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# The NOVA SCOTIA MEDICAL BULLETIN

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## FINDING ONESELF IN MEDICINE

The motives that impel a man to choose medicine as a career are complex. The social scientist views them as a dynamic system made up of many components of unequal strength. The greater part of the driving force behind the individual as he enters medicine is incompletely understood by the student himself. The value of these psychic forces as a source of motivation in his future professional life depends on the individual's deepening insight, and as he matures, the student rearranges his early drives into a consistent and stable system of values. His success in this endeavor will determine the kind of doctor he will become; a man of expediency or a man of principle—the one a superior technician rooted in material values, the other something of a philosopher who conceives medicine not solely as a job or source of personal gain but as a way of life.

The young man who enters medical school comes from a highly competitive world that has a limited loyalty to the current religious standard. Part of his answer to the question "Why medicine?" is likely to reflect some of the conflict and inconsistency existing in modern society. The desire for a good living conflicts with the desire to aid suffering humanity. The motives characterized by "money" and "compassion" need not be mutually exclusive in the honest man, but the young are unlikely to be able to discriminate between them. The desire for money is born of an aspiration toward power, prestige and influence. The student's compassion may be an assumed attitude, rather than a feeling arising from his experience and thus an expression of his true self. He may acquire this attitude because his peers and his culture expect it of him, and it may make his drive for material success sit more comfortably on his conscience. In some, a yearning to play God may lurk beneath this very commendable feeling.

A third motive, that of curiosity, interest and a desire for knowledge is prominent in the student. One can accept this as a most important component of the dynamic complex called motivation. The desire to *know* is a deep, constant and abiding need in many human beings. The pursuit of knowledge for its own sake is the task of the scholar and scientist. Some of this zeal must possess the student-physician and compel him along the path of self-examination and criticism so that he may ultimately view his goals in their proper perspective.

If, at the end of five years of medical study, the young physician has reached a sufficiently high level of maturity, he will demand of himself certain definite standards without exhortation. The necessity of remaining a student, the importance of adequate medical records, the inherent dignity of the patient as a person, the refusal to foster dependence in his patient or to veer away from what he knows to be good medicine because he fears losing a patient—all these will be part of his medical creed and serve to strengthen him in the search for truth amid the weeds of his own small vineyard.

C.W.B.

# THE MEDICAL SOCIETY OF NOVA SCOTIA

NOVA SCOTIA DIVISION
OF
THE CANADIAN MEDICAL ASSOCIATION

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| Cumberland | D. R. Davies |
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| Chairman Medical Economics Committee | A. L. Sutherland |

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| Nova Scotia Society of Ophthalmology & Otolaryngology | E. I. Glenister |
| Nova Scotia Society of General Practitioners | A. G. MacLeod |
| Nova Scotia Chapter of College of General Practice | J. R. Macneil |
| Nova Scotia Division of Canadian Anaesthetists' Society | A. S. MacIntosh |
| Nova Scotia Association of Pathologists | W. A. Taylor |

## INDEX TO TRANSACTIONS

THIRD REGULAR MEETING OF EXECUTIVE COMMITTEE
FEBRUARY 1ST, 1960


Page No.

Annual Meeting 1960—Nova Scotia . . . . . 110
Annual Meetings, Future—Nova Scotia . . . . . 112
Applications for Membership . . . . . 109
Board of Directors—Maritime Medical Care Inc. . . . . . 110
Blue Shield—re Dental Service (fractured jaw) . . . . . 111
Blue Shield—re Circular letter inviting participation in Blue Shield Service Plan . . . . . 115
Call to Order—Roll Call . . . . . 108
Chairman's Opening Remarks . . . . . 108
Canadian Association of Medical Students & Internes (CAMSI) . . . . . 114
Canada Shipping Act . . . . . 114
C.M.A.—Annual Meeting Halifax 1965 . . . . . 112
—Nomination for Senior Membership . . . . . 115
—General Council 1960 . . . . . 112
—Report from Representative to Executive . . . . . 114

COMMITTEES
Budget . . . . . 114
Bylaws . . . . . 115
Civil Disaster . . . . . 112
Fees . . . . . 114
Finance . . . . . 114
Health Insurance . . . . . 113
Group Automobile Insurance . . . . . 112
Group Disability Insurance . . . . . 112
Legislation & Ethics . . . . . 114
Medical Economics . . . . . 115
Membership . . . . . 109
Prepaid Medical Plans—Atlantic Provinces . . . . . 111
Public Relations . . . . . 111
Traffic Accidents . . . . . 114

Currie, Mrs. M.G.—Retirement . . . . . 114
Electrocardiograms—Qualifications for interpretation . . . . . 115
Examinations for Total Disability Pensions . . . . . 108
Legal Counsel for Medical Society of Nova Scotia . . . . . 109
Medical Sub-Committees on Hospital Standards—Chairmen of . . . . . 116
Maritime Medical Care Incorporated—re Bylaws . . . . . 110
Minutes of Executive Meeting—October 26th, 1959 (2nd Reg. Mtg.) . . . . . 108
Adjournment . . . . . 116

## TRANSACTIONS

THIRD REGULAR MEETING OF EXECUTIVE COMMITTEE
THE MEDICAL SOCIETY OF NOVA SCOTIA

LORD NELSON HOTEL, HALIFAX

FEBRUARY 1ST, 1960 - 9.30 A.M.

The Meeting was called to order by the Chairman, Dr. D. I. Rice, at 9.45 a.m. Present were:—

| | |
|---|---|
| PRESIDENT: | Dr. W. A. Hewat |
| PRESIDENT ELECT: | Dr. F. J. Granville |
| IMM. PAST PRESIDENT: | Dr. H. J. Devereux |
| CHAIRMAN EXECUTIVE: | Dr. D. I. Rice |
| HON. TREASURER: | Dr. A. W. Titus |
| *EDITOR BULLETIN: | Dr. S. J. Shane |
| EXECUTIVE SECRETARY: | Dr. C. J. W. Beckwith |

**Representatives from Branch Societies**

| | |
|---|---|
| ANTIGONISH-GUYSBOROUGH | Dr. T. W. Gorman |
| CAPE BRETON | Dr. H. F. Sutherland—Dr. L. S. Allen |
| COLCHESTER-EAST HANTS | Dr. S. G. MacKenzie |
| CUMBERLAND | Dr. D. R. Davies |
| HALIFAX | Dr. D. M. MacRae |
| | Dr. A. M. Marshall—Dr. R. L. Aikens Alternate * |
| | *Dr. J. W. Merritt—Dr. J. S. Robertson Alternate |
| LUNENBURG-QUEENS | Dr. S. B. Bird |
| PICTOU COUNTY | Dr. M. F. Fitzgerald |
| VALLEY | *Dr. D. MacD. Archibald |
| WESTERN COUNTIES | *Dr. D. R. Campbell |

**Observers**

*Dr. R. O. Jones—Representative to C.M.A. Executive Committee
Dr. F. A. Dunsworth—Chairman for the Committee on Public Relations
Dr. A. L. Sutherland—Chairman for the Committee on Medical Economics
*—not present for evening session

(SECRETARY'S NOTE: This meeting had three sessions—9.45 to 12.45: 2 to 6.15 p.m.: 7.30 to 11.45 p.m. The Transactions are published in the order in which the items were taken up at the meeting).

