily checked

*With respect to new employer, marital status, dependents.

against the return filed. It may be maintained on cards or in books kept for the purpose.

Expenses:

2. Under the heading of expenses the following accounts should be maintained and records kept available for checking purposes in support of charges made:

(a) Medical, surgical and like supplies;

(b) Office help, nurse, maid and bookkeeper; laundry and malpractice insurance premiums. (It is to be noted that the Income War Tax Act does not allow as a deduction a salary paid by a husband to a wife, or vice versa. Such amount, if paid, is to be added back to the income);

(c) Telephone expenses;

(d) Assistants' fees;

The names and addresses of the assistants to whom fees are paid should be furnished. This information is to be given each year on Income Tax form known as Form T-4, obtainable from the Director of Income Tax.

(e) Rentals paid;

The name and address of the owner (preferably) or agent of the rented premises should be furnished (see (j));

(f) Postage and stationery;

(g) Depreciation on medical equipment;
The following rates will be allowed provided the total depreciation already charged off has not already extinguished the asset value;
Instruments costing $50 or under may be taken as an expense and charged off in the year of purchase.
Instruments costing over $50 are not to be charged off as an expense in the year of purchase but are to be capitalized and charged off rateably over the estimated life of the instrument at depreciation rates of 15 to 25%, as may be determined between the practitioner and the Division according to the character of the instrument, but whatever date is determined upon will be consistently adhered to;
Office furniture and fixtures—10% per annum.
Library—The cost of new books will be allowed as a charge.

(h) Depreciation on motor cars on cost:

Twenty per cent 1st year;
Twenty per cent 2nd year;
Twenty per cent 3rd year;
Twenty per cent 4th year;
Twenty per cent 5th year;

The allowance is restricted to the car used in professional practice and does not apply to cars for personal use.
For 1947 and subsequent years the maximum cost of motor car on which depreciation will be allowed is $2,500.

(i) Automobile expense; (one car)

This account will include cost of license, oil, gasoline, grease, insurance, garage charges and repairs;

Alternative to (h) and (i) for 1947 and subsequent years:

In lieu of all the foregoing expenses, including depreciation, there may be allowed a charge of 7c a mile for mileage covered in the performance of professional duties. Where the car is not used solely for the purpose of earning income the maximum mileage which will be admitted as pertaining to the earnings of income will be 75% of the total mileage for the year under consideration.

For 1940 and subsequent years where a chauffeur is employed, partly for business purposes and partly for private purposes, only such proportion of the remuneration of the chauffeur shall be allowed as pertains to the earning of income.

(j) Proportional expenses of doctors practising from their residence:

(a) Owned by the doctor.

Where a doctor practises from a house which he owns and as well resides in, a proportionate allowance of house expenses will be given for the study, laboratory, office and waiting room space, on the basis that this space bears to the total space of the residence. The charges cover taxes, light, heat, insurance, repairs, depreciation and interest on mortgage (name and address of mortgagee to be stated):

(b) Rented by the doctor.

The rent only will be apportioned inasmuch as the owner of the premises takes care of all other expenses. The above allowances will not exceed one-third of the total house expenses or rental unless it can be shown that a greater allowance should be made for professional purposes.

(k) Sundry expenses (not otherwise classified)—The expenses charged to this account should be capable of analyses and supported by records. Claims for donations paid to charitable organizations will be allowed up to 10% of the net income upon submission of receipts to the Director of Income Tax. This is provided for in the Act.
The annual dues paid to governing bodies under which authority to practise is issued and membership association fees, to be recorded on the return, will be admitted as a charge. The cost of attending postgraduate courses will not be allowed.

(l) Carrying charges:

The charges for interest paid on money borrowed against securities pledged as collateral security may only be charged against the income from investments and not against professional income.

(m) Business tax will be allowed as an expense, but Dominion, Provincial or Municipal income tax will not be allowed.

Convention Expenses

"Effective January 1, 1948, the reasonable expenses incurred by members of the medical profession in attending the following Medical Conventions will be admitted for Income Tax purposes against income from professional fees:

1. One Convention per year of the Canadian Medical Association.
2. One Convention per year of either a Provincial Medical Association or a Provincial Division of the Canadian Medical Association.
3. One Convention per year of a Medical Society of Association of Specialists in Canada or the United States of America.

