VOL. XXX No. 3

The Nova Scotia Medical Bulletin

Official Organ of The Medical Society of Nova Scotia Canadian Medical Association Nova Scotia Division.

MARCH, 1951

Published on the 20th of each month and mailed to all physicians and hospitals in Nova Scotia. Advertising forms close on the last day of the preceding month. Manuscripts should be in the hands of the editors on or before the 1st of the month. Subscription Price: $3.00 per year.

It is to be distinctly understood that the Editors of this Journal do not necessarily subscribe to the views of its contributors.

1. Manuscripts should be typewritten, on one side only of the paper and double spaced.
2. Should proof be sent to a contributor, corrections must be clearly marked and no additional matter added, and the proof returned promptly.
3. Orders for reprints should accompany the proofs.
4. Communications should be sent to the Secretary, Dr. H. G. Grant, Dalhousie Public Health Clinic, Morris Street, Halifax, N. S.
5. Please mention the BULLETIN when replying to advertisements.

Chronic Fatigue

WENDELL MUNCIE, M. D.
Baltimore, Md.

THE term "fatigue" is used for an experience of such universal occurrence as to lead to astonishment at the demand for closer definition. It may be best to refer to the etymology of the term as embodying a wealth of homely ancient wisdom. The adjective "fatigued" was no doubt introduced by the conquering Normans, taking the place of the Saxon "worig" (weary). This substitution derives from the rule expounded by Jesperson[1] that the language of the ruling class supercedes that of the defeated in polite speech. Furthermore, "fatigue" the noun and "fatigued" the adjective, have a definite advantage over wearisomeness, and wearied, being less clumsy. The Saxon term "worig" (weary) derives in turn from "worian", to tramp about, and "wor", a swampy place. Hence "weary" refers to the sensations incident to tramping about over a swampy place.[2] The clear implication is that fatigue is related to exertion, and so to "impairment of function" (Bartley & Chute),[3] and the non-critical use of the term today presupposes such a relationship. A great deal of research and observation have gone into this problem wthout adducing much of value to the issue we are discussing tonight. It is true that gross hypothyroidism, hypoadrenalism, and myasthenia gravis are accompanied by fatigue. But such cases are relatively rare and have nothing to do with the problem of chronic fatigue of psychogenic origin.

Bartley and Chute (l.c.), in a searching review of the subject, point to some common observations which lead to the only possible definition of fatigue as an "experiential pattern arising in a conficit situation in which the general alignment of the individual may be described as aversion." In summarizing their conclusions the authors state "Any fairly naive individual has probably made most of the following observations regarding his own experience with fatigue:

1. When he is tired, he feels he should not exert himself for fear of injury.
2. When he is tired, he makes many mistakes in what he is doing, and this in turn makes him even more tired.
3. He sometimes feels extremely tired without having exerted himself.
4. Following a day of active sport, he sometimes would rather go dancing than rest.
5. His fatigue sometimes disappears abruptly if something interesting suddenly comes up.
6. His fatigue comes on very quickly in certain types of unpleasant social situations.
7. He sometimes becomes extremely tired at the mere thought of doing certain kinds of work.

1. O. Jesperson—Growth and Structure of the English Language. 4th Ed. revised Oxford Basil Blackwell 1923.

2. All etymological derivations from Sheat Walter W.—A concise etymological dictionary of the English language. Oxford Univ. Press 1911 (Impression 1927).

3. Bartley S. H. and Chute E.: Fatigue and Impairment in Man. McGraw-Hill Book Co. Inc. New York and London 1947.

This paper was given at the New York Medical College on November 15 1950.

8. If once he felt tired in a given situation, he is likely to feel tired again when a similar situation occurs.
9. When he is tired, he is unlikely to feel enthusiastic about anything, and when he is enthusiastic he hardly ever feels tired.
10. He has been able in emergency situations to undergo unusual emotional strain, at the same time expending unbelievable amounts of energy without feeling correspondingly tired.
11. He has been able to go for long periods without rest when he was having a 'wonderful time.'
12. Sometimes he is more tired when he wakes up after a full night's sleep than he was when he went to bed.

It is not necessary to look further for the experiential quality of fatigue, with operational aspects including the subjective, which belies the assumption of the naive relationship of fatigue and exertion (and hence impairment of function).

Ten years ago (1940)[4] I discussed this subject pointing to the frequency of chornic fatigue in 1. endocrine-metabolic disorders, particularly with hypoadrenalism and hypothyroidism;

2. Post-infectious states, notably influenza, undulant fever, and the dysenteries. To this we might add the virus infections of today;
3. Emotional states, commonly diagnosed as neurasthenia.

In regard to the first group, I called attention to the difficulty in assessment of the absolute importance of the hypo-states for the actual symptom, and when mixed with neurotic attitudes, of the relative importance of the two factors.

As for the second category, I may profitably repeat the questions I then raised, for, as far as I am aware, they are still unanswered in any sure fashion, and each case of this sort called for the exercixe of balanced clinical judgment.

"To sum up the questions arising from the cases of chronic fatigue allegedly following infection:

1. How long after an acute infection may the fatigue syndrome be legitimately attributed to the infection?
2. What is the relationship between the severity of the acute process and the degree of fatigue?
3. What is the relation of blood serum agglutinins, increased sedimentation rate, cystic forms and other evidences of infection to the degree of fatigue?
4. How many infectious sequaellae be differentiated from latent and chronic infection?
5. How may treatment be best handled as a check on the diagnosis?"

Here again neurotic attitudes may develop and be camouflaged by the fatigue of the post-infectious state. To quote again from my 1940 paper: "In another case, a married woman suffered an acute infection with undulant fever. During the convalescent period her husband suddenly died from some heart affliction. They had married rather late in life, she was childless, and she had been completely wrapped up in him. With his death there fell over her a lack-luster attitude to a continuance of living which expressed itself in terms of the principal sequel to the undulant fever, namely tiredness. And five years

4. W. Muncie—Chronic Fatigue. Pschosomatic Med. 3- 277. 1941.

later she was still "tired." Since then I have seen numerous additional examples of this device.

The third category provides the largest number of cases and the most difficult to treat, since, in contrast to the categories noted above, specific treatment with hormone preparations, or antibotics or other specifics is not indicated neither is it safe to sit by and wait in an optimistic expectant manner for the natural termination of the difficulty.

In the neurotic fatigue states we deal with a set attitude to living expressive of:

(1) A primary attitude of immature parasitic dependency, on parents at first, and transferred later to others through a habit fixation, or of a defective development of incentives for living. The imitation of parents, and the social cultural value put on *the reaction* are important factors. N. Cameron[5] points to the relatively greater acceptance of the reaction in women than in men in our culture.