The Chairman welcomed Dr. T. W. Gorman as representative for Antigonish-Guysborough. He replaces Dr. A. J. M. Griffiths who had resigned as representative due to change in residence.

He also remarked on the lengthy Agenda, stating that this had led to its re-organization under seven headings. He stated that some of the material for the meeting had arrived as late as January 29th. This will be distributed to the meeting.

The Chairman then made reference to the recent deaths of Dr. V. O. Mader, Dr. David Morris, Dr. W. G. Colwell and Dr. H. O'Brien, stating that the Society had expressed sympathy and forwarded wreaths.

**Minutes of the Executive Meeting—October 26th, 1959**

These were regularly moved and seconded for adoption as distributed—carried.

**Total Disability Pension Examinations—Dept. of Welfare of Nova Scotia**

The item had been referred from the Executive Committee meeting of October 26th, 1959. The opinion was expressed that the present system leads to considerable misunder-

standing between patient and physician from which the physician frequently finds himself embarrassed. It was emphasized that the terms of the Act require that a patient be *totally and permanently disabled* before being eligible for pension; inability to work is *not* a criterion.

It was thought that the whole subject required clarification with the Department of Welfare. To this end it was regularly moved, seconded and carried that:—

"A letter be sent to the Old Age Assistance Board suggesting that all applicants for total Disability Pension be first interviewed by the local Welfare Department and that the Welfare Department only, refer these potential pensioners to:—

(a) Travelling Pension Examination Clinic, or

(b) Pension examiners appointed by the local County Medical Society (these appointments to be for short periods to distribute the workload)

Consideration be given by the government agency to paying for this examination."

**Legal Counsel for Medical Society of Nova Scotia**

The Chairman stated that arrangements authorized by the Executive on October 26th, 1959, had been made with a local legal firm whereby legal services would be available on a retaining fee basis plus fee-for-service for special matters. He requested a motion approving this for the sake of the record—this was done.

**Membership Committee**—Chairman Dr. D. M. MacRae

The membership of this new Committee is as follows—

Dr. D. M. MacRae—Chairman
Dr. A. M. Marshall
Dr. J. W. Merritt
Dr. J. S. Robertson
Dr. F. A. Dunsworth

The recommendations of the Committee are:—

(1) Re Corresponding Members: The Secretaries of each Branch Society to be a corresponding member.

(2) Re the Terms of Reference: That the Committee should strive to have all eligible medical doctors as members of the Medical Society of Nova Scotia and the Canadian Medical Association; that it should accept all duties referred by the Executive; that it should be available to the Executive Secretary for consultation on current problems of membership.

(3) That "members unable to claim fee (membership) as Income Tax deduction" should have applied to their membership the same proportion reduction as the C.M.A. is prepared to offer. This is 14/20 or 7/10ths of the membership fee and would work out to be $35.00 for the Medical Society of Nova Scotia and $14.00 for the C.M.A., giving a total of $49.00. The post-graduate levy would be added to this ($5.00).

(4) That the interpretation of "First Year Practice" and "Second Year Practice" be the first or second year of practice in Nova Scotia. (The present interpretation is that it is related to time of graduation).

(5) That the Executive be requested to send a directive to the Nominating Committee of the Annual Meeting that it recognize the valuable contribution which salaried physicians, who are members of the Society, can make to the affairs of the Society.

The report was regularly moved and seconded for adoption; after discussion the motion was carried.

**Applications for Membership in Medical Society of Nova Scotia**

The following applications received in the interval since the meeting of October 26th were, on motion, accepted by the Executive Committee:—

(1) BURRIS, John McCurdy, Elmsdale
(2) JOHNSTONE, Dennis Walter, Post-graduate
(3) SHULMAN, Sydney Solm, Sydney

(4) COOK, George H., Truro
(5) KELLY, Edward G., Amherst
(6) GRIEVES, John K., New Glasgow
(7) SCOTT, Anthony F., Yarmouth

**Annual Meeting—1960—White Point Beach Lodge, Queens County**

The General Chairman, Dr. W. A. Hewat, gave a verbal progress report outlining plans for the programme. Housing Application Forms will appear in the March issue of the Bulletin. A social registration fee of $10.00 was approved.

**Letter from M.M.C. Inc. Re Bylaws of Maritime Medical Care Inc.**

Background: The present Bylaws of Maritime Medical Care Incorporated call for a Board of Directors of fourteen members of whom three are laymen and eleven are physicians. These eleven physicians are appointed by Branch Societies and the appointment "confirmed or rejected" by the Executive of the Medical Society of Nova Scotia. At the Annual Meeting of Maritime Medical Care Incorporated, the Board of Directors elect from their members one physician who will be President of the Corporation for the ensuing year.

A request from Maritime Medical Care Inc. in the fall of 1959 requested that the Bylaws be reviewed because the election of a Branch representative to the presidency interfered with voting powers on the basis of representation. The Committee on Bylaws of the Medical Society of Nova Scotia reviewed this request and found that the Bylaws of Maritime Medical Care Inc. provided that the President would have one vote on any matter under discussion and if there were a tie vote that he would have the privilege of a second vote to break the tie.

Maritime Medical Care Inc. was so informed. The Committee on Bylaws expressed the opinion that there was no reason to change the Bylaws on the basis of the request.

The matter was further debated at a subsequent meeting of Maritime Medical Care Inc., the result of which had been a communication from Mr. D. C. McNeil relative to the subject.

The intent of Maritime Medical Care Incorporated is to protect the office of the President of the organization and to make that office as impartial as possible. If the President is in the position where he must express the views of the Branch Society which he represents then the office which he holds is not an impartial one. In order to maintain the Presidency as an impartial office, it is the desire of the Board of Directors that the Bylaws be reviewed with the intent of changing them so that another representative will be nominated from the Branch Society from which the President has been elected. If this is to be done, the right of the President to vote on every question would be removed but he would continue to have the privilege of a tie breaking vote on issues.

The subject had been referred to the Committee on Bylaws (Dr. H. J. Devereux); it had been recommended to the Executive Committee for discussion. After discussion it was moved and seconded that:—

> "The President of Maritime Medical Care Incorporated shall be replaced (on the Board of Directors) by a voting representative from the President's Branch of the Medical Society of Nova Scotia. The policy to be reviewed in one year." Carried.