The expenses to be allowed must be reasonable and must be properly substantiated; e.g., the taxpayer should show (1) dates of the Convention; (2) the number of days present, with proof of claim supported by a certificate issued by the organizations sponsoring the meetings; (3) the expenses incurred, segregating between (a) transportation expenses, (b) meals and (c) hotel expenses, for which vouchers should be obtained and kept available for inspection.

None of the above expenses will be allowed against income received by way of salary since such deductions are expressly disallowed by statute."

Professional Men Under Salary Contract

3. It has been held by the Courts that a salary is "net" for Income Tax purposes. The salary of a Doctor is therefore taxable in full without allowance for automobile expenses, annual medical dues, and other like expenses. If the contract with his employer provides that such expenses are payable to the employer, they will be allowed as an expense to the employer in addition to the salary paid to the assistant.

Name .....

Address .....

FINANCIAL STATEMENT FOR YEAR ENDING DECEMBER 31, 19 . . .

Professional Income

Gross income from practice ..... $ .....
Professional income from other sources
..... $ .....
..... $ ..... $ .....
Gross Professional Income ..... $ .....

Professional Expenses

Drugs and Dressings ..... $ .....
New Instruments (under $50 each) ....
Depreciation on instruments $ ..... @ % .....

Depreciation on office furniture and fixings at 10% .....
Professional assistance .....
Office Salaries .....
Telephone .....
Printing, Postage, Stationery .....
Malpractice Insurance .....
Business Tax .....
Office Sundries .....
Medical Association Fees .....
New Books .....

Automobile

(a) Depreciation and Expense (75% Total)
OR
(b) .....miles (75% Total) @7¢

Convention Expenses

Convention .....
Dates .....
Days present .....(attach certificate)
Transportation expenses .....$.....
Meals .....
Hotel .....

Office not in residence

(a) Rent .....
To whom paid .....
Address .....
(b) Insurance .....
(c) Laundry, etc. .....

House and Office combined

Fuel, light, water, laundry .....
Maid's wages .....
Insurance .....
Rent .....
To whom paid .....
Address .....
Taxes .....
Mortgage interest .....
To whom paid .....
Address .....
Repairs .....
Depreciation on building—2½% of .....$.....
Total combined expenses .....
1/3 combined expenses .....
Total professional expenses .....$.....

Net Professional Income .....$.....

Society Meetings

Lunenburg-Queens Medical Society

At the annual meeting of the Lunenburg-Queens Medical Society held at Bridgewater on February 23rd, the following officers were elected:

President—Dr. S. B. Bird, Liverpool.

Vice-President—Dr. A. L. Cunningham, New Germany.

Secretary-Treasurer—Dr. Samuel Marcus, Bridgewater.

Representatives on Executive of The Medical Society of Nova Scotia—
Dr. Samuel Marcus, Bridgewater
Dr. W. A. Hewat, Lunenburg

Members of Executive of the Lunenburg-Queens Medical Society—
Dr. H. A. Creighton, Lunenburg
Dr. J. C. Wickwire, Liverpool

The Nova Scotia Society of Ophthalmology and Otolaryngology

The annual meeting of the Nova Scotia Society of Ophthalmology and Otolarynology was held at Keltic Lodge, Ingonish, Cape Breton, September fourteenth to September sixteenth, nineteen forty-eight in conjunction with the annual meeting of The Medical Society of Nova Scotia. The President, Dr. J. P. McGrath, Kentville presiding at the several sessions at which the following papers were presented.

Dr. D. M. MacRae, Halifax—"Retinoblastoma."

Dr. H. R. McKean, Truro—"Some Nasal Conditions."

Dr. H. F. Davidson, North Sydney—"Contact Lens—A presentation of two cases successfully treated."

Dr. R. S. Shlossberg, New Glasgow—"Some Observations on Retractions."

There was a general round table discussion of the question of fees and eye, ear, nose and throat practice in Nova Scotia. The report of the Secretary-Treasurer was read and passed by the meeting. A suggestion was made that the in-coming executive would consider the feasibility of holding a joint meeting with the New Brunswick specialists society at a mutually convenient place possibly at Moncton.

