

The Nova Scotia Medical Bulletin

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Skeletal Suspension as a Method of Management of Supracondylar and Transcondylar Fractures of the Humerus

E. G. Vaughan, M.D., E. F. Ross, M.D., W. A. Curry, M.D.
Halifax, N. S.

In the absence of marked displacement and soft tissue injury, management of extension type supracondylar fractures of the humerus presents no great problem. Gentle manipulative reduction under general anaesthesia, followed by immobilization in right angle flexion using a posterior plastic slab is acceptable treatment. Transcondylar fractures, however, are notoriously unstable, and usually are displaced and rotated thereby rendering this type of management difficult if not impossible. In either type fracture, if displacement is moderate or marked and if soft tissue injury has resulted in much swelling, this simple method not only is difficult or impossible, but is dangerous in that it predisposes to vascular obstruction and nerve compression.

The purpose of this paper is to stress the importance of recognizing the danger of treating such a fracture by the conventional method, to point up the safety, simplicity and effectiveness of an alternative method and to outline the technique of that method as employed at the Halifax Children's Hospital.

In active children, the elbow is one of the most common sites of injury. Sixty per cent of fractures at this site are of the supracondylar and transcondylar types, and they occur most commonly in the six to ten year age group.

Limitation of movement and alteration of the carrying angle, an unsightly local deformity, nerve palsy, myositis ossificans, and ischemic muscle contracture are the inherent complications of this injury and of its treatment. Restoration of normal function of course is the goal, but avoidance of complications is the real challenge.

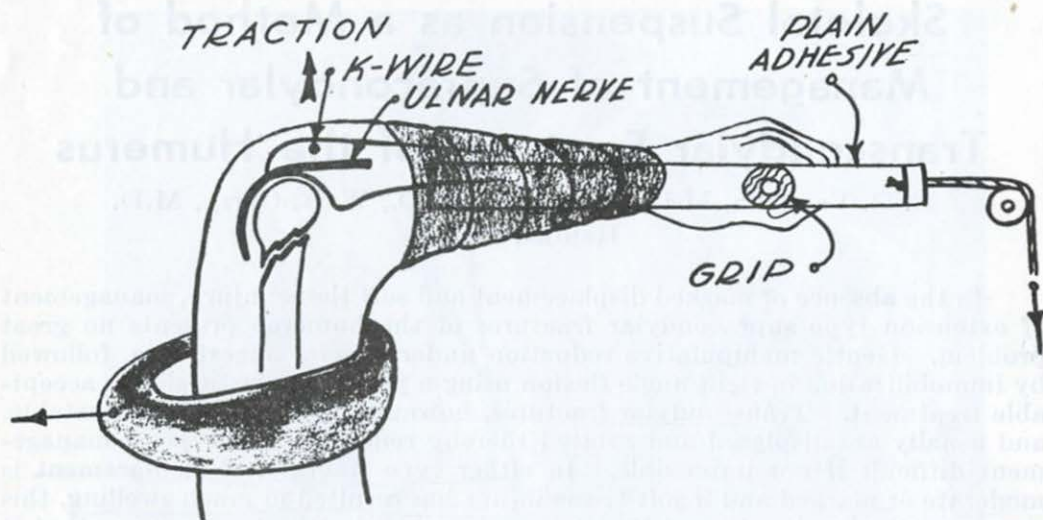
The fracture must be reduced both early and adequately, and the reduction must be maintained. Injured soft tissues must be freed from existing pressure and further injury must be avoided.

If swelling is marked, bony landmarks are obscured, the fracture is unstable, and conventional treatment is therefore hazardous. To wait for swelling to subside with the hope that manipulative reduction will then be possible is to insure nothing save an increase in the risk of irreversible soft tissue damage in the interim.

Correction of anatomy to "normal" by the use of metal appliances introduced at operation is met with functional diaster more often at the elbow than elsewhere. In making a decision to introduce such appliances one should be influenced by the adage, that which is anatomical is not necessarily functional and that which is functional is not necessarily anatomical.

In 1952 Hammond¹ advocated skeletal suspension traction as a method of choice for supracondylar and transcondylar fractures in all patients with moderate to severe displacement and in all patients with serious swelling, embarrassed circulation and nerve dysfunction.

This method of management has gained increasing popularity at the Halifax Children's Hospital during the past few years.



Follow up examinations have just been made on seven children with transcondylar fractures and supracondylar fractures treated by us using this method in the summer of 1956. This surgery reveals excellent results three years after treatment. The children were checked for range of motion, deformity, alteration of the carrying angle, weakness, nerve injury, pain or tenderness, evidence of infection at the site of insertion of the traction wire. Six of the seven had no demonstrable difference in their arms while the seventh child had ten degrees limitation of flexion and increase of extension plus ten degrees decrease of the carrying angle. It should be noted that she had suffered a second fracture at the same site one year after the original injury; this second injury was treated by manipulative reduction and immobilization. She has a strong and very useful arm however.

It is noted that Hammond¹ recommended the use of a screw-eye inserted in the olecranon process, in order to avoid the possibility of damage to the ulnar nerve. Maylahn and Fahey² report the use of this method also. A Kirschner wire with horse-shoe attachment was used in our cases and the technique of insertion we feel is very important.

The child's bed with overhead frame, cross bar, ropes, pulleys and weights is assembled and made ready at the operating room door. This preparation is important in that it allows the patient to be placed in traction as soon as the Kirschner wire has been inserted, and while he is yet anaesthetized, so that the entire procedure is painless. General anaesthesia is employed and strict aseptic technique is followed. By inserting the wire from the medial side, the ulnar nerve can be avoided and the wire can be accurately directed into solid bone opposite the joint. This point is made because it is all too easy to insert the wire too superficial, and thus through subcutaneous tissue or periosteum rather than into bone as is desired. We feel one can best judge the depth of insertion and also best avoid the nerve using the medial approach.

The skin at the site of entry and exit of the wire is incised with the point of a pointed scalpel. The wire is wrapped with gauze at the points of entry

and exit and the gauze is then saturated with tincture of benzoin as an antiseptic protective dressing.

The horse-shoe attachment is then applied and when the anaesthetist agrees, the child is moved onto his bed and ropes and weights attached. A portable A.P. and Lateral X-ray indicates any final adjustment prior to discontinuing the anaesthesia. Narrow traction strips on either side of the forearm, held in place with an elastocrepe bandage, not tightly applied, permits the inclusion of a broom-stick grip for the child to hold onto. This has proven to be an ever present stimulus to active finger, hand, and wrist exercises as well as a preventive measure against rotation of the distal fragment.

The procedure has been found to be simple and maintenance of reduction easy. It is a gentle and effective method of reduction of an unstable type fracture. Nerves are not compressed nor are vessels obstructed. Swelling is afforded the best possible method of treatment in this elevated position. The patients have been truly comfortable and co-operative.

After ten to fourteen days of such immobilization, a posterior plastic slab is applied, the wire removed, the point of entry and exit covered with a sterile gauze square, and the cast completed and after care is then no different than ordinarily.

Complications of treatment have been negligible. Infection in the tract of the wire did not occur. The children had no detectable functional impairment. One of seven has altered extension, flexion, and carrying angle as described, and it is noted that she had suffered a second injury.

In essence, skeletal suspension has been found to be a very satisfactory form of primary treatment because:

- (1) the fracture can be easily and adequately reduced;
- (2) manipulative trauma in this "danger area" about the elbow is minimized;
- (3) the reduction is easily maintained;
- (4) the elevated position assists reduction of existing swelling and discourages further swelling;
- (5) compression of important nerves and vessels is avoided;
- (6) the child with a severe injury is kept in hospital under close observation rather than being discharged to his home where complications can develop insidiously and unobserved.

Summary:

The treatment of transcondylar fractures and supracondylar fractures of the humerus complicated by swelling is hazardous, difficult and often impossible by the manipulative method. The technique of skeletal suspension is outlined and the method is recommended, not as a last resort after manipulation has failed, but as a primary procedure for all transcondylar fractures and for supracondylar fractures complicated by much swelling, displacement and rotation, and nerve injury or vascular compression. Facts, which we feel make the procedure desirable, are outlined. A sketch of the suspension apparatus is included.