**Branch Representatives to Board of Directors—M.M.C. Inc.**

The Secretary stated that the five Branch Societies required to submit nominations had been written; that to date nominations had been received from two:—

Halifax Medical Society — Dr. J. Murray Fraser
Dr. MacD. Corston
Western Counties — Dr. D. J. MacDonald

Nominations were to be received from Lunenburg-Queens, Antigonish-Guysborough and Cape Breton Medical Societies. The Executive Committee has ". . . . the right to approve or reject any nomination. . . ." and it is required that ". . .all members (of the Board of

Directors) appointed by the Executive shall be forwarded to the Secretary of M.M.C. Inc. . . . on or before the second day of April each year."

It was moved and seconded that:—

"Nominations to Maritime Medical Care Incorporated Board of Directors presently available and nominations forthcoming from Branch Societies be accepted."

Carried.

**Communication from Blue Shield Re Dental Services in the Treatment of Fractured Jaw**

This communication requested an expression of opinion as to whether such services should be provided under a medically sponsored prepaid plan.

Discussion resulted in the following motion being moved and seconded:—

"Prepaid Medical Plans pay only for services rendered by medical men"

Carried.

**Prepaid Medical Plan for Atlantic Provinces**—Chairman Dr. A. A. Giffin

The Committees from the three Medical Societies of New Brunswick, Prince Edward Island and Nova Scotia met in Moncton December 6, 1959 to open preliminary discussions on a possible Prepaid Medical Plan for all the Atlantic Provinces.

The Minutes of this meeting as recorded by our Executive Secretary, Dr. Beckwith, constitute an accurate, succinct summation of the discussion and action taken, and as such, constitute the official report of the Nova Scotia Committee.

Comment is directed to three points:—

(1) The provision in New Brunswick for two fee schedules, the one for contract and the other for private practice. The danger of the lower contract fee becoming the overall fee under a provincial insurance scheme under whatever auspices is clear.

(2) The suggestion that a third party, such as the Blue Cross-Blue Shield organization, should administer the plan, and in effect set a fee schedule outside of direct Provincial Medical Society control, should be cautiously examined.

(3) The fact that Health Matters are a provincial responsibility; and therefore it may be wise to preserve Provincial Medical Society autonomy.

On request, Dr. Beckwith made remarks on Dr. Giffin's report. This meeting of the Committees from the New Brunswick, Prince Edward Island and Nova Scotia Medical Societies had been exploratory. There had not been a committee from Newfoundland. The decision had been that any one of the Committees could request further meetings at any time.

Dr. Devereux remarked that there is value in these discussions. Further discussion resulted in the following motion:—

"That the study of Prepaid Medical Plan for the Atlantic Provinces be kept alive by having it brought forward to the next Executive Meeting."

Carried.

**Committee on Public Relations**—Chairman—Dr. F. A. Dunsworth

Dr. Dunsworth requested authority to proceed with the publication of the now final editing of the pamphlet "Information for Patients". Quotations for printing had been obtained and the approximate cost would be $300.00 for 20,000 copies. After further explanation and discussion it was moved and seconded that:—

"We approve the pamphlet "Information for Patients" and approve the printing of 20,000 copies for free distribution to members of the Medical Society of Nova Scotia. Further copies requested by members to be charged for at cost."

Carried.

Dr. Dunsworth reported that the A.M.A. film "I am a Doctor" had been reviewed by several groups including principals of High Schools and representatives of Vocational Guidance. The opinion had been that it was not suitable for purposes of recruitment for Medicine at the High School level.

**Future Annual Meetings—The Medical Society of Nova Scotia**

Dr. Rice presented a preview of Annual Meetings from the standpoint of location and dates. It was correlated with known dates of the C.M.A. up to and including 1965. The necessity of advance bookings was emphasized. It was agreed that the locale for the 1961 meeting would be explored by Dr. F. J. Granville, President-Elect, in consultation with the Pictou Medical Society. It was also agreed that locale for the 1962, 1963 and 1964 meetings be explored by the Secretary.

**Annual Meeting—Canadian Medical Association in Halifax 1965**

Resulting from a letter from the General Secretary of C.M.A., the Chairman asked for a motion formally inviting C.M.A. to have the Annual Meeting for 1965 in Halifax. It was moved and seconded that:—

"Canadian Medical Association be invited to hold the Annual Meeting in 1965 at Halifax, the Nova Scotia Division to be the host Division."

Carried.

**General Council, C.M.A.—June 13th & 14th 1960—Banff**

The Chairman introduced the subject of representation from the Nova Scotia Division to General Council of C.M.A. This Division is entitled to nine representatives, five of whom are the officers. Time and expense involved in going to Banff and the proximity of our own meeting on June 25th (for Executive) makes representation more difficult this year. Financial assistance has been offered by this Society to the extent of $100.00. The subject of financial assistance is being studied by a C.M.A. Committee. It is important that our representatives have knowledge of affairs in the Division and at C.M.A. level. A survey was made of those present as to who planned to attend. A report will be made to the Executive Committee Meeting.

The meeting recessed at 12.50 p.m. for lunch to reconvene at 2 p.m.

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The meeting reconvened at 2.10 p.m.

**Automobile Insurance**—Chairman—Dr. J. W. Merritt

Dr. Merritt reported that he had looked into the matter of group automobile insurance and the only way it could be accomplished was by fleet ownership of cars by The Medical Society of Nova Scotia. All members would have their cars registered in the name of the Society in order to come under a fleet type of insurance. The premium assessment could not be ascertained until after one year's experience. He recommended that the enquiry be discontinued. Dr. Merritt then moved adoption of this report, which was seconded and carried.

**Civil Disaster**—Chairman—Dr. J. W. Merritt

Dr. Merritt presented this report. He said a request had been made by Dr. A. R. Morton to appoint five local members to work on Civil Disaster in the Halifax area; from the Victoria General Hospital, the Children's Hospital, Camp Hill Hospital, Halifax Infirmary and Dartmouth. This had been done. Dr. Morton had agreed to act on our committee. Dr. Merritt suggested that the representatives from Branch Societies to the Executive Committee see that each Branch has a committee to organize Civil Disaster in their respective areas and that each representative be a member of the central committee of this Society. He then moved that the report be adopted, which was seconded. Motion carried.

**Group Disability Insurance**—Chairman Special Committee—Dr. J. W. Merritt

Dr. Merritt reported that discussions with the Continental Casualty Company had continued in the interval since the last Executive meeting and that Mr. J. R. Carr, a Company representative, is present at this meeting.