The Nominating Committee brought in their report and the following slate of officers was elected for the ensuing year.

President: Dr. B. E. Goodwin, Amherst.

Vice-President: Dr. D. M. MacRae, Halifax.

Secretary-Treasurer: Dr. E. I. Glenister, Halifax.

Executive: Dr. J. G. Cormier, Sydney, Dr. E. F. J. Dunlop, Bridgewater, Dr. R. H. Fraser, Antigonish, Dr. C. K. Fuller, Yarmouth and Dr. L. G. Holland, Halifax, and Dr. J. P. McGrath, Kentville, representative to the executive of The Medical Society of Nova Scotia.

At a recent meeting of the new executive it was decided to hold a meeting in Halifax on Wednesday, May eleventh, nineteen forty-nine. The morning session will be a clinical meeting at the Victoria General Hospital with a luncheon and business meeting with presentation of several papers in the afternoon. Details of this meeting will be forwarded at a later date.

Personal Interest Notes

DOCTOR G. R. FORBES of Kentville left for England early in March to pursue post-graduate studies in internal medicine at several London hospitals.

Surgeon Lieutenant Commander C. M. Harlow of Halifax was one of six Reserve Medical Officers from across Canada who attended a five-day course at United States Naval Medical Centre at Bethesda, Maryland, in February, on medical aspects of special weapons and radioactive isotopes.

Doctor C. J. W. Beckwith of Halifax addressed a meeting of the Oxford Home and School Association during February in connection with the campaign against tuberculosis.

The BULLETIN extends congratulations to Doctor and Mrs. D. G. Black of Bear River on the birth of a son, John Douglas, on January 30th; and to Doctor and Mrs. E. J. Cleveland of Dartmouth on the birth of a daughter, Jean Gertrude, on February 17th.

Doctor C. B. Stewart of Halifax gave a very interesting talk on healthful housing and slum clearance at the annual meeting in February of the Halifax Citizens' Housing League, at which it was decided to press for the establishment of a housing authority for the City of Halifax.

Still Not Certain About Socialized Medicine Plan

London, March 16. Is Britain's new socialized medicine programme "just what the doctor ordered?" Opinion varies.

"Not exactly yet," says the doctor. He is watching to see whether the plan will stand the test of an epidemic. Also, he thinks he should get a better reward for his services.

A majority of Britons seem to think it is the answer to their prayers. Among them, of course, are millions of workers who were enrolled in the old Health Insurance Act. They were merely absorbed into the new plan.

"Nothing has changed," they say. "The standards of care are the same either way."

But you can find as many who say medical care is harder for them to get now.

"If I want to get fast attention, outside of an emergency, I still pay the doctor," these say. "Then I don't have to wait."

The British Medical Association is leading a fight to amend some sections of the law, particularly to raise the average fee for each patient on the doctor's list.

A doctor participating in the service may be paid on one of two ways: by a capitation fee of 18s. ($3.60) a year for each public patient, or by a fixed annual payment of £300 plus a capitation fee at a rate about one-seventh lower than otherwise. In addition, he gets extra fees. A baby delivery, for example, gives him an extra £7 7s. A country doctor receives an automobile mileage fee which recently was raised fifty per cent.

The B.M.A.'s Medical Journal says a survey showed the average income of doctors has gone down. It also reported "widespread dissatisfaction in the profession with the conditions of service under the national health scheme."

A doctor is permitted to take 4,000 public patients plus any private patients he wishes. Or he may continue to practise privately exclusively.

Under either method of payment, a doctor with 1,000 public patients receives a gross basic income of approximately £1,058 or with 4,000 patients about £3,333 before tax and expense deductions.

The medical practitioners union, a socialist organization, protests in its magazine "Medical World" that 4,000 patients are "too many for any doctor."

While all these problems still are under study, the British Medical Association believes it has over-come the biggest bugaboo of socialized medicine—the danger that doctors would become salaried servants of the state.

The medical profession demanded—and won—an amendment which eliminates the chances of the state dictating to the doctor as its employee what his patients need. That key battle won, the vast majority of general practitioners decided to work in the health programme.

