The Treatment Of Anxiety States In General Practice*

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DEFINITION OF ANXIETY: Anxiety may be defined as the simplest bodily manifestation of emotional disturbance. Physical symptoms are characteristic of anxiety, are universal, not only among mankind but among the lower animals. Dr. W. B. Cannon has designated them as a preparation for "fight or flight". The heart rate is increased; muscles are tensed; digestion comes to a standstill; blood pressure is elevated and the pupils are dilated. It is a mass reaction to danger. In most human instances, however, the response cannot be expressed in either "fight or flight", hence, instead of serving as a preparation for better adaptation, the anxious reaction often disorganizes bodily processes. Attacks of accelerated heart beat, difficulty in breathing, digestive disorders, trembling, dizziness and weakness are often the manifestation of non-specific disorganization of anxiety. We think of anxiety as different from fear in its less clear relationship to external danger. Fear is a response to a specific threat—anxiety is a more diffuse reaction to a poorly defined or consciously unrecognized danger. Chronically anxious patients are rarely aware of the meaning of their sense of apprehension and tend to fix it on one thing or another indiscriminately. Psychologically, an anxiety reaction is a disturbance essentially related to the threatened loss of ego-control. One thinks of the ego, the "me" part of the personality as the mediator between the demands of the instinctual drives, the dictates of the conscious or super-ego, and the adaptor of behaviour to the realities of the outer world. The balance achieved by the ego is more or less labile and may be disturbed by either intensified external demands, for example, war—or by intensified internal strivings which are alien to the conscious or to the demands of society. The above mechanism is inherent in most neurotic, psychosomatic and psychotic conflicts but we shall confine our remarks to the frankest expression of this kind of disturbance, known as the anxiety state. In its acute form, it may be experienced as an affect of panic with prominent bodily symptoms such as palpitations, dyspnoea, nausea or diarrhoea, sweating, trembling and feelings of extreme weakness. In others, the bodily symptoms may be minimal and the patient may complain of a state of acute apprehension in which he feels he will die or "go crazy." Most chronic anxiety states are characterized by persistent weakness and tension and the emphasis may be on a hypochondrical preoccupation with ill-health. An anxiety state represents a disequilibrium per se and like other disequilibria in nature, it tends to resolve itself but not always in a reasonable and healthful solution of the conflicts involved. Anxiety must be reckoned with, not only as a cause of

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illness, but a complication of other types of illness. The person who worries excessively, whether realistically or not, about his pathological condition may confuse his physician by adding symptoms which express his emotional turmoil. This is especially true in surgery where fear and misunderstanding often add to the conflicts already lighted up by the threatened loss of organ or tissue plus the very natural fear of pain, disfigurement and possible death. Anxiety is communicable and a severely anxious patient can often "transmit" this anxiety to his physician, who, if he betrays this can add to the patient's panic. This has a very important bearing on the handling of an acute anxiety state in practice. When the patient has experienced none or few attacks previously he will be genuinely terrified and perplexed, often feeling he is in imminent danger of sudden death due to "heart failure," "shock," "stroke" or some such misconception. Time spent by the physician on the first visit to such a case will pay rich dividends. A careful, quiet history-taking, a reasonably detailed but not over-long physical examination will serve to disclose the nature of the attack and differentiate it from attacks of paroxysmal tachycardia, auricular fibrillation and thyrotoxicosis. When the diagnosis has been made a careful and simple explanation to the patient of the cause and mechanism of his attack should be made. Once having done this, the doctor must behave consistently as if he really believed it. For example, after telling a patient that his rapid heart rate is due to emotional conflict the exhibition of digitalis, coramine or other "drug" to strengthen the heart not only may negate the doctor's explanation but further fixes the patient's idea that he has heart trouble and that the physician is benevolently concealing this from him. When drugs, usually sedatives, are to be employed, their actions should be told to the sufferer and it should be made clear that these are not curative but merely pallative, a crutch to help him over the difficult part of his illness. Having done this and quieted the patient, the doctor can soon expect a panic call when it will be reported to him that the victim is "as bad as ever." The physician, if he dashes madly to the scene with his hypodermic syringe ready for action, can easily undo all the good of his patient handling in the initial interview. He must explain on the phone to the relatives or to the patient that he realizes that the patient is acutely uncomfortable but that he is in no danger and that he must continue with the routine previously agreed upon. This may seem harsh treatment but I can assure you that it is much kinder than constant attendance which dramatizes the situation in a harmful way and tends to produce the well-known complication of acute anxiety states—the iatrogenic illness when the anxiety becomes somatized in the heart, stomach, bowels, etc., and the situation is rendered much more difficult to treat. The resolution of acute anxiety states may be in three ways:

(a) It may subside either spontaneously or as a result of treatment.

(b) It may go on to a chronic anxiety state.

(c) It may lead to somatization and be expressed through various organ disfunctions and oblique stroke or organ pathology.

One word of warning—an acute anxiety attack may be the herald of a more serious illness, for example, schizophrenia, deliria of various causes, or an agitated depression.

Chronic anxiety can be a severe, chronic and crippling illness which interferes to a greater or lesser extent with successful living. Many times it is manifested by over-concern with bodily functions and disfunctions and it is often confused with malingering. The treatment of these patients is difficult and taxes the ingenuity of both the general practitioner and the psychiatrist. When it is the result of deep-seated, longstanding conflict it often defies the most skillful analysis. Thus, the doctor should not berate himself for his lack of spectacular cure. He must remember that the condition can be very chronic and results in severe and irreversible personality changes, and just as one would not expect a tuberculous patient with severe lung scarring to do hard manual labor one should not expect the chronically anxious patient to resolve all his conflict and thereafter lead a healthy and useful life. A brief outline of treatment would consist of regular but not frequent office visits; patient listening to the complaints; limitation of the use of drugs, especially laxatives and sedatives; the disuasion of the patient from unneeded operations; and the pointing out of the patient's assets; his need for interests in reality instead of hypochondriacal preoccupation.

In both acute and chronic anxiety states, when a physician is so minded and the conflict sufficiently transparent, a try at getting the patient to verbalize his conflict will often result in considerable improvement. The most common conflict is ambivalent feelings to significant persons in the patient's life, for example, parents, siblings, spouse. If the patient is able to express his unconscious hostility to those persons normally considered as loved ones, if he is supported and prevented from acting out this hostility by a good doctor-patient relationship great benefit can result. This happy situation does not exist too frequently. Most human conflicts in civilian life are complex, deeply repressed and firmly defended. Also, most general practitioners have too little time to spend in this kind of work so that usually the firm, paternal type of support in the manner outlined above is all that can be provided. Drugs can be of considerable help but the control of them must be firmly in the hands of the physician. Barbiturates are the most commonly used—seconal for short action and barbitol or phenobarb for more prolonged action. Usually these should be given by mouth and unless clearly indicated by a severe G.I. upset hypos should not be used. Chloral is a more satisfactory drug for the elderly and paraldehyde in doses of three to eight drams for the severely disturbed. In very severe states the newer drug chlorpromazine, sold under the trade name of largactil, has given good results—usually in doses of 150 to 400 milligrams a day over several days or weeks. In my own and my colleagues' experience tolserol has been disappointing except in those conditions characterized chiefly by muscular tension, for example, post-alcoholic tremors and so forth. The new old products of rawolfia or its derivitive reserpine in spite of "time and life" have not given good results in our hands except in cases associated with hypertension. Bromides and alcohol are each effective drugs for the control of the symptoms of anxiety but both are dangerous—the former

from the danger of toxicity; the latter from addiction. Opiates, including demerol are obviously mentioned only to be condemned. Anxiety is prominent in immature and dependent people and these patients readily become addicted. While it is recognized that in acute attacks sedation is needed and needed in adequate dosage, the danger of addiction must be kept in mind and drug weaning must be begun as soon as reasonable.

Amphetamine and allied products, tea and coffee, tend to increase anxiety and should be interdicted. Hormones, especially in anxiety attacks during the menopause may exaggerate anxiety and if so should not be used. At the risk of boring by iteration, I should like to re-emphasize that the patient must not be given the idea that his condition can be cured by drugs—that these only help over the crisis—and that more healthful attitudes, interests outside his own body and mind, and courage to face the discomforts of his condition are more conducive to his eventual ease.