(2) A secondary attitude of defeatism, the result of continued failure in meeting life's problems, and accompanied at some stage of the reaction with anxiety of unbearable degree. It can be shown that the term, "Life's problems" refers not only to the objectively demonstrable but also to the imagined state of affairs.

As I noted in 1940, the complaint of being "tired" is best understood as shorthand for 'tired of it," by the employment of those devices inherent in the use of metaphor.

In the years since, the second category has been illuminated by a group of patients exhibiting this tiredness in a special developmental setting. Extracts from a recent case history will serve to illustrate the reaction.

The patient is a married woman of 44, a virtual invalid for years from fatigue, and fears attached in an inconstant way to any and all activities, social, home, etc. She first came to hospital notice in 1939 as an undulant fever suspect because of the complaint of marked exhaustion. Her physicians could find no real evidence for the disease, reassured her, and sent her home where she did relatively well for about three years. Returning to hospital for the same complaints, she found her physician away in the service, was dissatisfied with the plans for treatment and returned home again, with sporadic efforts at local psychiatric treatment until 1947. She then returned seriously ill, depressed, and was thought transiently to be suicidal. She remained under hospital care for almost two years. During that time the patient's overt behaviour and the detailed history revealed:

(1) A profound sense of being under complusion at the hands of literally everyone of importance in her past life and her present setting: family, husband, daughter, physician, nurses, other patients friends.

(2) Deep resentment against all these figures for the real or imagined compulsion.

(3) A marked inability to express her resentment for fear of retaliation and loss of approval. This resulted in a superficial docility, or apathy.

(4) A sense of lack of intrinsic worth, with respect to others, but not in the usual sense of the worthlessness of the depressive. It had never been any different.

5. N. Cameron—The Psuchology of Behaviour Disorders—Houghton Mifflin. Co. N Y. 1948.

(5) A family constellation of a dominant mother, worrisome, rigid, demanding and effective in her pursuit of goals for self and children; a father who was tense, absorbed in his work and gave little of himself to the family; a large number of siblings, the patient being the next to youngest (and the youngest girl), all of whom were successful in school and business, but two of whom remained neutoric in a somewhat similar fashion to our patient, until after the death of the mother, with whom they lived. Toward the ideals and expectations of this family as she conceived they applied to her, she had lived in abject slavery for all of her 44 years, unquestioning, and to a large extent unaware of the dimensions of the problem. The tiredness was her defense against that she interpreted as being "pushed around."

At times the interpretation of the therapeutic situation (as of the historical facts) seemed almost delusional, and was saved from such an evaluation only by her obvious efforts in searching for helpful alternatives. For example, she accused her physician of maintaining a casual reporting contact with her husband only for the purpose of keeping him in line and thwarting a divorce: i.e., she could not believe that the physician was primarily interested in her own problem, but insisted he was interested in a peripheral issue. Direct challenge by the physician served to bring to a head her fears of being rejected by him and resulted in a resolution of this issue. (This would hardly have been possible in a paranoid setting.)

Treatment was most difficult for two other reasons:

(1) The detailed history-taking over the months in effect demanded of her the retracing of her path, so liberally strewn with defeats to her ego, and so mobilized much of the original anxiety. This in turn made her more dependent on us, and led again to a feeling of being pushed around therapeutically.

(2) And always she felt pushed to get well by us and by her husband. In fact, there was some truth in this for we had to combat that "hospitalitis" which was the exact opposite of the practical end we were hoping to achieve.

She left hospital through a virtual ultimatum, which charged her to attempt to put into practice the insight and the lessons she had so sorely learned.

Recheck, after three months away from hospital and with no intermediate psychiatric contacts, shows that she has come to a more thorough-working understanding of the attitudes and sentiments so painfully worked over in hospital, and she sees herself coming to a truer understanding of her essential freedom—a freedom to do and to be what she wishes, with no further need to submit or to flail about in resentful defiance. She refers to herself as being more mature.

Diagnostically, her problem is mixed psychoneurosis, with neurasthenic, anxiety, and complusive features.

The essential features of this case have been seen time and time again so that I have come to look for them in any case of marked fatigue with or without over anxiety features.

One similar case needs mentioning because of the special social-cultural factors in the development of the reaction and for their manipulation by the patient to a final successful resolution of the reaction.

This is a 27 years old single man, the only child of a Spanish-American father and a Scandinavian mother. He early became aware of severe parental conflicts, themselves resting to no little extent on the differences in their

cultural backgrounds. While still a boy, the parents finally divorced and he went to live with his mother. He was aware of the social opprobrium attaching to his mother because of the divorce and he suffered severely from ambivalent feelings in regard to her. With her death in the United States after a prolonged illness, he suffered severe anxiety attacks, and on returning to Spanish-America, he soon settled into a state of chronic fatigue. He came back to the United States for treatment, was hospitalized for approximately six months, and worked through the facts of his difficulties with considerable courage. He realized that it was not necessary for him to follow inevitably the ideals of his parents, either one or both, but that he was free to make his own cloices and decisions. He made a satisfactory practical resolution of his conflicts by accepting a diplomatic post for his country in Scandinavia, and at the last report is doing well.

I have gained the distinct impression in these and other cases that this reaction arises in adults who as children had an emotional interpersonal diet rich in conditional love and approval, and deficient in that free, unconditional love and affection which I deem to be the *sine qua non* for the development of a healthy self respect. When the latter is present, the child can endure, yes, even thrive on the challenge inherent in conditional affection. When the basic self respect is lacking, the challenges of conditional love or approval are interpreted as threats to the weak secuitry, and there results a compulsive striving to please, which never matches the doubts of pleasing. The anxiety in this situation which touches every aspect of personal contact may reach staggering proportions and lead eventually to a sense of defeat. Why they suffer such complete defeat while others siblings acheive a better adjustment is not clear. In effect, they have suffered at the hands of complusive parents. If the dynamics as here outlined hold true, there are obvious implications for the mental hygiene of childhood. At least in the case of obviously complusive mothers (and fathrs) helpful therapy could be brought to bear. Where the state of affairs is essentially a imagined one on the part of the child, a problem more difficult but theoritically not insoluble, would be present. It is my impression that the offending parent in this situation is practically always the mother. The father's role has been less clear.

The upshot of all this is that the chronic fatigue state is not infrequently observed as a final defeatist sequel to chronic anxiety in obsessive-complusive personalities, who have suffered from the need to *conform* to parental demands (real or imagined) and with decreasing satisfaction in the confronting.

Treatment of this condition is most difficult since all therapeutic moves are suspected of harboring like complusive demands, much open anxiety and hostility are germinated (in fact need to be, one might say), and the patient is led painfully back over his series of defeats often covering the entire lifetime. Only the courageous survive this return trip and then only through the repeated demonstration of the physician's understanding and desire to help, including being made the whipping boy of the patient's neurotic defenses.