1. Hammond, G. — S. Clin N.A. 32:747-762 (June) 1952.
2. Maylahn and Fahey — J.A.M.A. Jan. 18, 1958.

Salute to Edinburgh 1959

During the course of a memorable week in July a thousand or more physicians from all parts of Canada invaded the historic and beloved city of Edinburgh to attend along with their British colleagues a joint meeting of the British Medical Association and The Canadian Medical Association. Not least amongst this great gathering of medical men were those who made the pilgrimage from "New Scotland" to the "Old Scotland" from whence so much of our provincial traditions stem. Some were to relive memories of student days now long past, many to sample for the first time the warm hospitality of the people and the charm of "Auld Reekie," and all I suspect to visit that sacred piece of land within the precincts of the Castle which is forever a part of Nova Scotia.

The sunshine that was Edinburgh 1959 has now given place to the snow and ice of another Nova Scotia winter but it is our hope that as you sit by your fireside this Christmas before the crackling yule logs this anthology of memories which follows may remind those, who were fortunate enough to go, of a wonderful holiday, and the rest of us, mellowing our disappointment with another "Scotch", a rosy vision of future travels.

H.C.S.

The centre of all activities was a large building known as the Assembly Rooms and Music Hall, on George Street, in the heart of the city. At this location we found conveniences that one might expect in a large city club—information bureau, post office, dining halls, bar, lounge, etc., and this provided a common meeting place for Canadian and British doctors and their families.

All Canadians were supper guests in various homes in Edinburgh on Sunday evening, which was in itself a very delightful experience. Following this we were entertained by the B. B. C. Symphony Orchestra in Usher Hall, where the guest soloists were Duncan Robertson, tenor, and Jean Harvey, who thrilled the audience by playing both a piano and a violin concerto, which, in itself, is a very unusual feat.

Monday evening we were guests of the B.M.A. at their adjourned annual general meeting. An outstanding address on medical science was delivered by Lord Adrian, the world renowned Physiologist. The vote of thanks to the speaker was made by our own Dr. Wilder Penfield, who remarked, "I have spent the week-end with Lord Adrian. I am amazed how humble a great man can be, and how great a humble man can be."

Tuesday morning at 8.15, the annual Breakfast of the Christian Medical Fellowship was held at the North British Hotel. The same evening we were guests of the B.M.A. at their annual dinner at which time over two thousand sat down as one huge family. Both of these events will long be remembered.

Wednesday afternoon, by the gracious permission of Her Majesty, the Queen, we were guests at a garden party in the gardens of the Palace of Holyrood House, where our host was the Duke of Hamilton. The huge crowd, the great gardens, the Scottish Military Band, and the old castle in the background presented, on this fine afternoon, a spectacular sight.

Wednesday evening, we were fortunate to witness a special performance of the "Military Tattoo," which is a highlight of the Edinburgh Festival in August

of each year, and is repeated every night on the grounds of Edinburgh castle for the three weeks during this period. The grandstand had been constructed in advance to accommodate some two thousand of the medical group. The skirl of the bagpipes and the "swish" of the kilts seemed to be the last word in precision drill. The haunting tones of the "Lone Piper" from his perch high up on the walls of the great castle, and the music of the combined brass and pipe bands provided a grand finale to a very unique occasion.

All in all the doctors and their families were wined and dined on every side and the city was alive with activity during the whole week. One will long remember this beautiful Edinburgh with its great shops, its streets lined with grand old buildings, its monuments to Scott, Burns, and to its war heroes, its gardens, and, towering over it all, Edinburgh Castle. Above all we shall never forget its people and their genuine gift of hospitality.

J. C. WICKWIRE

As one of the senior members, I thought it might be fitting if I chose the Service at St. Giles' Cathedral, leaving an account of banquets and other entertainment to my junior colleagues.

St. Giles is a medieval building of rugged grandeur. It has figured largely in the early history of Scotland, the scene of intrigues and strife, at times seeming to be a fortress rather than a Christian church. It was destroyed several times and rebuilt so that different types of architecture are in evidence. From its pulpit John Knox thundered denunciation at all and sundry, including Mary, Queen of Scots.

The great past of this cathedral gave a dignity and a solemnity to the service not soon to be forgotten by the doctors who were present that beautiful Sunday afternoon; and there were over a thousand doctors there—for over an hour, the long procession wound its way into the church. Headed by church dignitaries, the Lord Provost and aldermen, the doctors in their vari-coloured gowns were followed by guards in their ancient uniforms with halberds and battle-axes. These guards stationed themselves at various positions inside the cathedral, no doubt following an ancient ritual of which we knew nothing, but whose observance added to the occasion.

Scripture lessons were read by the Chairman of the B.M.A. Council and by Dr. Norman Gosse, Chairman of the C.M.A. Council. While the present minister, Rev. Dr. Whitley, did not follow the example of his great predecessor John Knox, and hurl imprecations at us, he did preach a forceful sermon especially applicable to the medical profession. In it, he described the differences between the doctors of an earlier day and those of to-day. In the old days a doctor often had to be minister, lawyer and friend as well. To-day doctors have too many "escape hatches" in the shape of specialists, antibiotics and tranquilizers. He hoped that modern tendencies would not altogether destroy the doctor-patient relationship, and that the family doctor would continue to be the important factor in medical practice.

This coming-together in worship of doctors from Canada and Britain in the historic cathedral of St. Giles, stands out among all the other events (entertaining and enlightening though they were), made forever memorable by the splendor of its scene and ritual. To paraphrase Wordsworth: "Dull would he be of soul who could forget a sight so touching in its majesty."

J. C. BALLEM

Conventions come and go, but I am sure that none of us who visited Edinburgh in July of this year will ever forget it. We have always prided ourselves on having everything administered well, and have been particularly careful to see that our visitors' stay was made as happy as possible when a convention has been held in Halifax. However, Edinburgh is large, the convention was large, and I am sure no one could ever say the atmosphere was unfriendly, or that the people of Edinburgh did not do their utmost to make us welcome and happy. They arranged everything down to the very last item. Things went off so well that not once did I hear a complaining voice. To accommodate all the scientific and social events that must of necessity be carried on at such a meeting, it was necessary to have these occur at various points in the city. One would think that there would be difficulty in finding these places, and when one did find them difficulty in getting transportation to and from; but there always appeared to be a bus or someone there to direct your way and show you, if necessary, by actually accompanying you to the area. It was not difficult at all to stop someone on the street and ask for information, and as soon as they saw your badge they went out of their way to be as helpful and co-operative as possible. This then is my high light of Edinburgh. The friendliness and helpfulness of all the Edinburgh people in making our stay one of the happiest conventions we have had.

W. R. C. TUPPER

The country, the homes and the Institutions presented an air of permanence that only the centuries can impart. The warmth of hospitality made one, at the same time, proud of being Canadian and happy that some Scottish ancestry could be claimed. Concerning the meeting itself, both its professional and social aspects were characterised by the utmost degree of unobtrusive attention to detail. At the massive banquet in Waverley Market and at the meetings of the Section in Cardiology, the ability of the British speakers to make themselves clearly heard without the distortions of an amplifying system was a welcome change.

No one who was there will ever forget the spine tingling sight and sound of the pipes, drums and band, and the sunset ceremonial at the Castle—the sheer perfection of which epitomised the entire week in Edinburgh.

L. C. STEEVES

In our Department the meetings were of a high order, but in no way the most singular I have ever attended. As the papers were delivered and the discussion progressed, one was left with the pleasant reassurance that the people of Nova Scotia are served by well-informed medical men. This, I feel, is the usual happy realization that most physicians enjoy at such a meeting.

The most impressive thing, even above the restrained grandeur of "Auld Reekie" herself, and even beyond the nearly impossible perfection of the out-sized formal dinner arrangements for the more than five thousand, was the incredible detailed attention given to the comfort and convenience of every delegate and family member. Within the hotels or in the places of assembly, or in the specially arranged pick-up-and-deposit transportation arrangements,

it was ever present and very real. This type of warm and personalized relationship will, for a long time, prove to be a very tangible target for any other medical convention, large or small.

D. K. MURRAY

(Editor's Note: An unsigned appendage to Dr. Murray's contribution suspected of having been perpetrated by Mrs. Murray, states: "Greatly appreciated the thoughtfulness of Kleenex furnishing unlimited supplies of all their wares.")

It is dangerous to ask a Scot to speak of his native land, particularly after a visit home; so I will merely tell you of one moment that will be mine forever.

It was high up on the esplanade of Edinburgh Castle, and beneath us the city was settling herself down for the night after a perfect Summer day. The castle as ever stood firm and stark against the sky, and there were many of us gathered there to see the Military Tattoo. Our two boys sat hugging their knees, excited at being up so late, and I too was curiously moved. Suddenly out onto the wide sweep of the floodlit esplanade marched a band of pipers, with a gentle wind stirring here a plume, there a plaid, and all the while the pipes crooned a lament that most surely broke my heart. This I will remember, and it is enough.