Mr. Carr gave a background of the experience of his Company. He outlined the conditions required as a basis for application from this Society for "take-over" of the group

presently participating in Group Disability Insurance as well as new applicants. A brochure was presented outlining a *flat-rate* premium plan covering accident and sickness. Plan A being for lifetime accident—2 yr. sickness 1st and 8th day. Plan B being for lifetime accident—5 yr. sickness 1st & 8th day. He stated that the Committee had recently requested information on a *step-rated* premium for these 2 plans as well as information on plans which would start on the 31st day of disability.

After extended discussion it was agreed that all information requested be forwarded to Executive Committee members to present to their Branch Societies.

It is to be noted that the present Group Disability Contract continues with Union Mutual through Blaker Hearns & Co.

**Committee on Health Insurance**—Chairman—Dr. C. B. Stewart

Dr. C. B. Stewart, Chairman, Dr. C. M. Jones, President of the Nova Scotia Association of Radiologists and Dr. D. R. S. Howell, Chairman of the Committee on Fees were present.

Dr. Stewart reported that his Committee, as directed by the Executive on October 26th, 1959, had studied the Brief presented by the Nova Scotia Association of Radiologists to that meeting. He reviewed his report which concluded with the following recommendations:—

(1) That the principles and concepts relating to remuneration of physicians providing insured services, as previously enunciated and approved by the Society and as contained in this report, be reaffirmed.

(2) That the Health Insurance Committee should not be responsible for proposing or preparing specific plans for the remuneration of any group of the medical profession, but only for considering whether the plans or proposals of various specialty groups fit into the general pattern or concepts enunciated by The Medical Society of Nova Scotia and The Canadian Medical Association and thus protect the future of the profession as a whole.

(3) That the plan proposed by the N.S.A.R. in its brief should not be supported by the Medical Society because it does not adhere to these concepts.

(4) That any optional plan which may be presented by the N.S.A.R. and which does incorporate these principles and concepts be supported by the Medical Society.

(5) That the Medical Society recognize the right of any individual radiologist or group to negotiate remuneration according to plans other than that approved by the Medical Society on the distinct understanding that if such a plan does not incorporate the principles and concepts of the Medical Society, no support or help in such negotiations would be provided by the Society.

The report, which also included a supplementary report on a letter from The Nova Scotia Hospital Insurance Commission, was moved and seconded for adoption. Discussion included the following:—

(1) Presentation of Resolutions from the following Branches
    Cumberland Medical Society
    Cape Breton Medical Society
    Halifax Medical Society
    Valley Medical Society

(2) Presentation of a Resolution from the Committee on Fees.

(3) Remarks by Dr. C. M. Jones

(4) A letter from the President of The Nova Scotia Association of Pathologists which indicated that the Pathologists are following the recommendations of The Medical Society of Nova Scotia.

(5) Questions from members of the Executive Committee.

(6) Extended discussion by the Executive Committee.

The Chairman of the Executive requested the meeting to decide whether to adopt the report of the Committee on Health Insurance or to recommend to the Annual Meet-

ing 1960 the adoption of the proposals included in the Brief from the N.S.A.R. (October 21st, 1959).

The motion for adoption was called for and carried: 12-2.

**Report of Representative to Executive of C.M.A.**—Dr. R. O. Jones

Moved and seconded that this report be adopted—Carried.

The meeting recessed for dinner at 6.20 p.m.

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The evening session convened in the East Seminar Room of the Dalhousie Public Health Clinic at 7.30 p.m.

**Committee on Legislation & Ethics**—Chairman—Dr. D. F. Smith

The report is of an interim nature and for information. Moved and seconded that the report be adopted. Motion carried.

**Traffic Accident Committee**—Chairman—Dr. A. L. Murphy

This report is of an interim nature and was adopted.

**Canada Shipping Act & Sick Mariners' Service**

The Secretary reported that only two members of the Executive had forwarded comments following discussions with physicians in their Branch Society; the Secretary of The Halifax Medical Society had sent in comments from his Branch Society.

The C.M.A. Executive had considered the subject at the November meeting when the following resolution had been passed:—

> "That a communication be sent to the Federal Government with regard to the Sick Mariners' Service requesting revision in administration, comparable to other medical services in this country, to facilitate the identification of persons eligible for treatment; that such communication include an expression of our concern that one segment of Canadian citizens has available to it an essentially free medical service at the expense of the Canadian tax-payer".

**Retirement of Mrs. M. G. Currie**

This had become effective on December 31st, 1959. Approval of the Executive Committee was given to the presentation made on behalf of the Society.

**Canadian Association of Medical Students & Internes (CAMSI)**

Approval was given for the Executive Secretary to meet with local representatives of this Association to discuss matters of mutual interest.

**Committee on Fees**—Chairman—Dr. D. R. S. Howell

This report was in the form of a resolution relative to a new Schedule of Fees proposed by the N.S.A.R. for Diagnostic Radiology. After discussion it was regularly moved and seconded:—

> "That the report of the Committee on Fees be referred back to that Committee for reconsideration in view of the fact that the Executive of The Medical Society of Nova Scotia has adopted the report of the Committee on Health Insurance on February 1st, 1960."

Carried.

**Reports of Budget and Finance Committees**—Chairman—Dr. J. A. Charman

These reports were presented by the Hon. Treasurer Dr. A. W. Titus. The Executive Secretary and recording Secretary were asked to retire during presentation and discussion.

Both reports were adopted and will be presented to the Annual Meeting.

**Communication from Blue Shield Addressed to Physicians in Nova Scotia Re Participation in Blue Shield Comprehensive Medical Service Plan**

The Chairman stated that there had been an immediate adverse reaction to this invitation to become participating physicians; that resolutions had been received from The Valley Medical Society, from Maritime Medical Care Inc. and from a group of eight physicians in Halifax. It was remarked that many physicians do participate in Blue Shield *Indemnity* Plan. However, the conditions for participation in the Blue Shield *Service* Plan were such that the Executive Committee should express an opinion re participation.

It was regularly moved and seconded

"That a letter be sent to all members of The Medical Society of Nova Scotia expressing disapproval with the recent circular letter from Blue Shield—Blue Cross inviting participation in the Blue Shield Comphrehensive Service Plan and recommending that the members refuse to become participating physicians."

Carried

**Committee on Medical Economics**—Chairman—Dr. A. L. Sutherland

Dr. Sutherland referred to that portion of his report dealing with the Agreement between The Medical Society of Nova Scotia and the Department of Welfare concerning medical services to the "Welfare Group". He requested authority to review the agreement in the light of experience during 1959. It was moved and seconded:

"That the Committee on Economics continue their efforts with Government to have the grant increased for care of welfare group".

Carried.

**Committee on Bylaws**—Chairman—Dr. H. J. Devereux

Amendments to the Bylaws proposed by the Committee were explained and discussed in detail. These were designed:—

(1) To clarify the status of Branch Societies (geographical) and Affiliated Societies.

(2) To provide the Executive Committee with disciplinary action and to provide for the formation of a Disciplinary Committee which will have authority to make enquiries when such are required.