The differentiation from more conventional hypochondrical reactions and from paranoid delusional states must be made.

I can claim no flaming successes, but even partial resolution can bring sufficient relief to allow a return to a relatively normal life—at least with the only ingredient that really counts, the priceless ingredient of freedom, of choice, of opportunity, of action.

Postoperative Chest Complications*

‡G. A. Copping, M.D.

IN attempting to deal in the course of an hour with the subject of postoperative chest complications it is necessary to restrict oneself to those which, for reasons of their frequency or their severity, are of the greatest importance. I propose discussing only three of these complications but to present them as broadly as possible, stressing the basic principles involved; the three upon which I intend to speak are: postoperative pulmonary collaspe, pulmonary emboli and cardiac disorders consequent to operation.

Postoperative Pulmonary Collaspe

There was so much discussion in the lierature and from the platforms of medical meetings a few years ago concerning postoperative lung atelectasis and so much made of the error of calling the condition "postoperative pneumonia", that one would think it hardly necessary to call attention to the condition further. And, yet, one still sees patients on the first and second postoperative days in whom an acute event in the lungs is being treated with antibiotics and high Fowler's position and digitalis. The importance of drainage of the bronchial tree postoperatively is still not fully realized. The "pneumonia" of unconsciousness, be it from drug, injury, cerebral accident or general anaesthesia, is primarily atelectatic and the secret of its prevention is to aid the drainage of the bronchial tree.

The most interesting case of pulmonary atelectasis I ever saw was not a postoperative one but occurred in the following way. A cook in one of our hospitals overseas came down with a cold. As his quarters were not entirely comfortable and in the hope of sparing his hutmates the annoyance of his coughing, he was admitted to hospital for a day or two until he should recover. He entered the ward in the early evening, afebrile, and was gone over by one of the junior officers who found his chest negative, gave him a sedative and made him comfortable for the night. Curled up in his bed on his left side, he slept the night through without coughing and at rounds the next morning commented on how restful and quiet a night he had had. Going over his chest I was surprised, knowing the negative findings of the night before, to find crepitations at his left axillary base with absent breath sounds and his heart in his left axilla. An X-ray had been taken on admission, and its comparison with one taken following the new clinical findings, revealed a massive atelectasis in what had previously been normal lung. The patient was removed to the X-ray department where, after posturing him with his collasped side uppermost, he was thumped several times on that axilla. There was an immediate severe paroxysm of cough and he produced two or three ounces of thick sputum. The breath sounds immediately reappeared in the left axilla and X-ray showed a return to complete aeration with a few small scattered shadows as the only residuum of the event. The case dramatically demonstarted that the secretion from a mild bronchitis left a few hours undisturbed in dependent bronchi can lead to a massive bronchial blockage. It is not difficult to translate the event into the splinted abdomen, the fixed lung base and the Fowler position

*Delivered at the Annual Meeting of the New Brunswick Medical Society, August 24, 1950.

‡ Assistaut Professor of Medicine, McGill University

of a postoperative case and to visualize resulting atelectasis and, perhaps, secondary infection and, finally pneumonia.

As in most medical complications, prevention of pulmonary atelectasis is the key to success. In all postoperative cases, until coughing is effective, a few hours with the foot of the bed elevated and the head down may do much to prevent trouble; thorough aspiration of the pharynx and larynx before the patient leaves the operating room, and, if indicated, following return to the ward, are wise percautions. Deep breathing exercises and frequent changes in posture in the bed are time-honored. Perhaps the most frequently overlooked and simplest measure, however, is to anticipate the possibility of the complication. These patients not infrequently give a preoperative history of chronic and productive cough of long standing which, if it is enquired into, will put the medical attendants on guard. Hospitalization and treatment for the cough with postural drainage for a few days prior to operation may considerably lessen the risk.

Pulmonary Emboli

The second complication about which I would like to speak is the occurrence of pulmonary emboli. There are few more dread terms to chill the heart of the surgeon or the referring physician and upon few conditions have more hopeful attempts been made toward prevention and treatment. With the establishment of the factor of stagnation in the peripheral veins as of major importance and with the relatively recent differentiation between phlebothrombosis and thrombophlebitis, new interest in the subject has arisen. To this there has been added the impetus given by our newer knowledge of the anticoagulants. Unfortunately, difficulties have arisen in the practical application of this knowledge. The expense of heparin, the unpredictability of dicuomarol's absorption and action and the necessity for an expensive and difficult laboratory control of its effectiveness have interfered with the whole-hearted use of the anticoagulants. Understandable hesitation in advocating a second operation in the preoperative or postoperative phase has deterred those who might otherwise have adopted ligation of the veins as the procedure to be used routinely. Early ambulation after operation, bed exercises and deep breathing are generally accepted in principle but, with the exception of early ambulation, it is doubtful if they are given the personal supervision which their effective use demands. The staffs in most hospitals are overworked and making sure that post-operative cases regularly carry out the necessary tension, movement and deep breathing exercises seems to prove an unsupportable extra load. Moreover, there are recent papers in which it is suggested that, even if one does carry out all these preventative measures, the anticipated good results may not follow.[1] McCann's observations on blocks of from five to six hundred patients showed an incidence of 2.7% of thrombotic manifestations and one embolic death for a group in which the postoperative bed period was ten days and in which no particular effort was made towards bed exercises or other standard preventative measures. In a second block of patients of similar size ambulation on the third to the seventh days was instituted together with elevation of the extremities, exercises, protection of the legs from pressure, adrenaline administration to increase the circulation, etc.; there resulted a thrombotic incidence of 2.3% and two deaths from pulmonary emboli. It is disappointing to find that under

controlled conditions all that could be done failed to lower significantly the incidence of thrombosis or emboli. It is, however, of interest that a third block of patients who, for reasons of age and debility, were not allowed early ambula- and to whom dicoumarol alone was given developed only 1.5% of thromboses and none died from emboli. The findings are particularly striking when one realizes that the anticipated incidence of thrombo-embolic events for the age group in this last block should have been 4%

The factor of age in the aetiology of thrombo-embolic post-operative complications is deserving of special mention. We know that the incidence rises in the fifties and that young paraplegics, whose paralysed limbs are immobile for long periods, rarely, if ever, develop peripheral venous thromboses. Since early ambulation and bed exercises are of questionable value, it would seem that preventative ligation or anticoagulant therapy might be the principal preventative measures and it is suggested that they be used chiefly in older patients. It goes without saying that such factors as dehydration with its increased blood viscosity is to be avoided and that the importance of a tendency towards vein disease, as shown by past attacks of phlebitis, should be taken into consideration, as should the known predisposition of abdominal and pelvic operations. Incidentally, we need an anticoagulant as dependable as heparin and as cheap as dicoumarol with easy laboratory control.