ANON.

To me the high lights of the B.M.A.-C.M.A. meeting were the following.

1. The terrific hospitality and generosity with which our British and Scottish colleagues welcomed us. As far as we personally were concerned, we were wined and dined from the first evening in Edinburgh until the last. As I said, this went to the point where concretely we had a bitter taste in our mouths at the end of the week; but in human relations terms the taste left by this tremendous hospitality was very sweet. Coupled with this was a great admiration for the efficient organization which particularly showed itself at the Waverley Market at which 2,500 people were fed without a hitch. When it is realized that the Waverley Market is the equivalent of our Halifax City Market and it actually served that purpose only a few days before, the tremendousness of the task that these people did can be appreciated.

2. Turning to the scientific programme, I, of course, was most interested in the psychiatric portion of this. It was unusual and I think indicative of modern medical trends to find that the speaker at the adjourned annual meeting of the British Medical Association was the noted Neuro-physiologist, Lord Adrian, who spoke on "Our Concern for the Mind." He discussed in a rather brilliant way psychiatric developments since World War I, attempting to bring together both the psychological and physical approaches to problems of human behaviour. Of most interest were his statements showing how little we really do know about behaviour in its relationship with the nervous system. He categorically stated that we still have no clear idea of what most of the brain does or of what part it plays in guiding our thoughts and behaviour.

3. The section on Psychiatry opened with a symposium on the teaching of Psychiatry in medical schools. This left little doubt that psychiatric teaching in British medical schools is much less developed than it is on this con-

tinent. For example, a survey of the Departments of Psychiatry in 25 British medical schools showed an almost complete reliance on the lecture form of teaching as follows:

Normal Psychology	—12 lectures with 4 demonstrations
Medical Psychology	—6 lectures
Psychological Medicine	—20 lectures and 10 clinical demonstrations, plus a small amount of time in the In-patient and Out-patient Clinic. Rarely was there any direct contact with patients.

In the section on Neurosurgery there was an interesting discussion on the place of lobotomy in psychiatric therapy, but a panel which included Dr. W. McKissop; a London Neurosurgeon, Dr. Walter Penfield; Dr. Alexander Kennedy of the University of Edinburgh, and Drs. Jim Tyhurst and Alan Walters of Canada. It was generally agreed by this panel that lobotomy was being used much less frequently since the introduction of tranquilizing drugs. Of particular interest was the opinion of the panel that lobotomy had no place in the treatment of psychogenic anxiety, and that the only form of neurotic illness in which lobotomy should be considered was a serious obsessive compulsive state.

R. O. JONES

For me, the highlights of the Edinburgh Convention were not the great dinner in the Waverley Market, the various splendid receptions, the garden party at Holyrood or the service at St. Giles. Impressive as these undoubtedly were, I remember better a whole afternoon when I played "hookey" and spent it seeing ghosts. I sat on the grass in the Princes St. Gardens and heard around me the pleasant Edinburgh voices of children playing. Above me white clouds sailed across the blue sky and appeared to almost touch the topmost turrets of the old Castle.

The ghosts I saw were old and new, but they all knew this spot. Bonnie Prince Charlie was there and Mary, Queen of Scots, James the Sixth and that Edwin whose borough it was. I saw as well the ghost of myself swotting Ian Aird's notes, and with more anxious countenance than ever poor Mary wore. Again I saw myself walking with my little boy, and I remembered the time when he listened to pipers and myself with equal appreciation. Here it was I bought him his first ice cream "slider." Here again I heard my first Air Raid Warning "for real," and once more I saw and heard the greatest of them all, Winston Churchill.

The other memories I like best are the little ones too. I remember coming out late at night into a Princes Street flooded with moonlight, and strolling hand-in-hand with Ruth Murray. How's that for a highlight!) What matter if my other hand was held firmly by my wife, or that Doug was on Ruth's other side with Gordon Mahaney and his fair lady as outriders? I remember too, watching the faces of Kit and Clarence Morrison as the Fishwives choir sang "Scotland the Brave"; and I won't forget Marg Corston and her competent abandon in dealing either with the Schottische at Montreux or insolent waiters in Paris. And for sheer terror and beauty what could compare with the ride down the Royal Mile with Arthur Marshall driving?

A hundred other memories there are, and how sorry I am for those who weren't there to share them.

W. E. POLLETT

I probably saw less of the United Kingdom than the other contributors to this article, as I was only away from home ten days. My stay in Edinburgh was enriched by being a guest of Dr. and Mrs. E. A. Cormack in their home. They made me feel like one of the family. They, and their son Jack, were deeply involved in the administration of the convention, and deserve a large measure of the praise which has been given by my co-authors. Through them I was "tipped-off" about the visit to Mellerstane House, which provided me with an extremely enjoyable afternoon. This "stately home" is the residence of the Earl and Countess of Haddington. The Countess is a Canadian by birth and a lady of exceptional charm. The house, and indeed the garden and entire estate, were conceived, designed and built by those architects and furniture-makers who have made the name of Adam so famous. The "first Adam" built one part of the house and the "second Adam" added to it at a later date. The gorgeously proportioned rooms, well thought out lighting, the beautiful ceilings, the "built-ins", which we think of as being so modern, the relationship of the house to its garden, the splendid panorama seen from the terrace at the back, stretching into the distance where a beautiful pond accented the scene, all these were combined into a satisfying and tasteful whole.

After leaving Edinburgh I visited Buxton for the meeting of the Heberden Society, which is the equivalent of our Canadian Rheumatism Association. Here, in a building which used to be the stable of the Duke of Devonshire, is a modern hospital for the treatment of patients with Arthritis who require long-term care. Some stable! It is topped by a tremendous dome, beneath which is a huge circular area of hardwood floor surrounded by stone pillars. This area is used for recreation, dining, therapeutic exercises and occupational therapy, by the patients and staff. Many rooms, of course, open from the corridor which surrounds this central hall, and as you will see it is a most unusual hospital. The presentations at this meeting were of extremely high calibre. One in particular excited my interest. Mr. Charnley, an Orthopaedic Surgeon, believes that he has found a plastic whose physical, chemical characteristics closely approximate the lubricating characteristics of human cartilage. He is using this material in hip joint arthroplasties.

You should have been here!

JOHN F. L. WOODBURY

Abstract

Vogelpeol L., Schrire, V., Nellen, M., Swanepoel, A.: **The Use of Amyl Nitrite in the Differentiation of Fallot's Tetralogy and Pulmonary Stenosis With Intact Ventricular Septum**: American Heart Journal: 57: 803-819, June 1959.

After referring to previous work demonstrating differences in auscultatory findings in severe instances of these abnormalities, the authors report on studies of 37 cases not sufficiently severe to give clear-cut criteria by auscultation. They indicate that the inhalation of Amyl Nitrite produces changes in the systolic murmur and the right ventricular pressures, which readily distinguish the two conditions.

L.C.S.

Achieving A High Standard of Hospital Care Under A Hospital Insurance Program The Responsibility of the Hospital Insurance Commission

G. G. Simms, M.D.

Delivered at the Hospital Insurance Institute, September 12, 1959.

The development and maintenance of high standards (of services) and reasonable and proper utilization of services is the **prime** responsibility of the Hospital Insurance Commission.

To develop and analyze this very categorical statement, it is first necessary to give some thought as to what we mean when we speak of "services."

Ordinarily, when we use the term "**services**" in connection with hospitals, we have in mind such therapeutic and scientific facilities as nursing, the operating-room, physiotherapy, the clinical laboratory, radiology, the pharmacy, the dietary department, etc. These might be described as the "direct services", and they are the obvious ones.

All too frequently we forget what we might call the "indirect services," e.g., the services provided by the Medical Record Department, the Accounting Department, the Maintenance Department, the Housekeeping Department, etc. These services are of very real importance to the patient—they are essential for his comfort and safety.

Having reviewed briefly the connotation of the term "services" as it relates to hospitals, it would appear in order to turn our attention to the nature and extent of the responsibility of the Commission in respect to these services.

The **nature** of the responsibility of the Commission is tripartite; i.e., the Commission has responsibilities to the Provincial Government (representing the people of the Province), to the Hospitals (for it is a hospital plan and we and the hospitals are partners in the plan) and to the Federal Government (with whom the Provincial Government has entered into a detailed and definite agreement).