(3) To clarify the voting privilege of the Hon. Treasurer.

The report was moved and seconded for adoption.

Discussion: A letter from a member expressed the view that "Sections" would be preferable to "Affiliated Societies" to identify groups with special interests and training. This was recognized by the introduction of the term "Sections" along with "Affiliated Societies". Further study is to be given to the subject.

A motion for adoption of the report as amended was carried.

It was also moved, seconded and carried:

"That changes be made in the Bylaws according to the adopted report of the Bylaws Committee as of February 1st 1960."

This is a Notice of Motion to refer these amendments to the Annual Meeting 1960.

**Qualifications for Interpretation of E.K.G.'s**

The Chairman referred to the report of the Committee on Health Insurance. It was there stated that only five replies had been received from members of the Executive in response to a request from the Health Insurance Committee to express the views of physicians on the subject in the respective areas.

Following review and discussion, it was moved and seconded:—

"That the Health Insurance Committee be asked to continue its study of the problem of E.K.G.'s and take appropriate action. The resolution and discussion at this meeting should be made available to them."

Carried.

**Senior Membership—Canadian Medical Association**

Dr. M. R. Elliott, Wolfville, was unanimously chosen as the nominee for 1960 from the Nova Scotia Division for Senior Membership in The Canadian Medical Association.

**Chairman of Medical Sub-Committees of Hospital Standards Committees**

A communication drew to attention that when meetings of this group of Chairmen are called in Halifax the physician has to leave his practice. It was agreed to write The Nova Scotia Hospital Insurance Commission relative to this subject.

On motion the meeting adjourned at 11.45 p.m.

C. J. W. BECKWITH, M.D.,
Executive Secretary.

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# THE OBSTETRICAL EMERGENCY TEAM

On behalf of the Medical Society of Nova Scotia, the Committee on Maternal and Child Welfare has announced the availability of the Obstetrical Emergency Team. This service was instituted as of April 1, 1960, and all the doctors in Nova Scotia have received a letter announcing the plan and explaining the functions of the Team.

The Medical Society of Nova Scotia received an outline of the plan and a recommendation for its institution, from the Committee on Maternal and Child Welfare, and approval was given at the Annual Meeting in 1959. Through the co-operation of the Department of Health of Nova Scotia, the Red Cross Society and the Departments of Obstetrics and Gynaecology and Anaesthesiology of the Dalhousie School of Medicine and the Victoria General Hospital, the Obstetrical Emergency Team is now a reality.

The Obstetrical Emergency Team is available to any doctor in Nova Scotia in any obstetrical emergency to provide consultation or actual treatment services. Twenty-four hour telephone service, in Halifax, makes it possible for the Team to be reached at all times. In the event of extreme emergency, especially to the more distant points in the Province, the Armed Services are co-operating to provide air transport.

The Committee would like to thank the many different departments and individuals who have assisted in the organization of this service to the doctors of Nova Scotia.

If there are any questions concerning this project, they may be addressed to the Chairman of the Maternal and Child Welfare Committee, c/o The Obstetrics Office, Room 122, The Grace Maternity Hospital, Halifax, N. S., and every effort will be made to answer all inquiries.

M. G. TOMPKINS Jr., M.D.,
Chairman,
Committee on Maternal and Child Welfare.

# INFANTILE NUTRITIONAL DEFICIENCY OF VITAMIN C and IRON IN NOVA SCOTIA*

G. NIGRIN, M.D. and W. A. COCHRANE, M.D., F.R.C.P.(C)

*Halifax, Nova Scotia*

The prevention and treatment of scurvy and iron deficiency anaemia in infants and children has been known to the medical profession for many years. The recent alarming increase of cases admitted to the Children's Hospital, Halifax, suffering from scurvy and iron deficiency anaemia has stimulated the authors to report the clinical, radiological and biochemical findings in ten cases of scurvy and review the problem of iron deficiency anaemia.

That the occurrence of such cases represents a public health problem in Nova Scotia cannot be denied. A great deal of the responsibility for the prevention of such disorders rests with the family physician who must inform and impress upon his patients the importance of proper nutritional habits. He must also be constantly aware that certain non-specific symptoms such as poor appetite, irritability, listlessness, disinterest, recurrent fever, constipation, and vomiting may be due to some qualitative nutritional deficiency.

## Scurvy

This disease entity is due to an insufficient intake of ascorbic acid and was clearly described by Sir Thomas Barlow in 1883. The knowledge that fruit juices will prevent scurvy has been known for over 300 years when English seamen ingested lime juice for the prevention of this disorder—resulting in the reference to English sailors as "limeys."

A review of the records of the Children's Hospital, Halifax, reveals that an average of 3 to 4 cases a year of scurvy have been admitted over the past 10 years. From October 1959 to December 1959, ten frank and severe cases of scurvy have been seen at the Children's Hospital—a marked increase. The ages and the presenting symptoms have been included in Table I and II. The ten patients lived in an area surrounding Halifax, including Walton, Enfield, Tufts Cove, East Jeddore, Terence Bay, Dartmouth and Halifax, and also Digby.

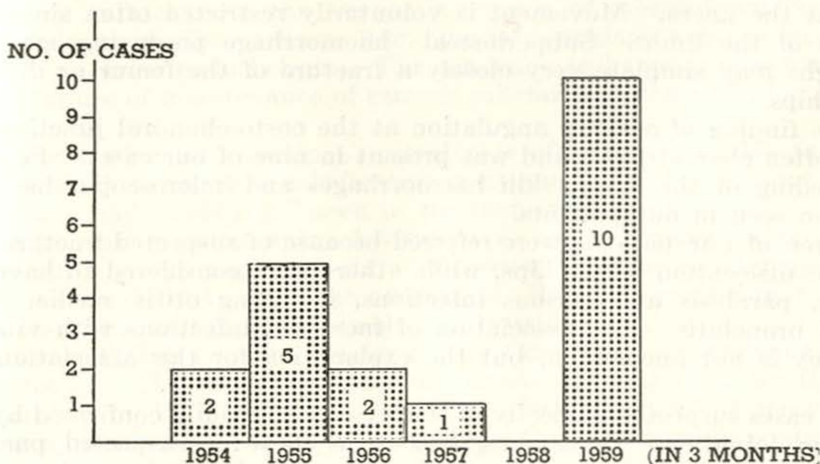


TABLE I.—CASES OF SCURVY IN HALIFAX CHILDREN'S HOSPITAL

*From the Children's Hospital and the Dept. of Pediatrics, Dalhousie University.