Cardiac Complications

The third group of postoperative complications to be discussed are those in which the heart is at fault. Doctors and laity share an emotional attitude in assessing this factor. To what stresses is the heart of the patient undergoing major surgery actually subjected? The heart is exposed to varying degrees of anoxemia, to tachycardia, to possible physical exertion and to direct, local, toxic effects of the medications and anaesthetic used. In cases done under spinal anaesthesia and in those suffering surgical shock, the possible ill effects of hypotention have to be considered.

With the exception of the toxic effects upon the heart of the preoperative drugs and anaesthetic used and the danger of falls in blood pressure from shock and anaesthesia, the hazards of operation.are essentially those of the exertions of everyday life. Tachycardia, with its systolic squeezing shut of the coronary capillary bed, interrupts the myocardium's blood supply just as often whether the rise in rate be due to climbing a hill or struggling during the induction of a poorly administered anaesthetic. Anoxemia is the same whether the result of vigorous exercise or of a plugged bronchus. If the patient has survived comparable tachycardia, exertion and cyanosis while awake he can do so when anaesthetized. The new things to be evaluated are the effects upon the heart of drugs and anaesthetic and the degree and duration of the fall of blood pressure which may take place. The use of large doses of morphine as a preoperative medication predisposes towards difficult breathing and anoxemia although it is, together with most of the modern general anaesthetics, free of direct lasting injurious effects upon the myocardium. Frequent studies made of the effects of various general anaesthetics at present in use have shown that as high as 79%[2] of cases followed by electrocardiograph tracings during operation show notable irregularities. These changes occurred more frequently in abnormal than normal hearts and, while they varied from pace-maker changes to complete heart block, they were not permanent.

That they did occur is, however, of some interest. That they can be abolished or at least controlled by judicious admixtures of the anaesthetics used is well known to the experienced anaesthetist.

The danger of the blood pressure falling to a level below that at which the coronary circulation can be well maintained has always to be reckoned with, especially when dealing with subjects known to have insufficiency of coronary flow such as occurs in coronary sclerosis, calcific aortic stenosis or aortic syphilis. In conditions of shock or following spinal anaesthesia or following extensive blood loss it is quite possible for the new level of the mean aortic pressure to be too low to maintin adequate flow thorough a narrowed vessel and ischaemia and myocardial damage may result. A proposed preoperative management of patients in whom one is fearful of the effects of an undue lowering of the blood pressure would be to ascertain by sedatives or by sleep to what level the pressure which is tolerated by the body's physiological mechanisms may fall. (This can be done by serial blood pressure readings taken hourly over a 24-hour period prior to operation.) Having determined this basal level one should aim at keeping the blood pressure at or above this point during the operation and the postoperative period. This ensures a proper pressure head for the coronary circulation, and has the further advantage of giving the anaesthetist a definite level upon which to base his management of the case during the operation. Should a fall in pressure occur in a subject with suspected coronary disease, immediate steps must be taken to restore it. It is wiser to give a vasoconstrictor drug than to wait for the effects of transfusion; ephedrine, in the experience of many, is the drug of choice.

The question often arises as to the importance of the factor of old age in assessing cardiac risk. The same generalization may be made that what the heart has been able to do before operation it will be able to do during it. Age of the patient is not as important as is the choice of a good anaesthetist and a competent surgeon. If, during operation, the tachycadria, the anoxemia and the myocardial effort are kept down and the blood pressure followed for evidence of oncoming fall, the patient may not be submitted to more hazard than that of his average, daily living. It is often surprising how well the elderly stand even massive surgical procedures. It should not be so surprising, though, when one realizes that old age is reached only because of a original endowment of unusually good coronary arteries. The young, the robust and healthy have not yet been tried out on the treadmill of the years. The youthful and apparently perfect surgical risk of today is, perhaps, tomorrow's coronary thrombosis.

The cardiac complications which one fears are cardiac standstill, various rhythm disturbances, congestive heart failure and coronary insufficiency with angina or infarction. Cardiac standstill, usually the result of ventricular fibrillation is, fortunately, a rare complication and its occurrence is not always easy to explain. Myocardial disease, such as recent coronary thrombosis or active rheumatic myocarditis, with their irritable foci, might be expected to predispose to it. The sensitizing action of chloroform and of cyclopropane towards adrenaline's tendency to set up ventricular fibrillation is commented upon by workers in pharmacology.[3] It is possible that the use of preoperative sedation in very tense individuals may have an important place in protecting them against the hazard of their own adrenaline. Most of the rhythm dis-

turbances such as extra systoles and auricular fibrillation, coming on during operation, can be disregarded providing the heart's assessment as a reasonable operative risk has been well done. The heart which has already been in congestive failure has thereby declared its inability to cope with the day-by-day demands being made upon it and its capacity to sustain the efforts and stresses which operation may constitute must be considered in that light. There is not much literature available on this point and no one seems decided as to whether emergency surgery is better borne by the recently or the remotely failed heart but, that a past history of congestive failure carries a poor prognosis in operation, is shown in the figures of Butler,[4] Feeney and Levine. Incidentally, they document the risk of operating on patients the subject of chronic renal disease, a feature given theoretical support in recent views of the narrow margin of the circulatory changes tolerated by the kidneys.

The wisdom of operating upon patients the subjects of angina pectoris calls for special consideration. Decisions regarding, on the one hand, purely elective or, on the other, emergency operations are not difficult. One worries whether to deny the patient with angina pectoris a needed herniotomy or to refuse him a gastrectomy for recurrent and incapacitating peptic ulcer. The present tendency is towards being more lenient but each case must be evaluated individually. The questions to be asked are these: Is the anaesthetic and the operation likely to produce more tachycardia, anoxemia or physical effort than the patient can at present tolerate without pain? Has he, under the influence of nitro-glycerine, carried out comparable effort? Can the anaesthetist be depended upon to induce anaesthesia without struggling; will he follow the blood pressure and see that the desirable level for the case is maintained? Is the surgeon careful and competent and not too slow? All of these balanced against one's estimate of the heart's capacity, its everyday performance and the findings on examination must be borne in mind in coming to a decision.

If, in spite of all these precautions, the cardiac patient who has been considered to be a safe risk gets into trouble during operation what can be done? In the emergency treatment of cardiac standstill adrenaline is often injected directly into the heart. When this is successful the credit may actally be due as much to mechancial puncturing of the heart muscle by the needle as to the adrenaline. Indeed, there is, as mentioned above, some contraindication to the use of adrenaline. Cardiac massage would seem to be the most dependable emergency measure for this complication and the literature contains references to its successful employment. Irregularities of rhythm occurring in the course of operation can usually be disregarded, although they are more likely to have bad omen in cases with coronary insufficiency. Cardiac failure, which must be a very unusual operative event, is to be treated as it is under other circumstances.