The **extent** of the responsibility may be delineated, rather generally, by stating that the Commission, which is the body set up to administer the Hospital Insurance Plan, has as one of its functions, "to take all proper steps to develop and maintain a co-ordinated system of hospitals, training schools, and related health facilities throughout the Province." More specifically, the Commission ". . . shall act as a Provincial Standards Committee to insure, in so far as is possible, the development and maintenance of a high standard of hospital services and reasonable and proper utilization of hospital services in all (participating) hospitals in the Province."

At this point, we may say that we have described what we mean when we speak of hospital services, and we have outlined very briefly the nature and extent of Commission responsibility in regard to such services.

The next logical step is to review the program of the Commission in respect to standards and utilization.

The initial action of the Hospital Insurance Commission (or, more properly, the Hospital Services Planning Commission) was to set up an over-all plan for standards control, which had as its basic premise the concept that such control should be vested primarily with the hospital board. Such a concept seemed both ethical and eminently practical; the board of a hospital, as the "supreme authority" in the hospital, has "the legal and moral responsibility for the conduct of the hospital as an institution"¹, and it is an accepted duty of a hospital board "to see that proper professional standards are maintained in the care of the sick."²

The specific technique, whereby standards control was vested primarily with the hospital board, was to incorporate into the legislation a mandatory "**Hospital Standards Committee**" (with representation from the board, administration and medical staff) whose function was "to assist and advise the hospital board in developing and maintaining high standards of service and reasonable and proper utilization of services."

While it was always assumed as self-evident by the Commission that the medical staff would advise the Hospital Standards Committee on fundamentally medical matters, it was not the original intent of the Commission to recommend legislative provision for such a medical advisory group—it was considered unnecessary and probably getting a little bit too much to the "fine print" stage. However, at the rather urgent request of the medical profession, the Commission did recommend, and the Government did approve, the inclusion of a regulation making it mandatory that each Hospital Standards Committee have a **medical subcommittee** whose function was to "study matters primarily of a medical nature and to report and advise the Hospital Standards Committee on such matters."

Having in mind that the Provincial Master Plan for a co-ordinated system of hospitals called for a regionalization of hospitals, it occurred to the Commission that it would be profitable to set up a **Regional Standards Committee** to conduct studies, particularly relative to regional problems, and disseminate the fruits of their studies to the member hospitals in the region. Having in mind also that each hospital in the region was independent and "a peer in his own right," we thought it inadvisable to provide for any authority or regulatory powers in this regional committee.

As the Commission had an inherent right and duty in regard to standards and utilization of services, and as this right and duty could not be abrogated, the over-all plan also provided for a **Provincial Standards Committee** which would exercise, when necessary, an ultimate control.

Very obviously, if the Commission, as the Provincial Standards Committee, were to have the serious responsibility of being the ultimate authority in the control of standards and utilization, then it was imperative that it be well informed and well advised. With this in mind, the Commission employed on its staff **technical counsellors** in such fields as hospital administration, pharmacy, laboratory technology, X-ray technology, and accounting. It is the duty of these counsellors to assist and advise hospitals. To effect this, they visit hospitals periodically, and answer queries by correspondence.

In order that the very best professional advice would be available, outstanding **consultants** were appointed. Some 14 of these consultants, cover-

ing the major specialties in medicine, and nursing, form the **Professional Technical Advisory Committee**. The purpose of this committee is succinctly and aptly described in the regulations—"To assist the Provincial Standards Committee in carrying out its function . . ."

As a further measure to insure that Commission decisions were just and proper, there was legislative provision made for an "ad hoc" **Medical Review Board**. The function of this board was to report on any case when, in the opinion of the Commission, a doubt existed concerning the medical necessity for hospital services.

As is evident then, the first step was to recommend legislation that would, in the opinion of the Planning Commission, provide for an effective and proper control of standards and utilization.

To the very real gratification of the Planning Commission, the Government approved their recommendations and enacted legislation accordingly. The second step was for the Hospital Insurance Commission to put the standards control program into actual operation.

Although experience to date covers little more than the first six months of the Plan, a very brief review would seem to serve a useful purpose—always bearing in mind that it is hardly what might be called "statistically significant."

Hospital Standards Committees. A simple, brief questionnaire was sent out to the forty-seven¹ participating hospitals on July 27. Replies may be summarized as follows:

1. Only 6 hospitals (13%) had less than 3 persons on their hospital standards committees. However, one of these was a hospital recently opened and the other was a Federal hospital for which there is no "board" as such. Therefore it can be said that some 90% of the hospitals, after 6 months operation, met the requirements in this respect.
2. Twenty-three hospitals (51%) had regular semi-monthly meetings of the hospital standards committees.
3. Excluding six outpost hospitals with one doctor on the staff, 29 hospitals (74%) reported that their medical subcommittees were active. Of course, this means that 10 hospitals (26%) did not have active medical subcommittees.

As stated before, the period under study is too short to make valid deductions on the results of this questionnaire. Moreover, the onset of the Plan was a major episode in the evolution of hospital care in this Province. Notwithstanding this, one comment surely appears warranted: **failure of acceptance of responsibility at the hospital level can only mean lessened authority at that level.**

Regional Standards Committee

As time is short, and another presentation deals with the matter, I will refrain from commenting on the status of Regional Standards Committees.

Provincial Standards Committee

With respect to the Provincial Standards Committee, suffice it to say that it is active and has met on demand.

The Professional Technical Advisory Committee, since its organization during the early months of the Plan, met practically regularly on about

a monthly basis, up until the summer holiday season. In all, six meetings were held. It is expected that it will reconvene early in the fall; The Commission is appreciative of the outstanding service rendered by this Committee and all its consultants. It is in all sincerity not an exaggeration to state that without the service and guidance of its consultants, the work of the Commission to date would have been a virtual failure.

The **Medical Review Board** has visited four hospitals and, with one exception, the visits were most profitable and successful.

The **hospital counsellors** in their various fields, have been active, and we believe that their efforts have been appreciated by hospital boards and staffs. There is rather urgent need for a nursing counsellor and a dietician counsellor. It is hoped and expected that these posts will be filled in the near future.

In conclusion, it may be said that the Commission does have a very real and a very important responsibility in the achieving of a high standard of hospital care. Much thought was given to developing a plan to realize this achievement, that would place the maxim authority at the hospital level. It is to be sincerely hoped that gradually there will be full acceptance of the responsibility that of necessity must accompany such authority.

- (1) Standards for Hospital Accreditation of Joint Commission or Accreditation of Hospitals, Revised Jan. 28, 1956.
- (2) American Hospital Association, Code of Ethics
- (3) Two hospitals had not replied as of Sept. 17, 1959.

Abstract

Drug Utilization. Dr. J. B. MacDonald, Stellarton, N. S. Presented at the Hospital Insurance Institute September 22, 1959.

This paper deals with the "overutilization" of drugs in hospital. The question is dealt with under four headings: (1) Unnecessary prescribing. (2) Needlessly large dosage. (3) Continuance beyond the optimum period. (4) Prescribing an expensive preparation when a cheaper one would be as good or perhaps better. Illustrative examples are given.

It is suggested that many physicians do not sufficiently weigh these matters and, in particular, fail to do so in hospital situations where drugs are included under insured benefits. The statement is made that failure in this regard is intimately associated with dereliction in respect to history and note-recording.

A plea for more adequate teaching of therapeutic economics is combined with the suggestion that parallel studies of the comparative therapeutic value of certain common methods of treatment should be made. An example given involves the treatment of non-specific gastro-enteritis with simple antidiarrhoeal mixtures instead of "fancy antibiotic-antidiarrhoeal preparations." Another pits antipyretics against antibiotics in fevers of unknown origin.

The author believes that attention to the foregoing would result in worthwhile benefit to the patients and a considerable reduction in the cost of treatment.

Utilization and Standards of Laboratory Services

Abstract of a talk given at Nova Scotia Hospital Institute, September, 1959, by Dr. O. C. MacIntosh, Consultant in Laboratory Services Nova Scotia Hospital Insurance Commission.

In terms of units; the amount of laboratory services utilized for in-patients throughout the Province has been approximately 25% higher during the first seven months of 1959 than for the corresponding period in 1958. A proportion of this increase is probably due to continuation of the progressive increase in utilization of such services noted over the past number of years and a proportion may be due to increased hospital occupancy. It appears, however, that a large part of the increase may have been due to the institution of "hospital insurance."

Hospital statistics on the utilization of in-patient laboratory services per hospital patient day (Per diem utilization) give a more correct picture of utilization trends as the effect of increased bed occupancy is nullified. The use of this index also eliminates the effect of extension of laboratory services. An increase of slightly over 10% occurred in per diem utilization for the first six months in 1959 as compared to a similar period in 1958.