Water Pollution and Sewage Treatment in Nova Scotia*

R. DONALD McKAY,** M.E.I.C., P. Eng.

WATER pollution has many aspects. One must consider the use to be made of the water in question. Recreational facilities may be affected; public nuisance may be created; and above all, if it is to be used as a source of water supply, treatment may be made very difficult and costly, or the source may even have to be abandoned.

Some decades ago, as methods of treating sewage were developed, it became the custom for public health authorities to sneer at disposal by dilution. Nevertheless, it is well to remember that there are really only two ultimate means of sewage disposal: dilution and ground absorption. Other methods of sewage treatment, however elaborate and imposing, are in essence auxiliary to one or the other of these basic methods.

Conditions in Nova Scotia are quite different from those of most areas. Our long and deeply indented coast line provides the fine harbors of which we boast. These harbors have led to settlement along the coast line, supported by industries which grew up to make use of these harbors and of the nearby resources of forest and mine. Wooden ship-building; later, steel ship-building; shipping; and fishing; all these and more helped to concentrate the population along the shores. In addition to this, it happens that much of our mineral wealth is near the coast. Indeed, none of it can be far, since no point in the Province is more than forty miles or so from ocean, gulf or bay. So we have few communities, and almost none of any size, any great distance from salt water.

Under such circumstances, most towns take their water from streams or lakes, and dispose of their liquid wastes in the ocean or in waters connecting rather directly with it. This is in great contrast to conditions elsewhere, even fairly near the Atlantic coast. It is common for some communities to dispose of their sewage in the same body of water which they or their neighbors use for drinking. Usually, indeed, there is no practical alternative.

Still, times change. We have some small, inland communities which have not needed to consider sewage disposal (or even public sewers) as long as individual sewage treatment was satisfactory. Some of these are now growing to the point where community sewers are becoming an important, even a pressing, need. Increased installations of plumbing facilities has gone ahead still faster, thus multiplying the need. It is now becoming necessary for some of these villages to look to the future (and not to the distant future), when sewers will have to be built; and treatment plants will have to be constructed.

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We live in difficult and uncertain times, with wars and rumors of wars. We have had, as never before, to provide for the defense of our country. Now many of the necessary defense establishments are and obviously have to be built near the coast. But some have to be built inland. An air station may have to be placed well inland in order to have flat land for runways, or for freedom from fog. A communications station may need a combination of high land and good electrical grounding conditions. An army training centre may have to go inland to find a large enough area, or for reasons of rail, highway or air transport. It thus happens that before any of our civilian communities have built sewage treatment plants, two National Defense communities have done so.

Before describing these, it would be well to look into the reasons for treating sewage, and some methods. We have already seen that the most pressing reason, the protection of drinking water, seldom if ever will apply in Nova Scotia. Probably the most important reason in many areas, will be the preservation of recreational facilities. More and more attention is being paid to this, all over this continent; and we, in a tourist area, cannot neglect it. There are also places where a fairly large flow of sewage must discharge into a small brook. It is obvious that treatment will be needed to prevent a noxious nuisance.

The principal methods of sewage treatments on a municipal basis depend upon removal of solid matter and oxidation of the liquid. To most people, probably the most familiar method of sewage treatment is the septic tank, together with what most people forget, the disposal bed. The removal of solids takes place in the tank by sedimentation, that is the solids settle to the bottom by gravity. The oxidation of the liquid takes place in the ground disposal bed. The solids which settle out have to undergo treatment as well. Their breakdown by anaerobic bacteria is known as digestion.

In the septic tank, the digestion process interferes with settlement, since the gas produced causes solid matter to rise from the bottom while other solids are falling from the top. It also interferes with the oxidation of the liquid, since the tank effluent has a serious oxygen deficit. These drawbacks are not too serious for a small system, such as is needed for two or three houses or a small institution. They become far too serious for a commuuity treatment plant.

For towns, therefore, other methods are necessary. Many years ago, a favorite method was sand filtering. This is still well liked in a few places where natural sand beds make its application easy, and other conditions are favorable. Another method, also developed many years ago, and more widely used to-day, consists of Imhoff tanks followed by trickling filters. The Imhoff tank is a two-story tank, with a settling chamber above and a digestion chamber below. The processes of sedimentation and sludge digestion do not interfere with each other to any great extent. The trickling filters are in a way, ground absorption filters artificially built in such a way that their rate of treatment is vastly accelerated.

Probably the best-liked method, however, is now the activated sludge treatment. This is the method used in the two defense establishments men-

tioned, is under consideration for a large new real estate development near Halifax, and is a likely choice for most Nova Scotia towns who may face this problem.

Briefly, this method consists of mixing air with the sewage for a period of several hours. The sewage is then allowed to settle, the liquid discharged, with chlorination as a final step, and the sludge which has settled out is drawn off. Most of this sludge is piped to a digestion chamber, but a varying percentage is recirculated, and enters the aeration tank with the incoming sewage. Raw sludge from this process is offensive and difficult to dispose of. The digested sludge, however, is quite inoffensive, and is usually easily disposed of by burning, or by giving it away as humus material for gardens.

At one of our two plants, that of a moderately large air station, the layout consists of a comminutor, which shreds the larger solids of the sewage in somewhat the fashion of a garbage grinder, a primary settling tank, four aeration tanks, and a final settling tank. The effluent is chlorinated, and the sludge is piped to a single digestion tank.

Aeration is provided in these tanks by pumping the effluent from the primary tank, together with some return sludge, up through a central shaft in each tank, and forcing it out over and through a set of baffles, into the main part of the tank. The splashing provides ample intimate contact with the air, so that oxygen is absorbed; and the pumping provides a thorough mixing action. The valves and pumps are so arranged that the four tanks can be (and usually are) used in series; or in two groups, each of two tanks in series. The pumping cycles can be altered to give almost any desired degree of treatment. The criterion is that the effluent shall contain an amount of oxygen, found by experience to be satisfactory. The operator will also be assisted in his judgment by other tests, such as the appearance of the sludge, the appearance of the effluent, and most of all by the resulting B. O. D., or biochemical oxygen demand. In most smaller plants, the laboratory procedure for determination of B.O.D. is not carried out, but rather a simplified version of the same test, commonly known as the relative stability test. This is the case at this station.

The other plant is smaller, but otherwise similar. A single tank is used, together with a longer aerating cycle. Much of the time, aeration is continuous, contrasted with about fifty per cent or less in the other plant.

The effluent of each of these plants is clear, free from offensive odor, and is high in oxygen. The sludge, after digestion for a period of months, is dried on open drying beds. It dries well, to an inoffensive tarry substance and altogether, conditions are excellent.

The Duty Of The Medical Profession In The Prevention of Tuberculosis*

By J. F. MACDONALD, M.D.
Hopewell, N. S. (1901)

We publish this as a tribute to the clear thinking of a small village practitioner in 1901 whose voice in those days was as of "One crying in the wilderness." The remarkable of yesterday is commonplace to-day.—Editor.

THAT tuberculosis is a contagious disease is an established fact. For many years evidence of its contagious nature has been recognized by many physicians and others.

That the facilities for propagating and spreading the disease are almost unlimited is well known though not seriously appreciated. It is such a common universal disease, always everywhere in evidence, that people become so familiar with it that the fear of contagion is lost. That "familiarity breeds contempt", is well exemplified in this case.

That it is not hereditary is pretty generally understood. That tuberculosis is a veritable plague, decimating to a large extent the populatiou of our country, being responsible for nearly twenty-five per cent of deaths from all causes in the Dominion of Canada is known.

It is also well known that this universally prevalent disease is preventable. If the above statements are true, if all this and more has for many years been known, we would naturally expect that practical efforts would have been made for the prevention of the disease, and that the medical profession as a body would have taken the initiative and kept up the agitation until the object sought was obtained. With the concerted action of so influential a body there could be no such a thing as failure. We all know the magnitude of the task with which we would have to grapple, as well as the necessity for action. What have we done? So far as I can hear no practical, concerted action has been taken by any medical organization in the Dominion for the prevention of tuberculosis. There has I admit been some talk, some writing, and lately a flourish of some large calibre trumpets whose strains were of high pitch and good tone; may we not hope that some practical good may result therefrom.