Conclusion

It has been stressed in this paper that there are things one can do towards preventing the postoperative chest complications of pulmonary atelectasis,

pulmonary embolis and cardiac disturbances. These preventative measures are sufficiently often successful to warrant their inclusion in routine preoperative surgical management. Suggestions for the management of the complications when they do occur are given.

References

1. McCann, James C., The New Eng. J. of Med., 242, 203, Feb. 9, 1950.

2. Kurtz, Chester M., Bennett, James H., Shaprio, Herman H., J.A.M.A., 106, 435, 1936.

3. Meek, Walter J., Physiology Reviews, 21, 324, 1941.

4. Butler, S., Feeney, N. Leviee, S.A., J.A.M.A. 95, 85, 1940.

Case Report

REPORTING a very interesting case that I can not understand, nor can I find any helpful literature. A lady patient—36 years old—referred to me for refraction, occupation housewife and bookkeeper in the afternoons. History of severe epileptoid seizures, with biting of tongue and cheeks, during the past 8 years despite the use of dilantin and phenobarb 4 times daily. The attacks occurred chiefly at night—seldom in the daytime. Refraction showed moderate amount of compound hyperopic astigmatism, marked esophoria for distance and reading and a varying amount of right hyperphoria. Rx. given with a slight over correction for constant use and +50 more sphere for reading, etc. Result—no seizures for nearly 9 months during which time the medication was gradually reduced to one daily dose on advice of her physician. Medication stopped on her own initiative with no siezure for 3 or 4 weeks and then a severe recurrence.

A new Rx. with small prism down left to correct manifest hyperphoria has again given relief during the past 3 months. Owing to the fact that dilantin frequently causes diplopia no prism was given in the first lens correction. The patient is trying to remember to take a daily dose of medication.

I neglected to state that the electro encephalogram indicates epilepsy. Will appreciate suggestions from any of your interested readers who may have had similiar problems. Will be rechecking the muscle balance in a few weeks. Muscle exercises at her age have not been helpful in my practice but may try them later—am inclined to leave well enough lone.

C. B. TRITES, M. D.
Bridgewater

An Editorial on the Subject of Minutes

A NUMBER of incidents in recent weeks have made it apparent that a few remarks on this ordinarily rather dull subject may be in order. Most of our readers have probably accepted ' the minutes of the last meeting" as a sort of necessary nuisance that must be gotten out of the way before "business arising out of the minutes" can be dealt with. It is our belief that it is the exception rather than the rule for a member of any ordinary society to read carefully the minutes of any meeting, whether he or she was present or not. We further believe that there is a widely held notion that the whole thing is of no importance and that therefore no fuss should be made. Unfortunately such ideas are far from sound or sensible.

The minutes of a meeting constitute the official record of the business discussed and the decisions made by a particular group upon a particular occasion. In view of the number of possible groups carrying on business and having minutes it is surprising to find that very little has been written in books of reference or law concerning the rules for the keeping of such records. There are a few exceptions but generally it is difficult to come by any comprehensive statements on the subject. The reason for this is presumed to be that each society or association sets up its own standards for the keeping of its own records. Two general kinds of organization seem to lay down specific rules about minutes. There are the so-called "ch rch courts" and business corporations and the nature of the rules in each case is such as to suit the activities of the body concerned. Thus a corporation, while properly interested in the accuracy of its minutes, is also concerned about their circulation, and from them we learn that it is not considered desirable that the minutes of the Board of Directors should be read by others than the directors themselves. In other words, while the minutes of any general or shareholders' meeting must be made public, the deliberations of those who bear the responsibility in the intervals between such meetings should not be made known beyond the directors themselves. This particular point would seem to have some bearing on minutes of meetings of executive committees who stand in the same relationship to the membership at large as the directors of a corporation to the shareholders.

It is not our purpose, however, to discuss in detail the proper keeping of minutes nor their proper circulation. In spite of the paucity of references to minutes in law books or Bourinot there is no real lack of precept or example, and such can be easily discovered by anyone seriously interested in the preparation of records whose usefulness will remain long after memory of a particular meeting has faded from the mind.

There seem to be two or three points which in our opinion need explanation or emphasis. The first is the matter of minutes which are "verbatim" and those which are not. Minutes are not verbatim unless they contain every word that was uttered just as it fell from the lips of the individual speakers in their turns, and nothing else whatever. The two well known bodies having verbatim minutes are the House of Commons in London and the House of Commons in Ottawa. In both cases the record is known as Hansard. The Congressional Record in the United States is an even more voluminous publication, since incorporated in it is matter whose bearing on the proceedings

of the government bodies in question may be somewhat indirect, to say the least. It is apparently not customary for verbatim minutes of other groups, whatever their nature, to be kept as the official record of the group. The secretarial assistant who takes down notes of what goes on at the time may make those notes as copious or as scanty as he or she wishes, the sole responsibility being to miss nothing of what is properly supposed to be contained in the minutes. The final product may be as brief and condensed or as fully detailed as the custom of the group dictates, but it should at all times be uniform and consistent. We would offer the suggestion that in an effort to get down too many unimportant details main items may be missed and the whole purpose of the record defeated. A point which is often not recognized is that a perplexed secretary has a right and a duty to insist upon being given clearly and correctly the wording of any motion being voted upon. So vital is this matter of the exact wording of important motions that it is common practice to require them to be written down by the mover. After all, it is by motions that an organization gets its work done.

Mention of a perplexed secretary brings us naturally to our next point. One does not need an over-vivid imagination to perceive that some meetings are dreams and some are nightmares, and if this is so for the mere member, what must it be for the secretary? So we must inquire what it is that makes the difference between the two, and the answer is at once all too apparent. In the one case there is a properly prepared agenda, a properly conducted meeting, and, dare we add, a properly informed membership. In the other any or all of these are lacking. Irrelevant matter cannot creep into the minutes unless it is first allowed to come into the discussion. But even if it has regrettably been allowed to enter the discussion, there is still no reason why it should intrude upon the minutes. If the meeting is untidy the minutes need not be.

Behind the matter of meetings and minutes, however, there lies a fundamental principle whose importance for organizations like medical societies is great and growing greater all the time. The days when their business could afford to be carelessly conducted and hazily recorded are past. Willy nilly, sometimes in spite of ourselves and against our wishes, we are being brought into contact with other bodies whose representatives are characterized by skill in debate, persuasiveness in negotiation, shrewdness in bargaining, and, above all, a lively appreciation of the exact meaning or meanings of every word they speak or write. Our own high traditions and proper interests can only be safeguarded by clarity of thought and purpose. We must think, and know what we think, and then say what we mean without ambiguity and in no uncertain terms.