A comparison of the per diem utilization of laboratory services in hospitals over 50 beds and hospitals under 50 beds indicates that, in general, 50% more services are being utilized in the former than in the latter. That some of this increase must be due to increased availability of services in our larger hospitals and the more complex type of disease treated in them, is immediately apparent. However, sampling of utilization of laboratory services with similar diagnoses in both classes of hospitals indicates that the nature of the case treated does not provide the whole explanation.

A comparison of per diem utilization in our hospitals, graded by bed capacity, indicates that in general the larger the hospital the higher the per diem utilization of laboratory services. In addition it shows the larger the hospital the more pronounced the increase per diem utilization for 1959 as compared to 1958.

A programme for the evaluation of standards in our laboratories is in the initial stages of development. Preliminary results in the field of biochemistry are most discouraging, particularly those from our small hospitals.

Due to the increasing complexity of laboratory techniques, it is quite evident that the day is past when the nurse superintendent or the average staff physician can adequately supervise the work of the laboratory technician. Personal experience has shown that technicians particularly in smaller hospitals do not usually run any controls or standards with their tests and are thus without any check on the accuracy of their findings or the reliability of their techniques.

Smaller hospitals often purchase sub standard equipment and technicians in such institutions institute and maintain sub standard techniques without obtaining expert advice on these matters.

It is felt that any significant improvements in standards is dependent on further development and implementation of the regional concept of laboratory

services. This concept has been developed to the regional laboratory stage in the eastern end of our Province but little progress has been made in the west. However, little has been done in any part of our Province to ensure close co-operation between our smaller hospital laboratories and regional laboratories under the supervision of a qualified laboratory director.

It is only through the constant and dedicated attention of an experienced laboratory director that a modern laboratory operation can achieve and maintain a reasonable standard of accuracy. If we are to make significant progress in raising the standards of laboratory services in this Province provision must be made for each and every hospital large and small to ensure qualified supervision and direction of its laboratory services. This can be done by establishing regional laboratories in those areas where they are not at present available and making the services of pathologist directors available to all hospital laboratories to a degree commensurate with the requirements of the hospital concerned.

Abstract

Utilization of Radiological Services. H. R. Corbett, M.D., Sydney, N. S. Presented at the Institute, Nova Scotia Hospital Commission, Halifax, Nova Scotia, on September 22, 1959.

The speaker defined the insured radiological services with respect to two categories of patients, (a) in-patients who have complete coverage and (b) out-patients who have insurance coverage for certain specific examinations including gastrointestinal tract, gall bladder, genitourinary tract and fractures within forty-eight hours of injury. (It will be noted that insured coverage has been changed since the time of this report to include neurological examinations, chest, initial and follow-up examinations of traumatic cases and vascular examinations using contrast media.)

Statistics were presented indicating that prior to 1959 there had been an annual increase in radiological examinations of approximately 5%. The estimated increase in radiological examinations expected in 1959 when insured services were instituted was 15%. The actual increase in examinations during the first six months of 1959 compared with a similar period of 1958 was 25%. During the first half of 1959, there have been (1) a greater number of in-patient X-ray examinations due to increased hospital admissions, (2) a greater number of multiple examinations on the same in-patient, and (3) increased out-patient examinations, especially in accident and gastro-intestinal cases.

The speaker felt the out-patient coverage has lessened the demand for hospital beds.

He discussed the optimum work load of 9,000 examinations per radiologist yearly. There are in Nova Scotia, eighteen full-time radiologists with an annual work load of approximately 164,000 examinations, however in certain geographic areas such as Cape Breton, radiologists have a much higher work load than the provincial average. He suggested that the situation had been improved in Cape Breton by appointment of an associate radiologist in Sydney. Additional equipment and increased size of radiological departments are necessary. Bursaries providing financial assistance to student technicians have resulted in increased enrolment.

It was stated that the quality of radiological service can be affected by (1) too heavy work load on the radiologist, (2) lack of sufficient number of trained technical staff, and (3) lack of space and X-ray equipment. The speaker felt that the demand for unnecessary utilization of radiological services would level off during the ensuing year.

Radiation Protection – The Clinical Problem*

A. J. M. Griffiths, MRCS, LRCP.

During the last five years there has been growing awareness of the potential dangers of excessive exposure to ionising radiations to the future well-being of mankind. It is generally agreed that the immediate benefits to be gained by the use of diagnostic radiological procedures outweigh the genetic disadvantages, which in any case are likely to become apparent in future generations after we are safely out of the way and can no longer be brought to book. The section of the population which is at the greatest risk from radiation is the under 35 age group and the fetus in utero. It appears statistically that the bulk of our reproduction is achieved before the age of 35, although we can console ourselves with the occasional reports of gentlemen whose prowess or credulity enables them to become fathers even at a ripe old age.

Diagnostic Radiology has already done much to set its house in order by technical developments which have reduced the exposure required to achieve satisfactory examinations. Now, radiologists by and large deal only with referred patients and it is the clinician who does the referring. At the risk of ruining my own livelihood as a radiologist, I would like to make some suggestions to you about the ways in which you can help to reduce the number and extent of the X-ray examinations which are done, and thus play your part in preserving the quality of our descendants. For I am sure that there is still room for improvement and that substantial numbers of unnecessary examinations are being made on younger people. Of course, you may still keep the wolf from my door by referring the elderly for confirmation of your clinical acumen in the diagnosis of osteo-arthritis of the spine and other joints.

One of my teachers used to say that before ordering any laboratory or radiological examination it was essential to have a definite question in mind and alternative procedures mapped out in advance; if the result is positive, so and so will be done; if negative, such and such. The point I wish to make is that today there must be a good indication for an X-ray examination in the younger patients; it is no longer fair to use the Department as a means of temporising while minds are made up. The risks of this practice to unborn generations have been published. This brings to mind the assault which is made in some centers on patients with abdominal symptoms. A cholecystogram, barium enema and barium meal may be ordered as a routine, (indeed an I.V.P. may be thrown in for good measure if there is an aversion to urinalysis), and nothing further is done until the reports of all these examinations are received. I know these cases may be difficult, but in many instances we have a shrewd idea of where the troubles lies and can deal with that area first and call off the search if we strike oil first time. I prefer to forget the number of times I have seen gall stones demonstrated, but the cholecystogram followed by a normal barium enema and meal. I know a case can be made out for excluding a co-existing ulcer before doing a cholecystectomy, but what are we trying to exclude in such patients when we ask for a barium enema? We really should think seriously about this because the gonad dose is substantial. While we are on the subject of barium studies, there are two more matters which I would like to bring to your attention. First of all, whatever the DVA may say, I think the symptomatology is a better sign of healing of a duodenal ulcer than

*Paper read before Antigonish-Guysborough Medical Society, September 1959.

the radiological appearances. In other words, a recheck barium meal is not often justified.

Gastric ulcers are a different problem because, as we all know, medical treatment may give symptomatic relief for a time in carcinomatous ulceration. But then again it is the under 35 age group we are worrying about now and gastric carcinoma is more common later in life than that. It has been indicated by one English group that there is little to be gained by re-x-raying a patient with a known history of duodenal ulcer who has a recurrence of symptoms identical with those of his previous ulcer. If the symptomatology changes, then re-examination is justified to exclude cancer. The second matter I want to mention is the patient who shops around with his ulcer and has a barium meal ordered by each surgeon whom he consults. This character may raise his head more frequently in Nova Scotia now that out-patient barium meals are insured services. I have personal experience of one such individual who developed an erythema in the small of his back as the result of many views of his duodenal cap being taken over a three week period by several different Radiologists. I had the misfortune to be the last and there were some anxious moments before the affair was cleared up. Patients do not always tell the truth when asked when they last had a barium meal, but we can be on our guard.

This raises another point which is worth considering. How often are radiological examinations repeated un-necessarily when a patient is referred from a small to a larger center? I worked in the Ivory Towers for nine years before seeking the greener and more restful pastures of a small town and I know how often we were asked to confirm the findings of smaller institutions, even though perfectly good films and interpretations accompanied the patient in his travels. This practice was declining and being replaced by consultation between the surgeon and radiologist at the larger center, who together reviewed the referred films and the clinical findings before deciding on further work. I am sure that this is what should be done; it is therefore most important that a good case history, films and interpretations should be sent with all referred patients.