The Nova Scotia Provincial Board of Health has done a little "marking time." It proclaimed tuberculosis a contagious disease. Very good! It had leaflets printed for, I presume, the information—the education of the public re contagious diseases. A few of these were sent, I suppose, to the members of the medical profession throughout the country, perhaps to others. How many of these found their way into the hands of the people would be difficult to determine. Besides this certain recommendations were made by the Board to our legislature, for which the credit should be given. The Board if I remember rightly asked our legislature for an appropriation for a sana-

* Read at meeting of the Maritime Medical Association, Halifax, July 4th, 1901.

torium for the treatment of tuberculous patients which was readily granted. How many years it will take to find a location for the sanatorium and get it built is difficult to predict. Sanatoria are most useful institutions if conducted upon right principles, for the treatment of tuberculosis. They are however of limited use in the way of prevention. While the contagion is allowed to be freely provided and as freely distributed we may go on building sanatoria for the accommodation of the manufactured article, for the prevention will be about nil. Sanatoria or consumptive homes for incurables especially for the poor would be of more service and a very large percentage of the contagious matter would be removed from general distribution, which would mean decided prevention.

In order to accomplish anything definite in the work of prevention certain legislation is necessary, viz:

1. To prohibit spitting on the streets, in all public buildings, wherever people congregate, and all public conveyances.

2. To provide for sanitary inspection of all public buildings and public conveyances.

3. To prohibit tuberculous persons from teaching in our educational institutions.

4. That all teachers, from those teaching in our primary schools to the university professor, shall be subject to medical examination and have a clean bill of health before being allowed to teach. The medical examination to be repeated every two years.

5. Also medical examination of all students attending public schools of all kinds. All tuberculous teachers and pupils should be prohibited entering the public schools. It is well known that our schools are prolific centres of infectious diseases.

6. Sanitary inspection of school buildings and premises as well as medical inspection of those attending schools is necessary.

7. Sanitary inspection of all places where food supplies are prepared and sold and medical examination of all persons employed in and about such places. The coughing, spitting consumptive must be prohibited from handling and coughing over our groceries and baking our bread.

It is well known that the animals from which we get a very large portion of our food supply are infected with tuberculosis; it is therefore necessary that these animals be carefully examined, and sanitary inspection made of the places where they are kept. Especially is it necessary to inspect our dairy stock, that the cows from which we get our milk should be perfectly healthy and free from tuberculosis. Sanitary inspection of dairies, creameries, cheese factories and products of these places. Tuberculous persons should be prohibited from working with and handling milk and its products. There is no article of food so generally used as milk. Children are largely fed upon milk; hence the necessity of having a pure article free from germs.

This is a partial outline of the means to be used and the legislation required for the prevention of tuberculosis.

The trend of ideas in this country seems to run upon the building of sanatoria for the cure of consumption. This is I think a mistake. Home treatment, outdoor or fresh air treatment, particularly among the well-to-do can be practised with as good results as can be gotten anywhere. Over thirty

year's experience in the treatment of this disease on the home, outdoor plan warrants the above opinion. It is very important to know how best to treat consumption but it is of far greater importance to prevent the disease. By proper effective, preventive measures, including homes or hospitals for poor incurables, in a few years tuberculosis would be among the rare diseases. Are we as a profession ready and willing to take the concerted action to secure measures for practical prevention of this plague?

It may be, has been, said that the preventive measures indicated would be oppressive interfering too much with the liberty of the citizen. Looked at in this way all the laws that make a country safe to live in are oppressive. The law says thou shalt not steal, yet the thief plies his business. In every community there are those who evade or openly break the laws of the country. Still the law is good and society could not exist without it. If it is oppressive to restrain the consumptive from endangering the lives of his neighbours, it is also oppressive to prevent the assassin from shooting his victim; the former endangering the lives of all with whom he comes in contact besides inflicting long drawn out misery not only upon those whom he may infect but on others also; the latter kills his victim and there is an end to the suffering. We cannot hang the consumptive but we can hang the murderer. The former is more dangerous than the latter.

But restraint need not be oppressive; the consumptive when informed how to avoid giving the disease to others can mingle with others safely provided he complies with stipulated regulations with which every consumptive should be provided.

I believe it is a positive crime for coughing, spitting consumptives to be allowed to prepare, handle and cough over food supplies. Consumptive mouths are never free from contagious matter, their hands seldom. Is the country, are the people ready for such legislation and restraint as above outlined? Were people ever ready for any reform although it were for their good? History says no! It is said that the country must be educated to the necessity of legislative prevention. How are the people to be educated, and who are to do the educating? It cannot be done by the medical press which is not in the hands of the people. The lay press has given the subject some attention but its teaching is not always in the right direction. The profession might use the press to some advantage.

I think our better course would be to educate our legislators, professional politicians and others of our *governing* class. The people give themselves little concern about making of laws, until after they are made.

What is wanted now is a united medical profession asking legislation for prevention of tuberculosis. And in Nova Scotia, if we ask for it, showing the necessity for it, I believe we will get it.

Do the members of the medical profession in Nova Scotia, in the Maritime Provinces, in the Dominion believe in prevention, believe in its necessity? From past experience, I sometimes think the answer might be in the negative. It seems to me we are a slow moving people, afraid to move until the rest of the world pushes us onward.

The object of this rambling paper is to keep the subject of prevention in view, and if possible to induce a united medical profession, through our organizations, to take concerted action in procuring preventive legislation, and I believe we can get it, if not at once, then by persistent importunity.

Case Report

ON August 26, 1954, I was asked to do a Post-Mortem on a man with the following brief history:

Age 66 years with home address California. He had motored to Nova Scotia accompanied by his wife and daughter for Tuna fishing at Wedgeport. While walking along the highway, he suffered a very severe abdominal pain, following which he collapsed by the roadside and was carried into a nearby house. He was seen by Dr. W. C. O'Brien about twenty minutes later who found him in a state of severe shock, pulseless and moribund and he passed away a few minutes later. A mass in the lower left abdomen was noted. His wife ventured the information that he had not been complaining and that he was supposed to have had a medical examination before leaving home.

The post-morten was asked for in order to establish a diagnosis. On opening the abdomen the peritoneal cavity was distended with blood and at least two quarts were removed. Blood was extravasated beneath the posterior parietal peritoneum through which it had ruptured to fill the abdominal cavity. A large saccular aneurysm of the abdominal aorta just proximal to the origin of the iliac vessels was found and there was a one inch tear in the aneurysmal sac, the sac being the size of a large orange.

Unfortunately the clinical history was not obtainable. The only justification for reporting this case is, that aortic aneurysm is rare in this area, that abdominal aneurysm occurs only about one in ten of all aortic aneurysms and the fact of the sudden and tragic disaster which befell a very enthusiastic sportsman.

L. M. MORTON, M.D.,
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101st Annual Meeting of The Medical Society of Nova Scotia

FIRST BUSINESS MEETING

THE first general session was held at the Isle Royale Hotel, Sydney, N. S., September 7th, 1954, at 4.45 p.m.

The President called the meeting to order, and welcomed the members to Cape Breton. He pointed out that the Society had suffered a great loss since the last meeting in the death of the Secretary, Doctor H. G. Grant, who had contributed so much to the Society over many years. He had been responsible for making the preliminary arrangements for the present meeting. Doctor Tompkins said that Doctor Grant had been of tremendous assistance to him during the year, and that the whole Society would feel his loss very keenly.

It was moved by Doctor A. L. Sutherland that the Minutes as printed in the Nova Scotia Medical Bulletins of December, 1953 and January, 1954, be taken as read. This was seconded and carried.

Doctor A. L. Sutherland was appointed as Acting Secretary.

Doctor Sutherland stated that the first things the Executive had dealt with were the two resolutions from the Western Nova Scotia Medical Society, as given in the Executive minutes, and that it had been moved that the first resolution regarding the Proprietary Drug Act be referred to the Executive of The Canadian Medical Association, for their ruling.