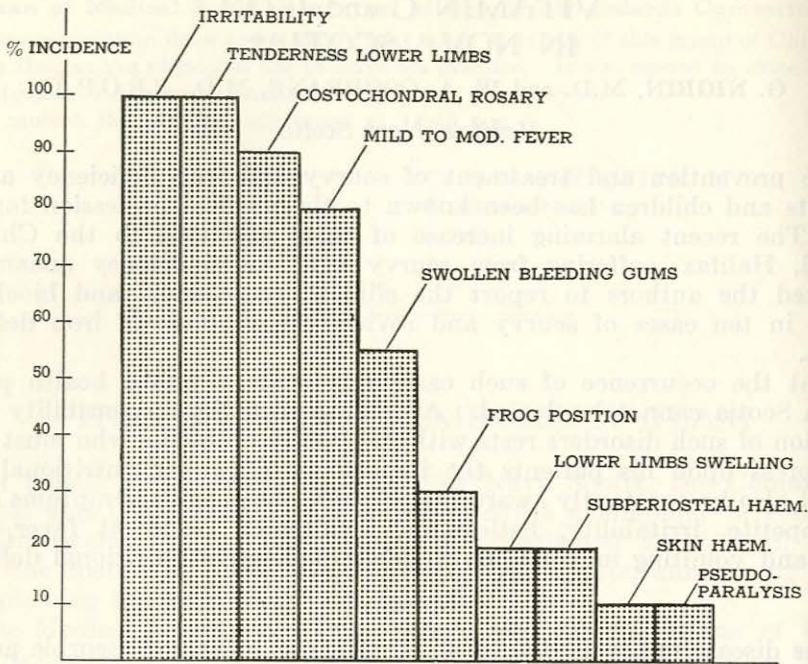


TABLE II.—SYMPTOMS AND SIGNS OF SCURVY IN 10 CASES ADMITTED TO H. C. H.

Scurvy is most commonly seen in the age group of 6 months to $1\frac{1}{2}$ years and the most common presenting symptom is irritability. The irritability is rather characteristic in that in place of the soothing comfort of the mother's arms, any handling of the infant produces increased irritability and obvious painful discomfort. The pain is caused by fragmentation and bleeding in the epiphyseal plate, and subperiosteal bone fractures. Handling of the lower limbs is very painful and the infant assumes a position of greatest comfort which is referred to as the "frog-leg" position. The legs are semi-flexed at the hips, externally rotated and abducted, and the lower legs are semi-flexed at the knees. Movement is voluntarily restricted often simulating a paralyis of the limbs. Subperiosteal haemorrhage producing swelling of the thighs may simulate very closely a fracture of the femur or dislocation of the hips.

The finding of a sharp angulation at the costo-chondral junction of the ribs is often characteristic and was present in nine of our cases. Fever, pallor, bleeding of the gums, skin haemorrhages and microscopic haematuria were also seen in our patients.

Three of our patients were referred because of suspected fracture of the femur or dislocation of the hips, while others were considered to have osteomyelitis, paralysis and various infections, including otitis media, tonsillitis, and bronchitis. The association of increased infections with vitamin C deficiency is not uncommon, but the explanation for this association is not known.

All cases suspected clinically of scurvy can be readily confirmed by radiological examination. Roentgenograms of the chest for suspected pneumonia may reveal the characteristic changes at the costo-chondral junction. Gener-

ally roentgenograms are taken of the long bones, particularly of the knee joint, for clear-cut evidence of scurvy. The findings consist of:

(a) Ground glass appearance of the shaft with blurring of the trabecular markings.

(b) Pencil line effect with thinning of the cortex.

(c) A white line of increased density at the end of the long bone representing the zone of preparatory calcification. This is often referred to as the white line of Fraenkel.

(d) The corner sign. This is the sub-epiphyseal separation of the epiphysis.

(e) The "halo sign", which is represented by a prominent outline of the ossification centre with decreased density of the body of the ossification centre.

After treatment one may see calcification of a subperiosteal haematoma which may persist for several months.

The ascorbic acid level in the blood is normally 0.5 mgm. per 100 ml. or greater, and this figure in seven patients tested may be seen in Table III. The ascorbic acid level in the blood is not necessarily correlated with the severity of the disease.

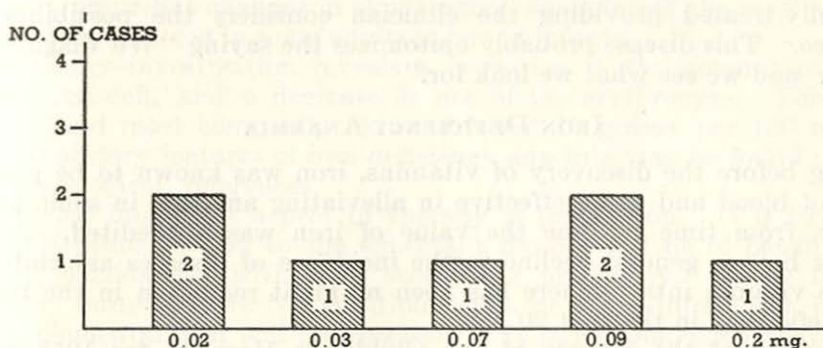


TABLE III.—VIT. C BLOOD LEVELS IN 7 CASES OF SCURVY

We do not know all the functions of vitamin C, but the abnormalities produced by a deficiency result in defective formation and maintenance of intercellular substance in the supporting tissue of mesenchymal origin, including collagen or fibrous tissue, bone matrix, cartilage and the intercellular cement of vascular endothelium. The tendency to haemorrhage may be the result of failure of maintenance of cement substance in the wall of small blood vessels.

In the absence of vitamin C, osteoblasts of bone are unable to produce normal osteoid tissue, but calcification continues and this accounts for the "white line" and "halo sign" seen in the roentgenograms.

The normal requirements of vitamin C by the young infant may be quite small, 10 to 15 mgm. per day. However, in some rapidly growing infants who are subject to stress, an amount of vitamin C greater than 15 mgm. may be required, and if not available scurvy will result.

Cow's milk has been known for a long time to be an inadequate source of vitamin C. The recommended daily intake of vitamin C by the young infant should be 25 to 50 mgm. per day. One quart of pasteurized milk provides approximately 12 mgm. of vitamin C. Breast milk contains more

vitamin C, but still insufficient to prevent scurvy in some infants. It is recommended that extra vitamin C be given in the form of orange juice or vitamin drops. An excellent source of vitamin C is found in Nova Scotia vitaminized apple juice, which is also quite economical.

In all of our cases the cause of the insufficient intake of vitamin C was a lack of knowledge or ignorance on the part of the parent on what foods or vitamins they should be giving their child. In some cases the infant would develop a "rash," or "diarrhoea" which was considered to be due to the orange juice and resulted in the intake of this substance being discontinued.