Having seen both sides of the battle, I would also suggest that those of us on the outside restrain our enthusiasm occasionally. For instance, we may have a patient with a lumbar disc protrusion who we know will be referred to a larger center for a neuro-surgeon's opinion. It is better to let the neuro-surgeon and the radiologist of his choice do the myelogram together rather than attempt the procedure ourselves, however competent we may be at the technique. The fluoroscopic findings are frequently very valuable to the neuro-surgeon and he may want to see these for himself, as well as the films which are all the radiological evidence we can send with the patient. A nice judgment is required on how much to do and how much to leave, but a little thought will often help reach the right decision in the interests of the patient.

Quite apart from patients who are likely to be referred away, we should perhaps pay more heed to the extent of the examinations which are requested in our own practice. As a radiologist, my hackles rise when I see a request for PA and lateral chest—just like that—with no indication for the lateral view, let alone any suggestion about whether a left or right lateral is desirable. The answer, to my mind, is to give some indication of what is being sought and leave it to the radiologist to order laterals if he sees good reason for them on the wet PA film. This implies the necessity for confidence in the judgment of your

radiologist and an atmosphere of consultation and not dictation. Those of us who enjoy such a situation are indeed blessed and our patients are very fortunate. If you do not have such a state of affairs in your Hospital, it is high time you did something about it. Remember that it takes two to make a quarrel and all the faults may not be those of the radiologist. It is by co-operation between the clinician and the radiologist that much can be accomplished in reducing unsatisfactory or unnecessary examinations.

I remember one occasion when I was a house-surgeon and with much aplomb diagnosed post-operative consolidation in the right lower lobe by inspection, palpation, percussion and auscultation and a glance at the temperature chart. To my mortification and the unconcealed delight of my Chief who did not confirm my clinical findings, the films showed no abnormality. The radiologist, however, restored my morale and wiped the grin off the face of the Chief by suggesting a repeat examination a day later; and there was the consolidated lower lobe in all its glory. This incident, of course, was a practical demonstration of what Brailsford has called the latent radiographic period, (March fractures and fractures of the scaphoid are other examples). You will notice that the patient had two examinations when only the second was of value. I am not suggesting that treatment should be delayed, but other things being equal, hold off chest X-rays for 24 hours if you are confident about that consolidation. Atelectasis will show up quickly, pulmonary embolism perhaps more slowly. If in doubt consult your radiologist. Proper timing may reduce the number of examinations performed.

We are all familiar with the fact that the radiological appearances of healing fractures are often more depressing than the clinical findings and yet we find some surgeons apparently unable to resist a weekly peep at the healing process, even through the overlying cast. Dare I suggest that apart from check of position on change of cast, followup films to show healing be deferred until you think that the time has come to remove the cast? An examination out of plaster is more valuable as a guide to healing and you may be tempted to leave the plaster on for an adequate time if you have to replace it when you have jumped the gun. Self discipline, so they tell me, is a wonderful thing.

The uses and abuses of diagnostic radiology in obstetrics is a rather specialized subject and one on which the most violent and extreme views for and against may be held. I am strictly neutral about pelvimetry and merely do my best to obtain accurate results with minimum radiation of the patient. If the obstetrician needs assistance in the management of dystocia, I think pelvimetry may help, especially at the mid pelvic level. In the present state of our knowledge, I do not think routine pelvimetries of all primigravida are justifiable. (In fact I would go further and question the desirability of any so called routine X-ray examinations.) What I would ask you all to bear in mind is that the first three months of fetal life is a highly dangerous period as far as irradiation is concerned and we should ponder carefully before conducting an X-ray examination on the abdomen of the expectant mother with an early pregnancy. If such examinations are indicated, the minimum number of films should be taken and fluoroscopy used very sparingly. As far as possible the pelvis should be excluded from examination. Once again a lot can be achieved if the surgeon and radiologist consult together and plan the attack. A single 15 minute film is often all that is needed for a satisfactory intravenous pyelogram and morning sickness and dyspepsia will usually pass without a barium meal. I hate seeing fetal parts as an incidental finding and enquiry into the menstrual cycle is usually part of the case history in younger women.

It is when we come to pediatric X-ray work that I really get worried over protection, and the smaller the child the worse the problem. It is much more difficult to confine the examination to the suspect area and all too often we are guilty of whole body radiation of babies. Young children are frequently uncooperative and repeat examinations may be needed before a film of diagnostic quality is obtained. I have been very grateful to my clinical colleagues when they have been thoughtful enough to order sedation for young patients before sending them to my Department, and I think more use might be made of sedatives, particularly before barium enema or pyelography. An X-ray machine is a pretty frightening thing on first acquaintance and children are rarely at their best in the strange surroundings of doctors offices, out-patient or X-ray departments. If sedatives are prescribed the dosage must be adequate; some children get quite intoxicated on a little nembutal. I have had some success when dealing with the really difficult child by having a dummy run at an examination and then sending him away for half an hour; on his return he is often much more manageable. Such a practice needs the forbearance of the clinician who is waiting for the result, especially if he has other urgent calls on his time. But we must be prepared to spend more time on pediatric examinations if we are to keep the radiation to a minimum. Incidentally, it is only being considerate if you have the chest X-rayed before the blood count. Laboratory and X-ray Technicians look much the same and no child is really well behaved after being punctured.

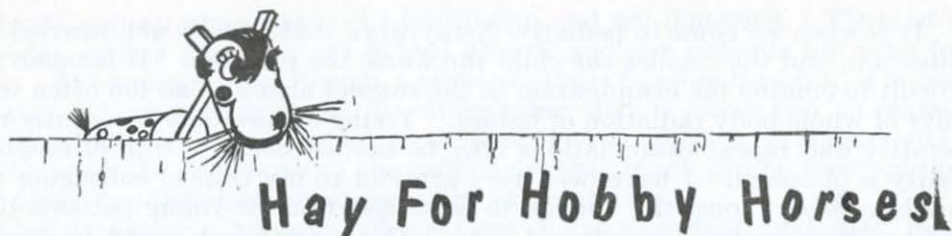
I hope that what I have said to-day is enough to remind you that the protection of the public from unnecessary exposures to radiation is quite as much your responsibility as it is the radiologists. The radiologists and the physicists and the equipment manufacturers have done a lot to cut down the exposure required to perform an adequate and satisfactory examination. But it is you who request the examinations and I venture to suggest that each of you with a little thought can play a part in the defence of the well being of future generations by using judgment and discrimination in the requests you make to the X-ray department. There is little doubt that all forms of radiation are double edged weapons and must accordingly be treated with respect.

Abstract

Zettner, A.: **Paradoxical and Knotted Embolism**: American Heart Journal: 57: 921-925, June, 1959.

For the development of a paradoxical embolism three conditions must exist: (1) embolus of venous origin, (2) open foramen ovale, and (3) reversal of the pressure gradient between the atria. After enlarging on these points, the author presents the case of a 55 year old negro woman who died suddenly after a thirty minute period of marked cardiac arrhythmia, and was demonstrated at autopsy to have massive bilateral pulmonary thromboses. The foramen ovale was occluded by an embolus consisting of two thrombi knotted together. While 51 case reports of paradoxical embolism were revealed by the author's review of the literature, this is the first instance of the knotting of two blood clots, there being one other instance of the knotting of a single clot.

L.C.S.



"A REQUIEM FOR A LITTLE RED CAR"

The Christmas after I became four years of age I was given the little red car. It was nine inches long and three and one-half inches high, cast iron even to the wheels. The car was a touring sedan perhaps an old McLaughlin-Buick, one of those in which celluloid windows were snapped into place when it rained. The car was fire-engine red and sturdy enough to stand up to the most energetic boy. This car was as much a companion to me as a play-thing. It travelled a million little-boy-miles over carpets, hardwood floors, along the arm and over the back of the leather chair, in and out between the legs of the dining room table, past the drafty French doors, across the tile in front of the fire place and disappeared into the dark jungle of the red velvet drapes. My little red car lasted throughout my entire boyhood and never lost its place in my affections despite other gifts that came after. It was an important part of my life for four or five years. My last memory of it was its slightly forlorn appearance when it was left too close to the fire place and the paint along one side had become blistered. I don't know what happened to it. I imagine it was given to a younger child after I had grown older.