The second resolution regarding Dental Anaesthesia had been referred to the general meeting for their opinion. It was moved that this be referred back to the next meeting of the Executive so that they take it up with the officials of Maritime Medical Care Incorporated. This was seconded by Doctor D. F. Smith. Motion carried.

The resolution from the Lunenburg-Queens Medical Society as printed in the Executive minutes, was read by Doctor Sutherland. The action of the executive was agreed to by the general meeting.

The next was the resolution regarding a secretary for the Society which was read by the President, who stated that most of the members of the Executive were in favour of employing a full-time secretary. The Cape Breton Medical Society went on record as not being in favour of a full-time secretary, and that the Society should continue with a part-time secretary. He stated that it was most important that the Society carry on for the time being appointing a part-time secretary and that the committee work to explore ways to get money to employ a full-time secretary.

Doctor C. L. Gosse stated that he would like to move now that the Society approve of the resolution of the Executive. He said there had been no dissenting votes in the Executive, and that the Halifax Medical Society had gone on record to employ a full-time secretary. He thought it was quite obvious to all the Executive that a full-time secretary was a most essential man in the

Society now, as he is the backbone of any organization. He therefore repeated his resolution and moved its adoption.

Doctor D. M. Cochrane seconded the motion. He stated it would cost the Society some money, and it would be necessary to get all members in, and yet the Society hesitated in spending extra money, although it was a very important matter. He felt that a full-time secretary was essential and had much pleasure in seconding the motion.

Doctor J. G. B. Lynch thought the position of a full-time secretary was a very important one, and did not think it would be handled in a week or a month. He moved an amendment that the Society have a part-time secretary until the matter was finalized. Doctor H. J. Martin seconded this motion.

Doctor H. J. Devereux: "Before we start any discussion could you give us any reason what benefit having a full-time man as a secretary would be to The Medical Society of Nova Scotia?"

Doctor J. W. Reid stated that he had been the only dissenting voice in the Halifax Medical Society, and that he was still opposed to a full-time secretary in The Medical Society, and that he was still at a loss to know what a full-time secretary would do. Until the Society got more members he still firmly believed the Society did not require the services of a full-time man. He moved an amendment to the amendment that a part-time secretary be employed if someone could be found available from the ranks of the general practitioners of the profession.

Doctor J. G. B. Lynch: "I would put in my motion that he be picked from the ranks of the general practitioners of the profession."

Doctor D. M. Cochrane: "I do not think there is much difference in the original motion and the amendment. I do not think the appointment can be made in a hurry. I think we will have to start off with a part-time man for one or two years. I think Doctor Lynch's amendment is very much in keeping with the original motion."

Doctor M. G. Tompkins thought that the amendment covered everything.

Doctor C. L. Gosse stated that the original motion was for a full-time secretary.

Doctor W. J. MacDonald thought there should be enough discussion to clarify matters.

Doctor A. D. Kelly was asked to speak on the matter and stated that he felt the medical profession and the public of Nova Scotia would be better served by The Medical Society by having a full-time secretary. He thought that a full-time secretary could increase membership in the Society. He stated there were approximately 750 physicians in Nova Scotia of whom 450 were members. He thought the support of all would be needed to finance a full-time secretary. He stated that a good full-time secretary was hard to find. He thought it was a useful occupation, and that his own work inclined him to a full-time secretary, and that the interests of the Society would be better served than by having a part-time secretary.

Doctor H. J. Martin: "I did not understand that the part-time would be just for a year. I would heartily agree with Doctor Reid that we find someone from the field of general practitioners."

Doctor J. G. B. Lynch thought that the Society should have a part-time man appointed at once.

Doctor M. G. Tompkins stated that the amendment was that the Society employ a part-time secretary to carry on for one year and that if he makes a success of his job that the Society keep him as full-time after the Society explores ways and means of financing.

Doctor Eric W. Macdonald thought that whether the Society should have a full-time secretary was for the general meeting to decide, and not for the Executive. He doubted very much if there were more than fifty who were not members of the Society. He thought that a full-time man would not do much more than dawdle at his desk most of the time. He would have to travel and the Society would have to pay large travelling expenses. The appointee would have to come up for election every year.

Doctor N. H. Gosse stated all the way from British Columbia to the Atlantic they had a full-time secretary in every Province. He found that that man was very busy keeping the profession aware of what was going on. He stated that he picked up the little medical journals in the other Provinces of Canada, and he found that information is being given, and that in Nova Scotia it was not being given. He found that in the Nova Scotia Medical Register there are approximately 750, and that more than 200 men at least who are practising in Nova Scotia are not members of the Society. He knew the effort that was made to get information published in the Bulletin with respect to Canadian affairs; information that perhaps members of the General Council could bring back. He thought the time had come when the Society should do something about it, and he would hate to see the hands of the Executive tied. He thought that the Society had had an unanimous vote from the Executive, and that something should be done about it. He therefore moved an amendment to the amendment that in the employing of a part-time secretary it would be an interim appointment.

Doctor J. A. McDonald: "Do they want a full-time secretary or a part-time secretary? That might be decided by a vote. He would be for one year if the appointment is to be made by the Nominating Committee."

Doctor W. J. MacDonald wanted to know how the Executive voted on this matter, if there were any absentees at the Executive.

Doctor N. H. Gosse's amendment to the amendment was seconded by Doctor J. A. McDonald.

Doctor J. F. Barton stated that a former classmate of his, a member of the Society and now practising in New Brunswick, Doctor W. E. Hirtle, was present, and asked that he be allowed to speak on the matter.

Doctor Hirtle stated that he was a Nova Scotian first, last and always, but was practising in New Brunswick. He said that the Society in New Brunswick had appointed a full-time secretary and that man had paid dividends; that the members received letters from him once a month stating just exactly where the Society stood. He stated that the dues in New Brunswick were

$60.00. He thought that a full-time secretary was a necessity for any Society.

Doctor N. H. Gosse stated that if the mover of the first amendment would withdraw his amendment he would withdraw his amendment.

Doctor E. F. Ross thought that the Society should have an opportunity to express their opinions.

Doctor M. G. Tompkins stated that one way to settle the matter would be to vote on the original motion; which was agreed to. Then he put the amendment to the amendment that in the employing of a part-time secretary it would be an interim appointment, and on a show of hands there were 16 for the amendment and 16 against. On a show of hands for the first part of Doctor C. L. Gosse's resolution "that the Executive of the Nova Scotia Division of The Canadian Medical Association is in favour of a full-time secretary" 43 were for the resolution and 15 against.

Doctor J. A. McDonald thought that a motion should be put before the Society.

Doctor N. H. Gosse moved an amendment to Doctor Lynch's amendment that all the words following the words "Part-time secretary" be deleted and that the words "be appointed as an interim secretary be substituted therefor." This was seconded by Doctor J. A. Noble. On show of hands this amendment carried.

The third part of the resolution "That a committee be appointed by the Executive to explore all possibilities and report back to the next meeting of the Executive with a plan and nominations for the position and that the Executive be given the power to finalize the arrangements" was read by Doctor A. L. Sutherland.

Doctor N. H. Gosse moved that the words "Next meeting" be deleted. This was seconded by Doctor J. A. McDonald. Motion carried.

The resolution as amended was then read and carried.

The names of the Nominating Committee were then given by the President as follows: Doctors G. C. Macdonald, R. M. Caldwell, A. L. Murphy, C. B. Smith and A. G. MacLeod.

Doctor C. B. Stewart stated that he had a suggestion that the Nominating Committee might be interested in using; that in Prince Edward Island and New Brunswick it was very important to have their Committee on Economics appointed for four or five years for the sake of continuity.

Doctor N. H. Gosse stated that he would like the Nominating Committee to give very serious consideration to the appointment of members of General Council to appoint members who would go and attend Council.

Doctor E. F. Ross stated that the Halifax Medical Society Executive had recently had a matter brought to their attention by the radiologists of the Victoria General Hospital and the pathologists concerning their appointments, particularly that of radiologists who had been informed by the Victoria General Hospital that they must accept their appointments as full-time civil servants or be replaced by others who were. The Executive discussed this matter as a whole and it was the opinion of the Halifax Medical Society that this matter should be brought up for the consideration of The Medical Society of Nova Scotia and they had made out a document and with permission he would like to read it.