The therapy of scurvy is relatively simple. Our ten cases were given ascorbic acid 200-300 mgm. per day for a period of 2 weeks followed by the average daily requirement of 50 mgm. The response to treatment is rapid and dramatic. Within 2-3 days the irritability is markedly reduced and the patient is obviously more comfortable. The temperature returns to normal, the infant appears brighter and the appetite is markedly improved. Usually within 8-10 days calcium may be seen in the subperiosteal haematoma by radiological examination which may not be completely cleared for several months.

Finally the diagnosis of scurvy may be readily made and the disease successfully treated providing the clinician considers the possibility of its occurrence. This disease probably epitomizes the saying "We diagnose what we know and we see what we look for."

## Iron Deficiency Anaemia

Long before the discovery of vitamins, iron was known to be present in the ash of blood and to be effective in alleviating anaemia in some patients. However, from time to time the value of iron was discredited. Although there has been a general decline in the incidence of diseases associated with defective vitamin intake, there has been no great reduction in the incidence of iron deficiency in the past 20 years.

A review of the records of the Children's Hospital for 1958 revealed 148 cases of iron-deficiency anaemia. Frequent publications have emphasized the high incidence of anaemia in the first two years of life compared to the later years of childhood, and the fact also that much of this anaemia responds to iron therapy. As a cause of anaemia, iron deficiency far outranks other haematological disorders between the ages of 6 months and 2 years.

The onset of iron deficiency anaemia occurs when the supply of iron fails to meet the demand, i.e., when the iron present in "stores" plus that absorbed from food is insufficient to meet the body needs.

The newborn's store of iron in the liver is surprisingly small in contrast to the adult. The haemoglobin compartment represents the chief site of iron storage in the newborn. During the first 10 weeks of life the normal degradation of haemoglobin releases iron which is largely retained for future use. Therefore, an infant who begins life with a reduced haemoglobin level is immediately at a disadvantage and must obtain additional iron from dietary sources over the ensuing months. It has been shown that early clamping of the umbilical cord increases to a slight, but significant degree the severity of anaemia in late infancy.

In most of our cases the diet has been extremely poor. The anaemic infants have been on a diet of milk and other foods of low iron content. However, it is a fallacy to consider that an adequate diet will prevent all iron de-

ficiency anaemias. The combined evidence suggests that although the physician should continue to recommend a "good" diet, he should not depend solely on diet for the prevention and cure of iron deficiency anaemia in some children.

Clinically the onset of iron deficiency anaemia of infancy is insidious and its progress is slow. The infant may exhibit few signs and symptoms; anorexia, irritability and recurrent infections are the most common symptoms.

Surveys have revealed that pallor was seldom noted by the parent or attending physician when the haemoglobin exceeded 7 grams per 100 ml., and was appreciated consistently only when the haemoglobin was below 6 grams per 100 ml. We have commonly seen patients admitted to hospital for a surgical operation or treatment of an infection when the incidental finding on routine haematology was a haemoglobin of below 5 grams per 100 ml.

Other than pallor, few abnormalities are detected on physical examination. Hepatosplenomegaly may be noted in 10 percent of cases and retardation of growth in 20 percent. Precordial systolic murmurs with radiological evidence of cardiac enlargement may be present. Oedema of the face and eyelids may occur but changes in skin texture, spooning of the nails and atrophy of the tongue noted in some adults is rare in infants.

Laboratory investigation reveals a reduction in the amount of haemoglobin per red cell, and a decrease in size of the erythrocyte. The haemoglobin is found most commonly between 5 and 10 grams per 100 ml. Additional laboratory features of iron deficiency anaemia may be found in standard haematological references.

The most important aspect of therapy is prevention. It is likely that the administration of iron to the expectant mother will be of benefit to the child, and particularly with each succeeding pregnancy. If the infant is prematurely born or there is a multiple birth, or if the infant lost blood at birth, supplemental iron will be necessary. It is recommended that in such cases 10 to 15 mgm. of "*elemental*" iron be given daily started at 6 to 8 weeks of age. Haemoglobin determination should be made at 5 to 6 months of age, and iron prescribed if a value below 10.5 grams per 100 ml. is recorded. The responsibility of the physician in advising the parent about iron-containing foods is self-evident.

The specific treatment of iron deficiency anaemia is the proper administration of iron. Most widely used are the ferrous salts in the form of sulfate or gluconate. There is insufficient proof that other substances, including cobalt, molybdenum, copper or vitamin $B_{12}$ etc., play any role in the treatment of iron deficiency anaemia and these are therefore not recommended. In some mixtures the amount of *elemental* iron is inadequate. A wide variation in the cost of preparations for the adequate treatment of hypoferric anaemia exists, one commercial preparation costing about three cents a day, while another costs about fifty cents a day. A dose which furnishes 60 to 75 mgm. of *elemental* iron per day given in three or four divided doses is satisfactory for patients up to 3 years of age. For children, a dose of 4.0 mgm./Kg. of body weight per day has been recommended. Iron is less well absorbed when given in milk and should be given between meals, preferably when the stomach is empty. We have used parenteral iron therapy in a number of cases and have been very satisfied with the results. In cases of coeliac disease, ulcerative colitis, or for those infants whose parents will likely

fail to cooperate in the administration of oral iron preparation, this method of therapy is preferable. The amount of iron required to alleviate the anaemia is calculated by the formula

Body weight in Kg. × (13.5 - hgb. in grams%) × 2.5
= mgm. iron needed.

This is administered by intramuscular injection in doses of 40 to 100 mgm. per injection at intervals of a few days to a few weeks.

The haemoglobin after a delay of three to four days usually rises at the rate of 0.15 to 0.3 grams per 100 ml. per day.

We do not recommend transfusions of whole blood except in selected cases where complications exist, necessitating the immediate support provided by blood. Transfusions are uncomfortable for the patient, and potentially dangerous, since undesirable sensitization may result, and circulatory overload may lead to cardiac failure and death.

If, in a severe case of anaemia, the physician feels a blood transfusion is necessary, small amounts of packed red blood cells should be given.

Once the patient has been treated with iron the physician must re-educate the parents regarding proper food and eating habits. It is of little value to provide iron therapy only, without ensuring that a qualitative nutritional deficiency will not occur in some other member of the family.

*Since the preparation of this paper three further cases of scurvy have been admitted to the Children's Hospital.

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THE STATUS OF TRANQUILLIZING DRUGS 1959. Boshes, B; Ann. Int. M. **52**: 182, 1960.

The author presents a scholarly review of the development of sedative and tranquillizing therapy over the years. The neurophysiology of various personalities under the influence of the different tranquillizers is described. The value of placebo therapy is emphasized, as is the danger of powerful sedatives in older people, and the effects of sudden withdrawal of large doses of barbiturates leading to convulsions and psychosis. A paragraph length quotation of the benefits of therapy in disturbed patients, is so typical of many seen currently, that one assumes it is of recent origin until the author indicates that it is a 1926 report on the use of bromides in psychoses. Dr. Boshes' summary is that the tranquillizing drugs are very useful and, comparatively speaking, safe. They are to be employed in symptomatic treatment, are not curative, but are useful in that they render the patient more available for approach by the physician. They are never a substitute for a full doctor-patient relationship.