M. E. B. Gosse, M.D.

Summary of the Minutes of the Executive of The Medical Society of Nova Scotia, 1951

THE semi-annual meeting of the Executive of The Medical Society of Nova Scotia was held at the Dalhousie Public Health Clinic, Halifax, on Tuesday, January 16th, 1951, at 2.30 p.m. The President, Doctor J. J. Carroll of Antigonish, was in the chair, and a good representation was present from all parts of the province except Cumberland and Pictou. Doctor F. L. Whitehead the Secretary of the New Brunswick Medical Society and Mr. D. C. Macneill, the Business Manager of Maritime Medical Care Incorporated, and Doctor N. H. Gosse, President of the Canadian Medical Association, were present by invitation. Doctor T. C. Routley, the General Secretary, had planned to attend but due to adverse weather conditions did not arrive.

The first item of business was the report of the Economics Committee under the Chairmanship of Doctor H. J. Devereux. This report was to the effect that after careful study the Committee felt the present contract should be discontinued unless the Department of Welfare were willing to increase the payment from the present 75c per pensioner per month to 85c per month. Mileage was dealt with and no change was suggested. It was recommended that an effort be made between the Welfare Department and the Public Relations Committee of The Medical Society to educate the pensioners regarding the proper use of the Welfare Plan. Also it was pointed out that if there were any extensions in the Old Age pension Plan that the present agreement would be null and void.

A letter was read from the Lunenburg-Queens Medical Society expressing strong disapproval of the present agreement and stating that Lunenburg-Queens would even consider withdrawing from The Medical Society of Nova Scotia if the present agreement were continued. They advocated that the sum of money paid to The Medical Society of Nova Scotia for medical care to pensioners be paid directly to the pensioners and that they (the pensioners) be then held responsible for payment of their own medical bills.

The Executive endorsed the report of the Committee on Economics and requested them to draw up a new agreement with the Provincial Government and bring this new agreement back to the Executive for approval at a later date.

Mr. A. J. Sollows, Halifax City supervisor of the North American Life Assurance Company, spoke to the Executive on a plan for Group Life Insurance for members of The Medical Society of Nova Scotia. He was asked to put his plan in writing and that it be sent to all members of the Society and the Branch Secretaries so that the matter could be given proper consideration at the next meeting of the Executive.

The next report was that of the Committee appointed to consider the question of Income Limits and other matters in relation to Maritime Medical Care. Doctor G. B. Wiswell was Chairman of this Committee. His report consisted of fifteen items and each one was taken up separately and voted on.

1. That there be no income limit for subscribers to Maritime Medical Care Incorporated. On motion this was lost, the opinion being that there should be an income limit.

2. That the fees paid by Maritime Medical Care prorated or in full, be the only fees accepted by specialists and general practitioners and that no additional fees be charged to or collected from the patient. At first it was moved, seconded and carried that this item be accepted, but later this item was reconsidered and the original motion was lost.

3. That the physician or surgeon be paid on the basis of the service rendered, and that there be no distinction between specialists and general practitioners in this regard. (This was withdrawn on the motion of the chairman of the committee).

4. That certified paediatricians be paid as specialists and at the same rate as laid down in the schedule of fees for all other specialists for the examination, care and treatment of all patients between the ages of birth and the end of the 14th year. Adopted.

5. That the fee for normal new born care referred by a certified obstetrician to the general practitioner or certified pediatrician be $10.00 for the first month of life. Adopted.

6. That the fees for the care of the premature baby be at the rate of $10.00 per week until the baby reaches a weight of 6 pounds. Approved.

7. That there be no general practitioners rate payable to a certified specialist working within the limits of his specialty. With reference to this item, Mr. D. C. Macneill of Maritime Medical Care read the following from their Terms and Conditions of Enrollment: "Where the subscriber or his dependent requires the services of a Participating Physician in respect of a condition which is within the Specialty of such a physician the Corporation shall assume the charge, based on the approved schedule, for the first visit or consultation, but, if the Subscriber or the Dependent shall continue with such Specialist Physician for the purpose of treatment in respect to the condition, the Corporation will pay for the services so rendered on the basis of the most recent revised schedule of minimum fees as set by The Medical Society of Nova Scotia and as approved by the Corporation, and the Subscriber will assume all liability for charges made by the Participating Specialist Physician over and above the amount paid by the Corporaion." After considerable discussion item No. 7 was deleted.

8. That the general practitioner fee for office consultations be increased from $2.00 to $3.00. This was adopted.

9. That when a general practitioner refers his patient to a surgical specialist, he be paid for the services rendered his patient before and after operation. This was adopted.

10. That the fee for ordinary uncomplicated confinements, including pre and post natal care be increased from $50.00 to $60.00, and that the general practitioner or surgeon be allowed an additional fee of $50.00 for Caesarean delivery of his patient. This was adopted.

11. That the care and treatment of complicated pregnancy be paid for at the rate of general practitioner fees for the services rendered, over and above the fee of $60.00 allowed for ordinary, normal care. This was adopted with the addition that complicated pregnancy be charged at an extra fee of $25.00 over and above the $60.00 allowed for normal pregnancy.

12. That when a patient is referred by a general practitioner to a certified obstetrician or surgeon, the fee of the latter for the operation be $75.00,

and that the fee of the general practitioner be reduced by $25.00, but if he assists the surgeon at an operative delivery, he be allowed an assistants fee of $25.00 in addition. This was adopted.

13. That the fee of the certified obstetrician for an ordinary normal confinement, including normal prenatal and postnatal care be $75.00 and that an additional fee of $50.00 be allowed for Caesarean or operative delivery. This was adopted.

14. That all fees as laid down in the schedule of $100.00 or over for operative surgery be reduced by 10% in relation to Maritime Medical Care. It was first suggested that $100.00 be changed to $150.00, but after further discussion item 14 was struck out of the report.

15. That the subscription rates for subscribers to Maritime Medical Care be raised to allow for payment in full for all services rendered by physicians and surgeons to the Corporation, and that the physicians and surgeons be not penalized on account of lack of funds. To be solvent the Corporation must have sufficient funds to meet all its obligations in full. This item was deleted.

It was decided that the report be sent to the Committee on Economics and that they be requested to discuss it first with Maritime Medical Care and having done so to send a revised report to the Branch Societies before it came up at the next meeting of Executive.

The next report received was that of the Editorial Board presented by Doctor Margaret E. B. Gosse, Editor-in-Chief. This report dealt with suggestions for improving and expanding the Medical Bulletin. It suggested a monthly article on Medical Economics and told of efforts having been made to publish the proceedings of the weekly medical meetings on clinico-pathological conferences at the Victoria General Hospital at Halifax. So far these efforts have not been successful as the matter seems to present many difficulties.

The Editorial Board feels that we should attempt a Bulletin of about 1,200 copies to serve the four Atlantic Provinces. They suggest an Editor-in-chief, with three assistant editors in each Province, and point out that in the future there may be needed a part-time salaried editor. They requested permission to communicate with the Executives of the Medical Societies in the other three Provinces regarding financial arrangement for a new publication. They pointed out this new venture would cost more but hoped that at least part of the additional costs could be taken up from larger returns from advertising, although there was some doubt expressed about this.