"The Nova Scotia Division of The Canadian Medical Association recognizes the profound changes in the social conditions of our time and their effect on an increasing number of our members in carrying out their professional functions.

"In particular it recognizes the increasing number of physicians employed by governments, hospitals and other agencies in essential professional tasks.

"This Association can observe these changes with equanimity as long as the rights of these physicians are respected. Unfortunately, there is increasing evidence that such agencies are tending to depreciate the place of the physician and to circumscribe his privileges and functions.

"This Association accepts the view that, in certain situations, as in some phases of Public Health, the full-time physician may give the most practicable service.

"However, where patients, directly or through acceptable pre-payment plans, are able to pay for their medical care, and where the care is to be given through such an agency, no action shall be taken or contract made which may subordinate the usual rights and privileges between doctor and patient.

"Where medical service is offered to those who cannot pay and those who can, the principle of subsidy for the one is recognized, while, for the other, in so far as possible, the usual system of practice must be respected.

"The 'free enterprise' element in the practice of medicine, under which such great contributions have been made to the health and longevity of our people, must not be surrendered. Contracts made between an institution and a doctor must be phrased to preclude that possibility. This Association is not prepared to accept State Medicine from government, nor its equivalent from any private agency. In this connection it regards the application of Civil Service rules to physician contracts, where the 'free enterprise' element is involved, as unacceptable.

"In matters of health the state must assume great responsibility and our profession is privileged and happy to co-operate. But it is not in the best interest of our people nor our profession for government, hospital or any other agency to practise medicine, which is what they do when they accept fees from patients for the services of their salaried physicians.

"This Association believes it to be in the interest of all physicians, salaried or self-employed, to enjoy membership in their medical organization, where they may make their contribution to its thinking, and from which they may receive benefits accruing only to strong organizations representative of medicine. It believes that all physicians will find allegiance within their association, and commends to them the thought that solidarity and cohesion of the profession was never in greater need than it is to-day."

Doctor Ross moved the acceptance of this report, which was seconded by Doctor A. L. Murphy.

After a short discussion Doctor H. J. Devereux moved an amendment that discussion be post-poned until the next day's meeting at 2.30 p.m. This was seconded and carried.

Doctor Tompkins advised that he had had a letter from Doctor H. F. McKay stating that he could not accept the Presidency, and that he had tried

to get Doctor McKay by phone but was unable to locate him. Doctor Harries had advised at the Executive meeting that Pictou County had no desire to put up another man in Doctor McKay's place.

It was moved that the meeting adjourn at 6.40 p.m.

SECOND BUSINESS MEETING

The second business meeting of The Medical Society of Nova Scotia was called to order by the President, Doctor M. G. Tompkins, at the Isle Royale Hotel, Sydney, N. S., on Wednesday, September 7th, 1954, at 2.55 p.m.

The list of obituaries as given in the Executive minutes was first read, when one minute's silence was observed in commemoration of departed members.

It was pointed out by Doctor D. M. Cochrane that the name of Doctor Arthur Emerson Mackintosh of Amherst, McGill 1910, who died in Florida on April 7th, 1954, at the age of sixty-eight had been omitted from the list.

Doctor E. F. Ross spoke on the matter of radiologists at the Victoria General Hospital not being allowed to practise or consult outside, and that it was possible that some members of the Society had not been present at the meeting the day before. The matter had been brought before the Executive of the Halifax Medical Society by the radiologists and pathologists of the Victoria General Hospital with regard to their working conditions, that they would have no right to do any private practice. The Executive had considered it and had set down on paper what they thought would serve to introduce and discuss the matter, and also that it might serve as a policy for the Society. He then read the resolution, as printed in the Minutes of the First Business Meeting. This was seconded by Doctor A. L. Murphy.

After some discussion Doctor J. W. Reid moved an amendment to the effect that this document be circularized to the profession to study and that it be voted on later. This was seconded by Doctor H. J. Devereux. This was carried by vote.

The following resolution re Post-graduate programme which was passed at the semi-annual meeting of the Executive on January 12, 1954, was read by Doctor M. G. Tompkins.

"Doctor J. A. McDonald moved that The Medical Society of Nova Scotia contribute $900 at this time to Dalhousie University for the Post-graduate Programme to cover the estimated levy for 1954, and that the Executive of The Medical Society of Nova Scotia recommend to the Annual Meeting that a levy of $3.00 be made on the membership in 1955 for the 1955-56 programme, and a levy of $5.00 yearly for this purpose beginning in 1956. This was seconded by Doctor A. G. Macleod. Motion carried."

Doctor E. F. Ross moved the acceptance of this resolution passed by the Executive. This was seconded by Doctor C. L. Gosse. Motion carried.

Doctor N. H. Gosse asked what procedure would be followed in collecting this fee.

Doctor W. J. MacDonald moved that this levy be added to the regular annual dues and that in the case of non-members that they be solicited to contribute to it. This was seconded by Doctor C. L. Gosse. Motion carried.

Doctor M. G. Tompkins read the second resolution re Halifax Medical Society By-Laws which was also passed at the semi-annual meeting of the Executive on January 12, 1954, as follows:

"It was moved by Doctor D. M. Cochrane that the matter of changing the By-Laws of the Halifax Medical Society be referred to the next general meeting of The Medical Society of Nova Scotia. This was seconded by Doctor E. F. Ross. Motion carried."

Doctor N. H. Gosse moved that a Committee be set up at the first meeting of the Executive to draw up a new set of By-laws for The Medical Society of Nova Scotia, and bring in a report at the next meeting. This was seconded.

The following letter from John A. Walker, K.C., dated November 27th 1953, was read by Doctor M. G. Tompkins.

"In regard to the power of the Halifax Branch of the Nova Scotia Division of The Canadian Medical Association to amend its By-Laws so as to make membership in that Branch contingent upon the applicant for such membership being a member of the Nova Scotia Medical Society and Canadian Medical Association, I am of opinion that the Branch has power to amend its By-Laws so as to make this change, provided they obtain the concurrence of the Nova Scotia Division.

"You will notice that Article XII deals with the amendment of the By-Laws and that one of the conditions for making the By-Law valid is '(b) concurrence of the Nova Scotia Division of The Canadian Medical Association.'

"Whether the Nova Scotia Division wishes to give its concurrence is entirely a matter for the members of the Division. If they do concur it implies that they agree in principle that no person should be admitted to membership of the Halifax Branch unless he is a member of the two other organizations.

"If the amendment to the By-Law should be passed then Article III regarding membership should read as follows:—

1. "The members of this Branch shall consist of all members of the medical profession in the City and County of Halifax and the Town of Dartmouth in the Province of Nova Scotia, whose names shall appear in the Medical Register and who are members of both the Canadian Medical Association and The Medical Society of Nova Scotia and who shall have been elected as hereinafter provided.

"If it is decided to proceed with this amendment I would advise that the proceedings laid down in Article XII be strictly followed."

Doctor M. G. Tompkins advised that Doctor S. W. Williamson of Yarmouth, Doctor J. R. Corston of Halifax and Doctor J. G. B. Lynch of Sydney had been appointed honorary members of the Society. Doctor Lynch thanked the Society for the honour conferred upon him.

Doctor C. H. Reardon moved that the change in By-Laws with regard to membership in the Halifax Branch of The Medical Society of Nova Scotia and passed by this Branch be approved by The Medical Society of Nova Scotia. This was seconded by Doctor J. W. Reid. Motion carried.

Doctor M. G. Tompkins read the resolution regarding the fee schedule for membership passed at a special executive meeting on March 17th, as follows:

"It was moved by Doctor A. W. Ormiston that the fee schedule for membership in The Medical Society of Nova Scotia as suggested by the Secretary be approved starting in January, 1955, to be ratified at the next annual meeting. This was seconded and carried."