IMPORTANT NOTICE

Physicians registered in Nova Scotia who contemplate future registration on the Colonial List of the General Medical Council of Great Britain by virtue of Reciprocity should communicate, at once, with the Registrar of the Provincial Medical Board, Dalhousie University, Halifax, N. S.

Expansion of Psychiatric Teaching

An expanded programme of psychiatric teaching which will help to fill the personnel needs in this field in the Maritime Provinces is to be undertaken as a result of collaboration between Dalhousie University, the Maritime School of Social Work and the Departments of Health of Nova Scotia, New Brunswick and Prince Edward Island. Funds have been provided from the Federal Health Grants to these teaching bodies to allow them to expand their facilities to the point where post-graduate training in psychiatry, psychology, social work and psychiatric nursing can be undertaken. Short intensive courses will also be provided for general practitioners, public health nurses and other people especially interested in the field.

The Department of Psychiatry at Dalhousie has been augmented in equipment and staff with Doctor R. O. Jones becoming Professor of Psychiatry and head of the Department, Doctor F. A. Dunsworth being appointed Assistant Professor of Psychiatry and vacancies created for other teaching personnel as soon as available. The Department of Psychology will also add staff in clinical psychology and the Maritime School of Social Work will add a psychiatric social worker which will allow for training in these fields. Residency training will be arranged by the Victoria General Hospital, the Nova Scotia Hopital, Camp Hill and the other provincial hospitals in the Maritime Provinces. It is hoped that in this way a much improved mental service will be provided for the people of Eastern Canada.

Obituary

THE death occurred at Inverness on March 3rd of Doctor James Adam Proudfoot following a four weeks' illness. Doctor Proudfoot was born at Salt Springs, Pictou County, in 1876. After completing his high school education at Pictou Academy he entered Dalhousie Medical School and graduated in 1905. He practised at River Hebert for a time before going to Inverness where he resided for the past forty years. Doctor Proudfoot was a former mayor of Inverness and sat in the Nova Scotia Legislature as a Liberal member from 1928 until 1933. He enlisted with the Royal Medical Corps during the First World War and served in Egypt and Cairo and on the staff of Camp Hill Hospital. Besides his widow, Doctor Proudfoot is survived by two daughters, a son, James A., science student at Dalhousie University, and a brother and a sister.

The death occurred in South Porcupine, Ontario, on March 15th, of Doctor William Donald Rankin, who for several years engaged in private practice in Halifax. Doctor Rankin was born in Woodstock, New Brunswick, where his father had also been a medical practitioner. He graduated from McGill in 1929 and engaged in private practice in New York for six years before coming to Halifax in 1936. Early in the second world war he enlisted in the R.C.A.M.C. and was later attached to the Royal Canadian Air Force going overseas with the first fighter squadron. He is survived by his wife, the former Miss Dorothy Rainnie of Halifax, and one son, William.

Dr. Frederick Graham MacAskill died at Glace Bay on March 15, 1949, in his sixty-fourth year. He had been ill since last October.

He was born at St. Peter's, Richmond County, and graduated from Dalhousie University, Faculty of Medicine in 1911. Of this class an unusual number remained, or departed and returned, to work in Nova Scotia, and all have made noteworthy contributions to the profession and public of this Province. Like many another, Dr. MacAskill returned to his home town to practise, and remained there for four years until he enlisted in 1915 with the Royal Canadian Army Medical Corps in World War One.

On his return from overseas he associated himself with Dr. Alister Calder in Glace Bay, a partnership which continued until his recent retirement last autumn.

Dr. MacAskill was universally liked by all who knew him, both patients and confreres. His great capacity for friendship and his unquestioned skill gave him a large and busy practice. For several years he was a member of the Provincial Medical Board where his forthright judgment and common sense were extremely valuable and greatly appreciated by his associates.

Besides his widow he is survived by a daughter, Mrs. J. G. B. Lynch, Sydney; a son, Fred; five brothers of whom Wallace R., Claude and Frank, are in Halifax; Cecil, in Montreal, and Harley, in Glace Bay, and one sister, Mrs. Sybil Doane of Boston.

To Mrs. MacAskill and all members of his family, the BULLETIN extends sincerest sympathy.