The Executive approved the principle of expanding the Bulletin. The Editirial Board will present a final report at the annual meeting next September.

Opinion was divided on the question of appointing a full-time secretary. The members of Colchester-East Hants had voted 14 against and 1 for: Lunenburg-Queens 16 against; the Halifax Branch unanimously in favour; the Cape Breton Society unanimously against; the Valley Medical unanimously against: Western Nova Scotia Medical Society 18 for and 1 against; Antigonish-Guysborough unanimously against. There was no record of opinion either from Pictou or Cumberland Counties. It was suggested that Maritime Medical Care might perhaps in the near future need a medical director and that this position might be combined with that of secretary to the Society. Doctor

Whitehead, the full-time secretary of New Brunswick, spoke in favour of a full-time secretary and suggested that the matter be not dropped but brought up again at the next annual meeting. Doctor E. F. Ross suggested the matter should be again discussed by the Branch Societies. After further discussion it was decided that the original committee which was appointed to report on the advisability of a full-time secretary should communicate with the Branch Societies giving them full information on the subject and that it be brought up again at our next annual meeting.

The report of Doctor A. E. Blackett, our representative on the Executive of the Canadian Medical Association, was next read. It dealt first with the situation in Alberta, where the Government has taken over the registration of the medical profession. This matter is now being investigated by the General Secretary. Next the suggestion that beginning next June there be a registration fee of $5.00 for everyone attending the Annual Canadian Medical Association meeting. Mention was made of the report of Doctor W. V. Johnston on General Practice. The tenor of this report was the setting up of high standards for general practice and the recognition of competence by certification.

It has been reported that the American College of Surgeons plans to discontinue the standardization and approving of hospitals in Canada; and it was felt by the Executive of the Canadian Medical Association that this work should be carried on by the Canadian Medical Association together with help from the Royal College, the Canadian Hospital Association, the Catholic Hospital Association and the Federal Department of Health.

It was suggested that the permanent home of the Canadian Medical Association be at Toronto with the editorial offices at Montreal. The Quebec members asked that this be not finalized until the March meeting.

Reference was made to the annual meeting at Banff in 1952. Both the Banff Springs Hotel and the Lake Louise Hotel will be taken over. The report was received and the Executive approved a registration fee of $5.00 by the Canadian Medical Association at its annual meeting.

Doctor P. E. Belliveau next reported on the question of mileage charges in the medical care of pensioners. The Committee recommended no reduction in mileage charges and suggested that the rate remain at $1.00 per mile.

The report of the Public Relations Committee was received from the Chairman, Doctor C. H. Reardon. He told of having met with Mr. MacKinnon of the Department of Welfare, and that they had agreed to send out between them a letter to the pensioners telling them exactly what to expect from the medical services.

This Committee also had received the phamphlet "On Call" from the General Secretary of the Canadian Medical Association. They plan as a routine to rewrite the issues of "On Call" and to publish parts of it in the Medical Bulletin.

Doctor J. A. Noble was appointed Chairman of a Committee to co-ordinate the medical aspects of civilian defence.

The President, Doctor J. J. Carroll, told the meeting that he had been approached by Professor H. L. Bronson regarding The Right Honorable Lord Rutherford of Nelson Fund for Scholarships. It was agreed to put a notice in the Bulletin calling the attention of the members to this fund.

It was decided that the two following letters re the sale of drugs without prescription be published.

December 19th, 1950

Dr. H. G. Grant
Secretary
The Medical Society of Nova Scotia
Dalhousie Public Health Clinic
Halifax, Nova Scotia

Dear Doctor Grant,

At a recent meeting of the Council of the Nova Scotia Pharmaceutical Society a letter came up for discussion from the Department of National Health and Welfare concerning the sale of Appendix IV Drugs without prescription. I herewith enclose a copy of this letter for your information.

May we solicit the co-operation of your Society in advising your membership of this existing regulation either through the Nova Scotia Medical Bulletin or in some other way?

This regulation as you can see often creates embarrassing situations for both the medical practitioner and the practising pharmacist, particularly in the case of telephone orders for original and/or repeat prescriptions since the regulation called for a "written" order.

All members of the Nova Scotia Pharmaceutical Society have received a copy of this regulation.

Yours very truly,
Sgd.) C. E. Fader
Secretary-Registrar

DEPARTMENT OF NATIONAL HEALTH AND WELFARE

No. 42 TRADE INFORMATION LETTER November 20th, 1950

TO ALL RETAIL DRUGGISTS

RE: PROSECUTIONS FOR SELLING APPENDIX IV DRUGS WITHOUT PRESCRIPTION

Drugs or preparations containing drugs named or included in Appendix IV to the Food and Drug Regulations must only be sold on prescription. All druggists are urged to make themselves throughly familar with section C.01.016 and related sections of the Food and Drug Regulations and with Appendix IV.

Prosecutions are continuing against druggists throughout Canada for selling these drugs or preparations thereof without prescriptions.

Those who do not have a copy of the office consolidation of the Food and Drugs Act and Regulations may get them on application to the Director, Food and Drug Divisions, Department of National Health and Welfare, Ottawa

(Sgd.) C. A. Morrell
Director, Food and Drug Divisions

Nova Scotia Pharmaceutical Society

Excerpt from the Food and Drugs Act—The Food and Drug Regulations—Department of National Health and Welfare—1949

C.01.016. No person shall sell a drug or a preparation containing a drug named or included in Appendix IV[1] except on prescription, [2]nor shall any person refill such prescriptions unless the prescriber thereof so directs *in writing* thereon.

APPENDIX IV

Prescription Drugs

Aminopyrine and any salt, homologue, or derivative thereof
Amphetamine and any salt thereof
Aureomycin
Barbituric acid and any salt, homologue, or derivative thereof
Cinchophen and Neocinchophen
d-desoxephedrine and any salt thereof
Methedrine and any salt thereof
Ortho-dinitrophenol and any compound, homologue, or derivative thereof
Penicillin, its salts or derivatives, or preparations thereof, excluding preparations for oral use that contain not more than 3,000 International Units per dose.
Pervertin and any salt thereof
Phenytoin Sodium
Streptomycin and any compound thereof
Sulphonamides and any salt, homologue, or derivative thereof
Tetraethylthiuram disulphide
Thiouracil and any homologue, or derivative thereof
Thyroid
Thyroxin and any salt thereof
Urethane

Doctor S. R. Johnston was elected to represent The Medical Society of Nova Scotia on the Board of Directors of the Canadian Cancer Society.