FEE SCHEDULE

CLASSIFICATION	C.M.A. Fee	Medical Society Fee	Future Changes
Ordinary members	$20.00	$10.00	Same
First year in practice after graduation	5.00	5.00	Same
Second year in practice after graduation	10.00	10.00	Same
Taking post-graduate courses	5.00	5.00	Same
Husband and wife in practice,			
Husband	20.00	10.00	Same
Wife	10.00	5.00	Same
Senior Member, Canadian Medical Association	Nil	10.00	Same
Honorary Member The Medical Society of Nova Scotia	4.00	Nil	Same
New members joining after July 1st, half fee	10.00	5.00	Same
Non-resident members (outside of Canada)	10.00	10.00	Same
Retired physicians	4.00	10.00	Same
Internes (including Journal)	3.00		Same
Post-graduate students (if they wish to receive the Journals, otherwise no charge)	5.00	5.00	Same
Members-at-large, including medical officers in the Armed Forces (complimentary membership if in Armed Forces serving outside of Canada)	20.00	10.00	Same

Doctor J. R. Macneil moved the adoption of the resolution of the Executive regarding membership fees, which was seconded by Doctor W. J. MacDonald. Motion carried.

Doctor S. Arthur Green read the report of the Editorial Board Committee as printed in the Executive minutes. Doctor M. G. Tompkins went over the different recommendations. Doctor C. L. Gosse moved that the Society adopt the recommendations and pass them on to the incoming Executive for further study. This was seconded.

Doctor J. W. Reid stated that it was a very fine report and was very thankful that the Society had moved and seconded that the recommendations of the Editorial Board be accepted and adopted by the Society and passed on to the incoming Executive for further study and implementation of the resolution carried on. He said he would be delighted to move a vote of thanks and appreciation to the Editorial Board for the fine work they have done and the willingness with which they accepted this task, a very difficult thing to do. This was seconded by Doctor H. J. Devereux. Motion carried.

The report of the Tariff Committee was read by Doctor M. G. Tompkins, as follows:

"A meeting of the Tariff Committee consisting of Doctor J. W. Reid, Doctor J. J. Carroll and myself was held. but since there have been no new problems presented to us since our last meeting there was no new business accomplished. Our report is merely a progress one since our last meeting at Halifax a year ago.

"We were instructed to revise the new schedule of fees as passed at that meeting. This was done by our central committee and has since been printed in loose leaf form and has been sent to every member of the Society. Since that time there has only been one request officially and that is for an addition to the schedule of neurological fees and this will be taken care of when the first major change is necessary. If there are omissions or errors we have not been notified. We have heard rumors that some groups are not satisfied but nothing has been presented to us to correct. Perhaps the Executive of the Society should make it known to this Annual Meeting that if they have any complaints to please notify the Committee Chairman so they could be dealt with in a proper way instead of beefing all year to themselves in doctors' rooms at hospitals, etc.

"As Chairman of the Tariff Committee I beg to submit this report."

Doctor W. J. MacDonald moved the adoption of this report which was seconded. Motion carried.

The Treasurer's report as printed in the Executive Minutes was read by Doctor W. J. MacDonald.

Doctor M. G. Tompkins stated that he had taken it upon himself to continue the salary of the late Doctor H. G. Grant until the first of September, 1954.

Doctor E. F. Ross moved that the action of the President in regard to the payment of the late Doctor Grant's honoraria be approved. This was seconded by Doctor S. Arthur Green. Motion carried.

It was moved by Doctor D. M. Cochrane that the Treasurer's report be received and placed on file. This was seconded and carried.

The Report of the Nominating Committee was presented by Doctor G. C. Macdonald as follows:

President—Doctor D. M. Cochrane, River Hebert.

First Vice-President—Doctor G. R. Forbes, Kentville.

Treasurer—Doctor C. H. Young, Dartmouth.

Secretary—Doctor M. R. Macdonald, Halifax.

Place of Annual Meeting in 1955, Amherst.

Legislative Committee—Doctors A. R. Morton, Halifax; J. A. Langille, Amherst; P. E. Belliveau, Meteghan and W. A. Hewat, Lunenburg.

Cancer Committee—Doctors W. M. Roy and N. H. Gosse, Halifax; V. D. Schaffner, Kentville and A. W. Ormiston, Sydney.

Public Health Committee—Doctors C. B. Stewart, Halifax; B. J. D'Eon, Yarmouth; A. C. Gouthro, Little Bras d'Or Bridge; C. E. Stuart, New Glasgow and J. A. MacCormick, Antigonish.

Historical Committee—Doctors K. A. MacKenzie, G. H. Murphy and H. L. Scammell, Halifax and W. W. Patton, Glace Bay.

Workmen's Compensation Board Committee—Doctors C. H. Reardon and J. H. Charman, Halifax; E. W. Macdonald, Sydney; F. J. Granville, Stellarton and G. V. Burton, Sr., Yarmouth.

Editorial Board Committee—Doctors C. M. Harlow, H. L. Scammell and C. B. Stewart, Halifax.

Medical Museum Committee—Doctors D. F. Smith and G. W. Bethune, Halifax.

Cogswell Library Committee—Doctors A. W. Titus and R. M. MacDonald, Halifax.

Medical Economics Committee—Doctors H. J. Devereux. Sydney; D. M. MacRae, Halifax; J. B. Tompkins and A. L. Sutherland, Sydney, and T. B. Murphy, Antigonish.

Pharmaceutical Committee—Doctors P. S. Cochrane, Wolfville and R. A. Moreash, Berwick.

Public Relations Committee—Doctors F. J. Barton, Dartmouth; A. W. Ormiston, Sydney; L. C. Steeves, Halifax; A. A. Giffin, Kentville; J. C. Wickwire, Liverpool, and D. F. Macdonald, Yarmouth.

Divisional Representative, Editorial Board The Canadian Medical Association—Doctor C. M. Harlow, Halifax.

Industrial Medicine Committee—Doctors A. B. Campbell, Halifax; J. G. B. Lynch, Sydney and J. E. Park, Oxford.

Medical Advisory Board Committee to Lay Organizations—Doctors W. D. Stevenson, B. F. Miller, H. D. O'Brien and G. J. H. Colwell, Halifax and L. M. Morton, Yarmouth.

Member of Board of Maritime Hospital Service Association—Doctor W. E. Hirtle, Sackville, N. B.

Tariff Committee—Doctors A. W. Titus, Halifax; J. J. Carroll, Antigonish and H. C. Read, Halifax.

Provincial Medical Board, three year appointment—Doctors A. L. Murphy, A. E. Murray, A. Ernest Doull, Halifax; H. F. Sutherland, Sydney; C. B. Smith, Pictou and H. A. Creighton, Lunenburg.

The Nominating Committee recommended that the constitution be amended so that two men be dropped each year from the Provincial Medical Board, to be replaced by two men each year for a three year period, so that continuity would be maintained.

Doctor G. C. Macdonald moved the adoption of the Nominating Committee's report, which was seconded by Doctor W. J. MacDonald.

It was agreed that the appointment of a second vice-president be left in abeyance for the time being.

Doctor C. G. Harries nominated Doctor A. W. Titus as secretary.

The question was asked from the floor as to whether or not Doctor Titus were available for the post. Doctor E. F. Ross informed the meeting that Doctor Titus was available. It was further asked from the floor if Doctor M. R. Macdonald had permission from the Department of Health to accept the position of part-time secretary in addition to his present appointment. The Chairman of the Nominating Committee informed the meeting that Doctor Macdonald had such permission.

Doctor C. L. Gosse thought that there should be a little more co-operation with the Government and that the Deputy Minister of Health should be added, ex officio, to the Executive. He also felt that the number of the Executive should be increased to give greater and more proportionate representation. He gave a notice of motion that he would move at the next annual meeting an amendment to the Constitution to increase the number of the Executive. This was seconded by Doctor H. J. Devereux.

It was agreed that the Deputy Minister of Health be notified that it would give The Medical Society of Nova Scotia great pleasure to have him attend as a member of the Executive, ex officio.

Doctor M. G. Tompkins stated that the 1958 meeting would be held in Halifax with the Nova Scotia Division taking care of the housing accommodation, and the New Brunswick Division bearing the brunt of the work.

On ballot the nomination of Doctor A. W. Titus as Secretary was lost.

It was moved and seconded that the slate of officers as submitted by the Nominating Committee be approved. Motion carried.