The memory of that little red car brings back the excitement of those early Christmas mornings. The very air seemed to crackle and tingle with expectancy. My brother and I would awaken about 6.30 or 7 A.M. and sit wrapped in our bed-clothes in our twin beds almost writhing with suppressed excitement. We sat there in that cold room chattering like magpies about the surprises waiting downstairs. We would slip out on to the stairs and peer through the banister at the Christmas tree. There beyond the French doors lay a glistening tree with packages heaped around its base and smaller ones lodged among its branches. I do not even remember going farther than the French doors before breakfast was over. Even in that far-off day some concession was made to the anticipation and excitement of two small boys. Often we would find a preliminary gift left by Santa Claus on his departure. One Christmas we found a blackboard that we had asked for frequently since the previous July hanging on the back of the kitchen door at the foot of the stairs. We stayed at the blackboard from the time we came down until breakfast was ready. Thinking about it now there is an almost physical awareness of the difference in temperature between our room upstairs, the cold upstairs hall, the staircase and the warmth of the kitchen.

Christmas morning followed a firmly established ritual that was carefully observed by the children. We seemed to wait for an endless period until Mother went down to begin breakfast. Soon after we went down and, for one morning in the year, were seated at the table when breakfast was ready. Finally Father appeared wrapped in his faded green dressing gown with its tasseled cord. Twenty-five years later when my brother and I came out of

the Services this old dressing gown was still in use. Breakfast was a short excited meal eaten in view of the Christmas tree only partially hidden by the red velvet drapes. We scarcely knew what we were eating but at last when Father had finished his coffee we went in and took our places around the Christmas tree. My favourite spot was on the floor beneath the low front windows with my back pressed against the radiator. The next ten or fifteen minutes are all mixed up in my memory. Dad took the gifts from the tree at random and read out the names on the tags. At first we went up to receive them but finally they were passed or thrown to us. I tried to evaluate my gifts before I opened them. I wanted to open the least coveted of gifts first and save the real treasures until the last. In part, the reason was to prolong the excitement of the moment and partly to annoy my brother who always had his gifts open first. However, I did not pay complete attention to the gift I was receiving for I did not want to miss the reaction of Dad or Mother or Brother when they opened my small gifts to them. This was a family experience and even as a young child I realized that the magic time would have no meaning unless the whole family shared it.

Christmas seems so different now as I try to relive the festival in my own children. Looking back to those early Christmases between my fourth and eighth birthdays I seem to remember solid comforts despite a dim awareness of a threat of scarcity and deprivation current in the world outside. We had a few durable toys which were treasured because they were so keenly anticipated. They stood out in our minds clear of the distractions of abundance. We were lead to expect one "big" gift with a few minor or utility gifts. There would not have been a mass of glittering and expensive gadgets even if my father could have afforded them. The Christmas gift is a symbol. Whether the gift is large or small should not matter. If the spirit and atmosphere of Christmas is not present in the hearts of the family members the symbols, even in abundance, will not provide a true Christmas. My children seem so intent upon how much they are getting and so in competition with one another that I feel they miss much of the joy and magic of the Christmases I remember. Has all the warmth, mystery and good-will been gradually leached out of the Christmas festival since I was a boy?

Did the Halifax papers of some 35 years ago carry the symbol of Santa Claus in the advertisements in early November? When did the department store Santas begin to appear in this area? Why does the intense ballyhoo, the endless exploitation of the symbols of Christmas—(Santa Claus, the tree and the carols) begin so early? The purpose of this effort is to work the adults into a frenzy of buying and the children into a turmoil of anxious desire. I look forward to Christmas with foreboding. It is a time in which outside pressures arouse feelings of antagonism and resentment which undermine the true Christmas spirit. Did we have anything like the modern "curse of the Christmas card" 35 years ago. These gaudy impersonal "assembly-line" products have only the most meretricious of claims to our attention—that of novelty. Surely this is a pointless ritual, buying several hundred expensive cards and sending them without anything of ourselves. For many the chief claim to this recognition lies in the likelihood of their receipt of a similar card from you. If the gift without the giver is dead, then the whole Christmas card ritual has been dead from the beginning. I would much rather receive a short note on plain paper than the most ornate Christmas card ever conceived. I feel a pang of regret, almost resentment at having nothing from an old friend

except a card with a printed or hurriedly scrawled identification. The name may arouse faint memories of a happier time and this heightens one's resentment. The net effect of these cards is a feeling of unease and perturbation. One solution to this is to circulate a Christmas letter reviewing the past year's events. A duplicating service will do them up for you, decked in holly, for less than the cost of your cards. I have had such letters with a border which chronicled the doings of the family in amusing sketches. We can escape this bit of social hysteria which began with the best of intentions.

There is dissatisfaction with the present state of the Christmas Festival. The movement to restore this day to its former glory has for its motto "Put Christ Back into Christmas." This is a religious observance despite the overwhelming emphasis on material gifts and the punch-bowl. May I, faded and out-of-date tho' I am, make these suggestions for this Christmas and all of 1960.

Give more of yourself this Christmas. If you are all used up and have nothing of kindness, sympathy and companionship left—stop and recharge your stores of benevolence. Read whatever Mother read to you, to your own children this Christmas Eve, —the Christmas Carol or Mr. Pickwick's party with the Wardles is still charming stuff. Act as if Santa was really coming and, who knows, on Christmas morning he may leave his spirit 'round your hearth.

Seasons Greetings to All.

BROTHER TIMOTHY.

Abstract

Biorek, G.: **Social and Psychological Problems in Patients with Chronic Cardiac Illness**: American Heart Journal, 58: pages 414-417, September 1959.

Studying the social and psychological problems in a group of 223 cardiac patients in Sweden, the author and his social worker point up two deleterious trends in current medical practice. Regarding hospitalization he stated "The two most common complaints were: lack of rest in the wards, and lack of adequate information about their condition from the responsible physician, who generally appeared to have too little time to speak to the patients." Because of this fact—or perhaps it is an erroneous concept?—patients refrain from telling the doctors about their troubles and worries. Some of this information goes instead to nurses or social workers. I am personally afraid of this apparent tendency in the modern hospital, whereby the doctor becomes more and more of a technician, and the human relations with the patient and his family are delegated to other categories of personnel." The author closes by stating "In dealing with cardiac patients, much may be learned by listening to their heart with the stethoscope, but it may be even more important to listen to the patient himself, without a stethoscope."

L.C.S.

Personal Interest Notes

LOCAL NOTES

Cumberland Medical Society:

Dr. Norman Glen was recently reappointed District Commissioner, Amherst District of the Boy Scouts Association.

Dr. David Drury left November 25, 1959 to spend eight days in New York, accompanied by his son, Kenneth.

Dr. George Saunders recently visited friends in Saint John, Fredericton, N. B. where he met Dr. Moffatt, previously of Springhill, N. S.

Halifax Medical Society:

Dr. Arthur L. Murphy was recently awarded the Halifax Herald Trophy for the best drama written in Nova Scotia during the year. His play, "Call Me Michael" was a CBC-TV presentation.

November 4, 1959: First regular meeting of the Halifax Medical Society at the Victoria General Hospital Auditorium. The Clinical Program was a panel discussion on the topic of "Surgically Correctable Heart Disease." Members of the panel, chaired by Dr. W. A. Murray were: Drs. G. E. Davis, D. L. Roy, S. J. Shane, L. C. Steeves.

November 26, 1959: Victoria General Hospital Staff dinner was held at the Lord Nelson Hotel.

Tenders are being called for construction of the new addition to the Halifax Infirmary.

Dr. William Murray was re-elected president of the Dalhousie Medical Alumni Association at a dinner meeting held at the Lord Nelson Hotel. Dr. Murray Fraser, head of the nominating committee, brought in the same slate of officers as presented last year.

Western Nova Scotia Medical Society:

Dr. Gerald Belliveau, Yarmouth has recently returned from a short course on anaesthesia in Boston.

Dr. William Phinney, Dr. J. Balmanno, and Dr. George Buchn of Yarmouth, successfully reduced the deer and woodchuck population of Yarmouth County.

Dr. I. B. Barclay recently tendered his resignation as radiologist to the Yarmouth Hospital.

Tenders are being called for the construction of the new Yarmouth Hospital.

The Nova Scotia Society of Ophthalmology and Otolaryngology:

November 2, 1959: Combined meeting with the New Brunswick Society chaired by the president, Dr. L. F. Doiron, Digby. There were a large number of interesting case presentations which reflects the hard work of the secretary, Dr. C. F. Keays. A business meeting and several papers occupied the afternoon, including presentations by Doctors A. G. Shane, D. M. MacRae, E. I. Glenister.

University:

Dr. C. B. Stewart, Dean of Medicine, Dalhousie University has been made an additional Canadian member of the International Epidemiological Association. The Association which was started in 1954, consists of 90 members for 33 countries and is designed to facilitate informal communication between doctors who are engaged in full time teaching of Preventive Medicine. The appointment is a particular honour for Dr. Stewart and for Dalhousie University as there are only two members in the Association from Canada.