Nominations were then received for senior membership in the Canadian Medical Association. The following were nominated: Doctors C. B. Trites, O. B. Keddy, K. A. MacKenzie, R. E. Mathers, G. H. Murphy. It was left to the President and the Secretary to decide who were eligible.

Doctor C. B. Stewart who has been supervising a health survey throughout the Province asked the help of The Society in checking the accuracy of the diagnoses given by the enumerators. Approval was given his request.

It was agreed that if funds were available the out of pocket expenses of committees for attending Society meetings should be paid.

A resolution was presented from the Western Nova Scotia Medical Society asking that the Executive of The Medical Society of Nova Scotia attempt to have the present Poor Relief Act changed to include the payment for medical services rendered to indigents whilst in hospital and also to have the scale of fees allowed in the Act changed to conform to those accepted by The Medical Society of Nova Scotia.

Meeting adjourned at 1.50 a.m., Jan. 17th.

Post-Graduate Course in Surgery

THE VICTORIA GENERAL HOSPITAL

Halifax, Nova Scotia

A Post-Graduate course in Surgery will be given by the Victoria General Hospital, Halifax, Nova Scotia. It is designed to assist those writing Fellowship or Certification examinations, and for surgeons generally desiring further Post-Graduate Training.

The correspondence part will begin in April and continue through to August 1951.

The didactic lectures will be given for four weeks in October.

The course will include lectures in Anatomy, Pathology, Basic Sciences, Clinical Medicine and General Surgery.

The fee for the course is One Hundred Dollars.

Applications should be addressed to The Chairman, Post-Graduate Course Committee, The Victoria General Hospital, Halifax, Nova Scotia.

Welfare

A Contributed Editorial

A year ago the Medical Society of Nova Scotia undertook to administer for the Province a medical service for Old Age Pensioners, Mothers' Allowance beneficiaries and the Blind, giving such care as is ordinarily given in the home and doctors' offices on a capitation basis. The sum offered was 70 cents, later upped to 75 cents, and that was accepted by the Society though here were protests that it was too little.

In good faith the service was undertaken but it was soon found that through unfortunate misunderstandings there was considerable dissatisfaction. First, long before any negotiation with the doctors was undertaken, aspirants to the local legislature went on the stump and told the people of this province that they were going to get free Medical Care—without restriction. At no time, it seems were the beneficiaries under the service given any clear understanding as to what they were intended to get at the hands of the government and the doctors.

The result of this is known to all our readers. Demands for service were experienced beyond reason and this and some other things reduced the proportion of the funds available to pay for such services to some 50 or 55% of the required amount.

This was felt to be unsatisfactoriy and it was decided to approach the government with a view to getting the per capita payments raised.

The Economics Committee under Doctor Devereaux has done a very good piece of work in negotiating and reporting but their final report showed failure to get the amount raised, in consequence of which they feel that it should be left on the governments doorstep.

There is much sympathy with that view because it is said the doctors are underwriting half the cost of the government's service, and the government gets the credit for it all.

The government, on the other hand, points to other provinces which are giving similar service, plus some drugs, for what they call comparable amounts, though it is argued that in point of fact they are not comparable. It has been shown, however, that such provinces are indeed getting along very well paying 80% of taxed accounts, with a taxing system said to be much more strict than ours, and payment for mileage a great deal less.

Our profession, in this discussion that has been held, has shown itself divided on the manner in which the matter should be handled. Some of the branches from the first have held that negotiations should continue, others, which at first were deadly opposed to that step, have, on later discussion, changed their viewpoints, and now while recognizing its defeats wish to contine the scheme and the negotiations until the government sees the fairness of our position. They point too, to the fact that in the near future payment of Old Age pensions without a means test will likely be instituted when, of course, some other form of contract would have to be negotiated if the service were to continue.

A vote in the Halifax Medical Society produced a bare majority for continuing the negotaitions though it is understood that in the voting in the executive meeting referred to, four out of five Halifax members were against

doing so. It is only fair to say that Halifax men have been hardest hit since little or no mileage enters into their calculations.

The Bulletin here presents the facts and some of the arguments as it has them, but in a matter that may be said to be sub judice, to be decided within two weeks, expresses no views, and urges no course except that which is associated with all voting: *It is your privilege and your duty to get out and vote on April 4th.*

The following resolution adopted by the Lunenburg-Queens Medical Society and presented by Doctor Marcus at the recent special meeting of the Executive of the Medical Society of Nova Scotia but not voted on, has been submitted for publication in the Bulletin.

"Whereas we, the members of the Medical Society of Nova Scotia, consider that the present agreement with the Department of Welfare of the Province of Nova Scotia for the medical care of the Welfare group, in the light of the experience of the past twelve months, imposes too great a burden on the members of the medical profession, since about 5% of the cost is borne by about 400 individuals;

And whereas we, the members of the Medical Society of Nova Scotia, find it difficult to understand the uncompromising attitude of the Department of Welfare of the Province of Nova Scotia, in its refusal to consider an increase of but a few cents per month per pensioner, in order to compensate us partially for our 50% contribution;

And whereas we, the members of the Medical Society of Nova Scotia, are keenly disappointed at the failure af the Department of Public Welfare of the Province of Nova Scotia to inform the Welfare Group of the type of medical care to which they are entitled, and of the contribution by the members of the medical profession;

Be it resolved, therefore, that this special meeting of the Executive of the Medical Society of Nova Scotia go on record as being in favor of continuing negotiations with the Department of Welfare of the Province of Nova Scotia, in an attempt to arrive at some basis, in the light of the experience of Maritime Medical Care Incorporated, whereby there would be a more equitable distribution of the burden than exists at present, and in order that this service, promised to the Welfare Group by our elected representatives as a responsibility of *all* the people of Nova Scotia, may be continued;

Be it further resolved that we, the members of the Medical Society of Nova Scotia, realizing our responsibility as members of an ancient and honorable profession and realizing also the great need of a large proportion of the Welfare Group for this recently inaugurated service, shall, pending the outcome of further negotiations continue to provide the medical needs of this group as we have done during the past twelve months;

Be it still further resolved that, if this meeting of the Executive of the Medical Society of Nova Scotia deem it necessary in order to clarify our position a copy of this resolution by given to the press for publication."

March 20, 1951

Society Meeting

LUNENBURG-QUEENS MEDICAL SOCIETY

At the annual meeting of the Lunenburg-Queens Medical Society held at Bridgewater on March 16th, the following officers were elected.

President—Dr. J. C. Wickwire, Liverpool.

Vice-President—Dr. G. A. Barss, Rose Bay.

Secretary-Treasurer—Dr. Samuel Marcus, Bridgewater.

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

Members of the Executive of the Lunenburg-Queens Medical Society—Dr. D. C. P. Cantelope, Lunenburg, Dr. R. M. Rowter, Bridgewater.

SAMUEL MARCUS,
Secretary-Treasurer.