Doctor W. J. MacDonald read the list of new members, as printed in the Executive minutes, and moved that the names be added to the membership of The Medical Society of Nova Scotia. This was seconded by Doctor J. W. Reid. Motion carried.

The following Interim Report of Maritime Medical Care Incorporated for the period January 1, 1954 to June 30, 1954, was read by Doctor A. G. MacLeod.

"It is my privilege to-day to present to you, upon behalf of our President, Doctor J. C. Wickwire, an interim report on the activities of Maritime Medical Care for the first half year of 1954.

"High medical costs, which have been a disturbing factor for the past three years, continue to be a source of worry to your Executive and Board of Directors. A constant watch has been kept on these figures, but for the past six months they have further increased rather than diminished. It is noted that this latest increase is largely due to the large number of subscribers perthousand, who use the available services each month. In the past, our costs in the home and office care field, were the highest of any prepaid medical plan in Canada, but now we are reaching the point where some drastic action must be taken.

"Our statistics show the heavy financial drain that the reckless use of available services by subscribers has on the Corporation. On comparison, our medical costs for home and office care are thirty-five per cent and twenty per cent respectively higher than the Canadian average. In dollars and cents it is costing Maritime Medical Care $100,000 more for home and office care than any other prepaid plan for the same number of subscribers. A small part of this cost was brought about by the increase in the new fee schedule you introduced last Fall, but the greater part of it lies in the fact that our utilization of services is too high—that is, we have more subscribers making demands for services and we have more doctors making more calls per patient.

"In 1953, we finished the year with a creditable surplus. To date in 1954, we have only been able to meet our month to month expenses and, un-

less the situation improves in the latter months of the year, we cannot look forward to a similar situation this year.

"Doctors' Accounts:

"It has been a finding of the Medical Director and successive Taxing Committees, that many account cards are difficult or impossible to assess on an equitable basis, because of insufficient information given on these accounts. In some cases, the missing information may be obtained from our files, such as subscribers' names, ages and names of dependents, etc. However, this results in considerable loss of staff time and may result in inaccuracy in the posting of patients' history, due to confusion in names. In other cases, where account cards are submitted, lacking signatures, diagnosis dates and services rendered, there is no recourse but to return these cards to the physician for additional information. This, of course, results in a delay in processing the account and consequent delay in payment to the physician.

"In instances where the patient's condition has, in the opinion of the attending physician, warranted more visits than would ordinarily be made for the disease present, some brief explanation of extenuating circumstances may prevent this account from being taxed in what the physician may consider an unjust manner. Such additional information, if concise, is of value in taxing accounts and is always appreciated. Delay in submission of account cards is a frequent source of inconvenience; many accounting errors may be attributed directly to the practice prevalent among some physicians of submitting accounts several months in arrears. This situation is so serious that severe measures may have to be adopted in order to curb this tendency to delay.

"Your earnest co-operation in submitting accounts is solicited. Please see that your cards are legibly filled out as to names, dates, services rendered and treatment, that they contain additional information where necessary, that one card is submitted for each patient and that these are received by the Corporation within the stipulated time limit.

Participating Physicians:

"The number of Participating Physicians continues to grow and we now have 578 members, an increase of thirty in the past six months. No resignations were recorded for the period which augers well for the good relationship between the profession and Maritime Medical Care. It is the wish of your House of Delegates and Board of Directors to deserve the understanding and co-operation of all doctors in the Province.

Trans-Canada Medical Plans:

"Your medical plan continues to take an active part in the operation of the Trans-Canada Medical Plans. This association of medical plans has now passed through its origianizational stage and is now operating as a co-ordinator of the efforts of its members. We believe it is performing a well worthwhile service to the prepaid medical plans.

Medical Director:

"On July 1st, the Corporation appointed a full-time Medical Director in the person of Doctor G. B. Shaw. This has been a long felt need and Doctor Shaw comes to us with an excellent background in general practice. While the members of the Taxing Committee rendered most valuable service, it lacked continuity due to regular changes in personnel. We know that Doctor Shaw will greatly assist in the establishment of stabilization in the assessment of accounts. The new role of the Taxing Committee will be to adjudicate the more difficult accounts.

Provincial Welfare Plan:

"The Provincial Welfare Plan, which the Corporation administers for your Society, continues to operate on a sound financial basis.

Plan for Individual Enrolment:

"After two years of study by the Board of Directors and Executive Committee, a medical plan has now been developed for the enrolment of individuals. This plan will be offered to the public in certain sections of the Province within the next few days. This is a big step in making prepaid medical care available to the citizens of Nova Scotia. Details of the plan are now being prepared for mailing to you and we ask you to study them at your convenience. We feel that this is a big step towards the fulfilment of our goal in making medical care available to all insurable persons. The plan will first be presented in the Yarmouth area and other areas will be added from time to time. In preparing this contract, we have been guided by the experience of two other Provinces who have similar plans in operation, but we believe that we should move slowly until all details of its operations are solidly consolidated."

Doctor MacLeod moved the adoption of this report.

Doctor H. J. Devereux stated that there would be a meeting of Maritime Medical Care sometime in October. He thought there should be some definite recommendations from the Society. On December 31, 1953, they had a surplus of $30,000 and in July, 1954, a surplus of $28,000, and he thought the services should be increased.

Doctor D. F. Macdonald moved that the Society recommend to the Chairman of the Economics Committee that he meet with the Minister of Health and suggest that they pay for a certain number of days in hospital for those dependents needing either medical or surgical care. This was seconded by Doctor A. G. MacLeod. Motion carried.

Mr. D. C. Macneill advised that it had been decided to postpone the regular meeting of Maritime Medical Care and hold it in October in connection with the Refresher Course.

Doctor H. J. Devereux moved that the Annual Meeting of the Board of Directors of Maritime Medical Care Incorporated be held in conjunction

with the Annual Meeting of The Medical Society of Nova Scotia. This was seconded and carried.

Doctor W. J. MacDonald stated that he was not only expressing his own feelings, but the feeling of every doctor who had attended the Convention, that it was one of the most delightful conventions ever held, and that the scientific papers had been of a high calibre.

It was moved and seconded that either the Treasurer or Secretary have power to sign the cheques of the Society. Motion carried.

Doctor C. H. Reardon moved that the Executive of The Medical Society of Nova Scotia take the necessary steps to change the Constitution of Maritime Medical Care Incorporated to enable that body to choose their President from any member in good standing of The Medical Society of Nova Scotia. This was seconded by Doctor H. J. Devereux. Motion carried.

Doctor M. G. Tompkins read the letter from Doctor J. S. Robertson, as printed in the Executive Minutes, regarding representatives on Advisory Committes on Federal-Provincial Health Grants, and the representatives he had named. It was moved by Doctor C. L. Gosse that these names be approved. This was seconded and carried.

Doctor M. G. Tompkins thanked the members for having carried the meeting through so very quickly and having made his work very pleasant.

It was moved that the meeting adjourn at 6.55 p.m.

CORRECTION

On page 347 of the Executive Minutes in the September issue, paragraph six should read - Doctor J. R. Macneil and Doctor C. G. Harries were appointed representative and alternate on the Nominating Committee of The Canadian Medical Association.

THE COLLEGE OF GENERAL PRACTICE IN CANADA

The organization meeting of The College of General Practice took place at the Isle Royale Hotel in Sydney, N. S., on September 8, 1954, with Doctor A. G. MacLeod, President of the Nova Scotia Chapter of the General Practitioners' Society as chairman.

Present at this meeting were: Doctors A. G. MacLeod, J. R. Macneil, J. A. McDonald, C. B. Smith, R. M. Caldwell, B. C. Archibald, C. H. Young, A. A. Macdonald, H. J. Devereux, J. B. Tompkins, W. E. Hirtle, C. H. Reardon and G. C. Macdonald.

Doctor W. V. Johnston, Executive Director of the College, addressed the meeting and outlined the accomplishments to date, and urged all general practitioners to take an active interest in the formation of a local Chapter.

A resolution calling for the formation of a Nova Scotia Chapter of The College of General Practice was presented by Doctor A. A. Macdonald and seconded by Doctor H. J. Devereux.