Births:

Dr. and Mrs. Frederick MacInnes, a daughter, Grace Maternity Hospital, Halifax, November 9, 1959.

Dr. and Mrs. D. F. MacLennan, a son, Grace Maternity Hospital, Halifax, November 25, 1959.

Dr. and Mrs. W. R. Siddall, a son, Eastern Shore Memorial Hospital, November 1, 1959.

Coming Meetings

January 13, 1960: Halifax Medical Society—Third Regular Meeting—Camp Hill Hospital.

Obituary

Doctor Victor Owen Mader, well known Halifax surgeon, died in the Victoria General Hospital, Halifax, on October 25, 1959, at the age of fifty-eight. A medical graduate of McGill University, post-graduate work in Vienna, Fellow and Member of Council of the Royal College of Surgeons of Canada, and Associate Professor of Surgery at Dalhousie University. He went overseas in 1939 as Commander of the 22nd Field Ambulance Company and returned in 1945 with an outstanding record as Commander of No. 7 General Hospital. His outside interest included membership in the Masonic Order, Scottish Rite, Past Commodore of the Royal Nova Scotia Yacht Squadron, Past President of the Charitable Irish Society and Charter Member of the Halifax Flying Club. Medicine has lost a fine surgeon, Halifax a fine citizen.

The Nova Scotia Medical Bulletin extends sympathy to Doctor E. T. Granville of Halifax and Doctor F. J. Granville of Stellarton, on the death of their mother, Mrs. Mary Granville, Halifax, on September 18, 1959: Doctor A. B. Crosby, Halifax, on the death of his mother, Mrs. Veronica F. Crosby, Halifax, on September 27, 1959, and Doctor J. J. Carroll of Antigonish on the death of his brother, Very Rev. F. L. Carroll, Rector of St. Mary's Basilica, Halifax, on October 2, 1959.

INFECTIOUS DISEASES—NOVA SCOTIA
Reported Summary for the Month of September, 1959

	NOVA SCOTIA				CANADA	
	1959		1958		1959	1958
	C	D	C	D	C	C
Brucellosis (Undulant fever) (044)	0	0	1	1	9	0
Diarrhoea of newborn, epidemic (764)	0	0	0	0	4	0
Diphtheria (055)	0	0	0	0	25	6
Dysentery:						
(a) Amoebic (046)	0	0	0	0	0	0
(b) Bacillary (045)	0	0	0	0	136	0
(c) Unspecified (048)	0	0	0	0	4	0
Encephalitis, infectious (082.0)	0	0	0	0	3	1
Food Poisoning:						
(a) Staphylococcus intoxication (049.0)	0	0	0	0	0	0
(b) Salmonella infections (042.1)	1	0	0	0	0	0
(c) Unspecified (049.2)	0	0	0	0	76	0
Hepatitis, infectious (including serum ^h hepatitis) (092, N998.5)	15	0	42	0	191	0
Meningitis, viral or aseptic (080.2, 082.1)						
(a) due to polio virus	0	0	0	0	0	0
(b) due to Coxsackie virus	0	0	0	0	0	0
(c) due to ECHO virus	0	0	0	0	0	0
(d) other and unspecified	5	0	0	0	281	0
Meningococcal infections (057)	1	0	0	0	15	14
Pemphigus neonatorum (Impetigo of the newborn) (766)	0	0	0	0	0	0
Pertussis (Whooping Cough) (056)	12	0	15	0	947	571
Poliomyelitis, paralytic (080.0, 080.1)	3	0	0	0	420	48
Scarlet Fever & Streptococcal Sore Throat (050, 051)	92	0	145	0	411	721
Tuberculosis:						
(a) Pulmonary (001, 002)	16	2	16	4	363	407
(b) Other and unspecified (003-019)	1	0	4	0	79	22
Typhoid and Paratyphoid Fver (040,041)	0	0	0	0	12	20
Venereal diseases						
(a) Gonorrhoea—						
Ophthalmia neonatorum (033)	0	0	0	0	0	0
All other forms (030-032, 034)	31	0	18	0	1032	1196
(b) Syphilis—						
Acquired—primary (021.0, 021.1)	0	0	0	0	0	0
—secondary (021.2, 021.3)	0	0	0	0	0	0
—latent (028)	0	0	0	0	0	0
—tertiary — cardiovascular (023)	0	0	0	0	0	0
— „ — neurosyphilis (024, 026)	1	0	0	0	0	0
— „ — other (027)	0	0	0	0	0	0
Prenatal—congenital (020)	0	0	0	0	0	0
Other and unspecified (029)	0	0	4**	0	150**	132**
(c) Chancroid (036)	0	0	0	0	0	0
(d) Granuloma inguinale (038)	0	0	0	0	0	0
(e) Lymphogranuloma venereum (037)	0	0	0	0	0	0
Rare Diseases:						
Anthrax (062)	0	0	0	0	0	0
Botulism (049.1)	0	0	0	0	0	0
Cholera (043)	0	0	0	0	0	0
Leprosy (060)	0	0	0	0	0	0
Malaria (110-117)	0	0	0	0	0	0
Plague (058)	0	0	0	0	0	0
Pssitacosis & ornithosis (096.2)	0	0	0	0	0	0
Rabies in man (094)	0	0	0	0	0	0
Relapsing fever, louse-borne (071.0)	0	0	0	0	0	0
Rickettsial infections:						
(a) Typhus, louse-borne (100)	0	0	0	0	0	0
(b) Rocky Mountain spotted fever (104 part)	0	0	0	0	0	0
(c) Q-Fever (108 part)	0	0	0	0	0	0
(d) Other & unspecified (101-108)	0	0	0	0	0	0
Smallpox (084)	0	0	0	0	0	0
Tetanus (061)	0	0	0	0	0	0
Trichinosis (128)	0	0	0	0	0	0
Tularaemia (059)	0	0	0	0	0	0
Yellow Fever (091)	0	0	0	0	0	0

C — Cases D — Deaths

**Cases not broken down

Note: One case of polio for the month of August—Cape Breton South—paralytic.

REMARKS:

There is one additional case of V.D.G. in the Lunenburg-Queens Division in the month of June.

PARALYTIC POLIOMYELITIS
CANADA, 1959

During the 37th week ending September 19, 99 cases of paralytic poliomyelitis have been reported compared to 139 in the previous week. Decreases are noticed in Newfoundland, New Brunswick, Quebec, Ontario and Manitoba. Nova Scotia and the three Western-most provinces show increases. The total number of cases reported to date is 969 compared to 131 for the same period last year.

It is interesting to compare the figures to September 19 for each Province with the year of highest total incidence in each province since 1950.

REPORTED CASES OF PARALYTIC POLIOMYELITIS
Year of Maximum Incidence since 1950

Province	1950 to Sept. 19	Year	Total Cases
Nfld.	95	1953	162
P.E.I.	2	1954	49
N.S.	1	1951	205
N.B.	28	1952	67
QUE.	656	1954	498
ONT.	101	1953	985
MAN.	17	1953	1480
SASK.	16	1952	447
ALTA.	22	1954	221
B.C.	20	1953	407

Poliovirus Isolations—5 Eastern Provinces

The following table shows the poliomyelitis virus isolations in cases and carriers, in 1959, to September the 19th. The six type 3 isolations in Nova Scotia were made from a 38 year old woman with bulbar poliomyelitis and her five sons ranging in age from 2 to 15 years. They had all suffered from minor illnesses some weeks preceding their mother's illness and at the time of taking anal swabs they were in good health. The mother had not been immunized. The boys had each received three doses of poliomyelitis vaccine.

POOIOVIRUS ISOLATIONS IN CASES AND CARRIERS—1959.
to September 19

	I	II	III
Newfoundland	56	—	1
Nova Scotia	1	—	6
New Brunswick	—	—	1
Prince Edward Island	—	—	—
Quebec	117	1	5

Source: Dr. V. Pavilanis, Chief, Virus Laboratories, Institute of Microbiology and Hygiene, University of Montreal.

Dr. C. E. van Rooyen, Associate Director, Section of Virology, Department of Laboratories, Department of Public Health, Halifax—Sept. 22/59.

NOVA SCOTIA MEDICAL BULLETIN

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Abbreviations used: — Ab. for abstract; anon. for anonymous; biog. for biographical note; C. for correspondence; C.R. for case reports; diagr. for diagrams; Ed. for editorial; Illus. for illustrations; Pers. for personal item; port. for portrait; rev. for review.

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