Officers for the ensuing year were elected by nominations from the floor and the following slate was elected:

Chairman—Doctor F. M. Fraser, Halifax.

Secretary—Doctor C. H. Reardon, Halifax.

Treasurer—Doctor H. J. Devereux, Sydney.

Provincial Representative to Board of Representatives—Doctor A. G. MacLeod, alternate, Doctor C. H. Reardon.

Committee Chairmen were then elected for the following committees—

Education—Doctor J. A. McDonald, Chairman; Members, Doctors H. J. Devereux, A. A. Macdonald, C. H. Young, C. H. Reardon.

Hospital—Doctor J. R. Macneil, Chairman; Committee to be named later.

The meeting then elected the Chairman, Doctor F. M. Fraser, to be the Nova Scotia representative to The College on the Educational and the Constitution and By-Laws Committees, and nominated the Secretary to be a member of the Fellowship Committee as corresponding representative.

The meeting then decided that the matter of application for membership would now be a matter for the local Chapter, and the Question and Answer Booklets would be forwarded to local Chapters of The Medical Society of Nova Scotia for forwarding to general practitioners.

Attention was directed by Doctor Johnston, Executive Director, to the article dealing with General Practitioners and their relationship with the Mount Sinai Hospital in Montreal, which is to appear in the October issue of The Canadian Medical Association Journal.

There being no further business the meeting adjourned.

F. MURRAY FRASER,
Secretary, General Practitioners' Branch.

REGISTRATION

101st ANNUAL MEETING

THE MEDICAL SOCIETY OF NOVA SCOTIA

Sydney, N. S.

September 6th to 9th, 1954

Dr. Lewis H. Freeman, Saint John, N. B.
Dr. D. F. Smith, Halifax
Dr. T. B. Murphy, Antigonish
Dr. M. G. Tompkins, Glace Bay
Dr. D. F. Macdonald, Yarmouth
Dr. C. K. Fuller, Yarmouth
Dr. C. L. Gosse, Halifax
Dr. C. G. Harries, New Glasgow
Dr. A. A. Macdonald, Neil's Harbour
Dr. L. M. Morton, Yarmouth
Dr. G. R. Deveau, Arichat
Dr. B. S. Morton, Halifax
Dr. W. M. Nicholson, Reserve
Dr. H. D. O'Brien, Halifax
Dr. B. J. D'Eon, Yarmouth
Dr. D. S. Robb, Shelburne
Dr. D. M. Muir, Shelburne
Dr. G. R. Power, Halifax
Dr. J. G. B. Lynch, Sydney
Dr. A. M. Siddall, Pubnico
Dr. H. J. Devereux, Sydney
Dr. G. F. Strong, Vancouver, B. C.
Dr. C. H. Reardon, Halifax
Dr. Eric W. Macdonald, Sydney
Dr. G. R. Forbes, Kentville
Dr. M. J. DeKoven, Sydney
Dr. H. R. Corbett, Sydney
Dr. Francis Whyte, Grand Anse
Dr. G. B. Shaw, Halifax
Dr. C. L. MacLellan, Sydney
Dr. Alec M. Agnew, Vancouver, B. C.
Dr. J. F. McCreary, Vancouver, B. C.
Dr. H. B. Whitman, Westville
Dr. A. G. MacLeod, Dartmouth
Dr. E. F. Ross, Halifax
Dr. D. S. Brennan, Bear River
Dr. C. Uhma, Sydney
Dr. C. B. Smith, Pictou
Dr. B. C. Archibald, Sydney
Dr. D. McD. Archibald, Kingston
Dr. C. M. Harlow, Halifax
Dr. T. E. Kirk, Halifax
Dr. W. E. Hirtle, Sackville, N. B.
Dr. F. J. Barton, Dartmouth
Dr. C H Young, Dartmouth
Dr. R. W. M. Ballem, Halifax
Dr. L. T. Stead, Halifax
Dr. J. A. McDonald, Glace Bay
Dr. Gordon C. Macdonald, Sydney
Dr. A W. Ormiston, Sydney
Dr. D. M. Cochrane, River Hebert
Dr. A L. Saunders, Louisbourg
Dr. J. R. McLellan, Sydney
Dr. W. L. Muir, Halifax
Dr. Lloyd A. MacLeod, Liverpool
Dr. W. MacIsaac, Margaree Forks
Dr. D. N. Chisholm, Port Hawkesbury
Dr. W. W. Patton, Glace Bay
Dr. G. K. Smith, Hantsport
Dr. G. J. LeBrun, Bedford
Dr. A. R. Morton, Halifax
Dr. F. A. Dunsworth, Halifax
Dr. A. L. Murphy, Halifax
Dr. L. A. Skinner, North Sydney
Dr. M. J. Macaulay, Sydney
Dr. J. Philip Macdonald, Sydney
Dr. H. J. Martin, Sydney Mines
Dr. R. M. Caldwell, Yarmouth
Dr. Margaret E. B. Gosse, Halifax
Dr. Norman H. Gosse, Halifax
Dr A. D. Kelly, Toronto, Ontario
Dr. J. E. Hiltz, Kentville
Dr. S. Arthur Green, Glace Bay
Dr. J. R. Macneil, Glace Bay
Dr. A. W. Titus, Halifax
Dr. J. H. Charman, Halifax
Dr. J. A. Noble, Halifax
Dr. C. B. Stewart, Halifax
Dr. J. W. Reid, Halifax
Dr. T. W. Gorman, Antigonish
Dr. Harvey F. Sutherland, Sydney
Dr. Hugh E. Christie, Amherst
Dr. H. R. Ross, Sydney
Dr. N. F. Macneill, Sydney
Dr. H. D. Land, Sydney
Dr. J. G. Cormier, Sydney
Dr. J. F. Nicholson, Halifax
Dr. J. C. Young, Sydney

Dr. G. W. Sodero, Sydney
Dr. James Bruce, Sydney
Dr. H. B. Havey, Stewiacke
Dr. J. O. McNeil, Glace Bay
Dr. T. B. Acker, Halifax
Dr. U. E. Oberwarth, Glace Bay
Dr. A. L. Sutherland, Sydney
Dr. F. O'Neil, Sydney
Dr. N. K. MacLennan, Sydney
Dr. T. J. McKeough, Sydney Mines
Dr. W. A. Gardiner, Sydney Mines
Dr. A. J. MacLeod, Moser River
Dr. C. A. D'Intino, Sydney
Dr. J. K. Morrison, St. Peters
Dr. J. S. Robertson, Halifax
Dr. W. J. MacDonald, Truro
Dr. J. B. Tompkins, Glace Bay
Dr. M. R. Macdonald, Halifax
Dr. David Gaum, Sydney
Dr. H. J. Davidson, North Sydney
Dr. W. M. Roy, Halifax
Dr. T. J. Khattar, Glace Bay
Dr. K. A. Fraser, Sydney Mines
Major W. S. Hacon, Birch Cove
Dr. J. C. Ballem, New Glasgow
Dr. G. M. Moffatt, Springhill
Dr. D. B. Archibald, Sydney
Dr. Otto Bruckschwaiger, Glace Bay
Dr. A. C. Gouthro, Little Bras d'Or Bridge
Dr. R. E. Price, Amherst
Dr. W. Alan Curry, Halifax
Dr. A. J. Shaw, Sydney
Dr. H. Leslie Stewart, Halifax
Dr. W. I. Bent, Bridgewater
Dr. C. P. Miller, New Waterford
Dr. M. J. Chisholm, New Waterford
Dr. Lloyd Allen, New Waterford
Dr. A. Calder, Glace Bay
Dr. B. R. Maxwell, Glace Bay
Dr. H. A. Ratchford, Cheticamp
Dr. J. A. Roach, New Waterford
Dr. D. G. McCurdy, Sydney
Dr. M. F. Fitzgerald, New Glasgow
Dr. J. J. Carroll, Antigonish
Dr. W. D. Stevenson, Halifax
Dr. J. F. L. Woodbury, Halifax
Dr. H. I. MacGregor, Halifax
Dr. C. A. MacDonald, Sydney
Dr. J. H. Fraser, Westville