L.C.S.

# NUTRITIONAL EXCESS IN INFANCY AND CHILDHOOD*

W. A. Cochrane, M.D., F.R.C.P.(C)

From the Department of Pediatrics, Faculty of Medicine, Dalhousie University, and Children's Hospital, Halifax, Nova Scotia

For many decades great emphasis has been placed on nutritional deficiency—quantitative and qualitative. In the child, the increased needs of the growing organism will quickly result in a deficiency state if certain nutritional requirements are not met. The rapid increase in world population with dietary insufficiency in certain areas has resulted in an increased interest in the nutritional handicaps of infants and children in these areas. The clinical picture of malignant malnutrition or Kwashiorkor reported from Africa, India and Mexico is now well documented. However, in certain parts of the world malnutrition or undernutrition is no longer a problem and perhaps in these areas our interest should be turned toward the possible hazards of overnutrition.[1]

It is now generally accepted that obesity contributes greatly to the development of coronary occlusion, atherosclerosis, hypertension, diabetes mellitus and a shortening of the normal life span in the human adult. Dietary restriction of certain fats and an increased intake of protein is advocated by many physicians.

If overnutrition and overweight is harmful to the adult is it not possible that this could also be harmful to the child.

The case of overfeeding has been known for sometime. Actually some physicians classify overfeeding as a form of malnutrition.

Recently Johnson[2] in the United States has reported in a survey that 10% of the child population can be classed as definitely overweight. Generally the older clinicians in the past were convinced that the fat infant tolerated certain diseases poorly when compared to his thinner counterpart. Such diseases as gastro-intestinal and pulmonary infections are tolerated poorly by obese infants.

Eczema patients are often improved with a reduction in body weight.

Baumgartner[3] has shown that although there is an increased mortality in newborns with low birth weights there is also a greater mortality for the large, heavy newborn infant.

Today the modern mother is being constantly bombarded with advertising suggesting that bigger babies are better babies which is a frame of mind in our present day culture. Some commercial companies advertise the superior value of their product on the basis that it contains three or four times the amount of a certain substance such as Vitamin D, or that it contains a certain amino acid etc. to supplement the infant's diet for the promotion of growth. Generally pediatricians vie in the art of earlier and earlier introduction of solid foods. Indeed in a recent survey in the U.S.A. a large number of pediatricians placed their infants on most foods by 6-8 weeks of age.

The effect on the mother of all this is that if the infant has not gained at least 1 to 2 lbs. a month she is upset and suspects the inability of her physician to recognize some abnormality in her child to account for his "poor weight gain." Parents frequently compare their own child to the neighbours and more than one father is disappointed in his son because of his small stature,

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*Reprinted from Canad. M.A.J. 81: 454, 1959.

forgetting he himself may be below average size. The parents then proceed to administer large amounts of milk, vitamins and tonics, etc., to "promote growth."

Today the infant and child is bigger and grows faster than his counterpart of 50 years ago. The old dictum that a child should double his birthweight at 6 months and triple it by a year is fast losing ground as they may accomplish the doubling of their birthweight by 3-4 months.

Meredith[4] has concluded that a one year old infant is 7% taller than his 19th century counterpart, although the difference in length at birth is only 1%.

Nine to fourteen year old boys are 6-8% taller and 12-15% heavier than formerly. Is this due to better nutrition or lessening of disease, genetic factors, or is it merely "hybrid vigour," or possibly related to better socio-economic conditions.

One might for a moment consider the effect on potential longevity of this rather striking increase in the weight and height and rate of growth of todays child. It is quite conceivable that changes in the rate of growth would not materially affect the length of life because the process of ageing and senescence would proceed at their predetermined rates. However, it is possible that the rate of growth as such, might determine the rate of ageing and thus the duration of life. Accelerated growth night cause excessive expenditure and premature exhaustion of energy and thus a shorter life. Generally the life span of lower animals may be prolonged by restriction of food with reduction in body size or of vital activities. However, higher species with complex organization are, during the growth period, less adaptable to drastic food restriction than lower forms of animal life. More important however, is the fact that we do not know at what age dietary restriction should be instituted in order to accomplish an optimal effect.[5] Is it possible that dietary restriction should begin at the age of infancy?

In considering the effect on longevity of present day infant diets and feeding habits one must not forget that todays adults reaching 65 or 75 years of age were more commonly fed in infancy a diet lacking in vitamins and "proper nutrition" rather than an excess. Therefore the relationship of present day diets to longevity cannot be assessed for 30 to 50 years hence when todays infants and children have become older adults.

In encouraging the maximum growth the parent and frequently the physician confuse maximum growth with optimal nutrition. One may ask of so-called "optimal nutrition"—optimal for what? Do we seek the best diet or optimal nutrition for maximal growth, or freedom from disease, or postponement of death, or fitness for work or war, or reproduction, or even for cultural achievement through thought or social relations? We must remember there is no satisfactory mathematical model for the curve of human growth and that human growth data are empirical.

Not only are todays infants probably receiving an unnecessary amount of calories in the form of excess fat and carbohydrate, but one must also consider the possible harm from over administration of certain specific substances.

Of interest is the finding that breast milk contains significantly smaller amounts of dietary essentials than cow's milk. The average breast fed infant for the most part receives less of these essentials than the U. S. National Research Council recommends. The supermineralization or greater retention of minerals and nitrogen by the cow's milk fed baby is most intriguing. Tetany of the newborn occurs almost exclusively in the artificially fed baby as a result of the ingestion of the high phosphorous content in cow's milk.

Many nutritionists are suggesting the value of increased protein in the diet of the young infant. Recent work by May[6] would suggest that the increased intake of protein in the infants diet does not necessarily increase the percent of protein in the body composition. Harmful consequences have not been observed with increased protein in infant feeds except when water is lacking for the excretion of accumulated nitrogenous waste. However, experiments in young rats by Kennedy[7] reveal that pathological lesions ordinarily seen in the kidneys of aged rats are made to appear at a much earlier age by as little as a two-fold increase in the load of protein. Is it conceivable that this could happen to the young infant on a high protein intake?

One fascinating disorder that has been reported primarily from Great Britain and Switzerland is the so-called idiopathic hypercalcaemic syndrome. This is a disorder of calcium metabolism occurring in young infants resulting in multiple signs and symptoms. These include abnormal development both physically and mentally, constipation, vomiting, abnormalities of kidney function and elevated blood pressure. The blood calcium level is found to be high. A number of causes have been suggested but there exists a strong opinion that this is partly due to the excess ingestion of Vitamin D.

In comparison to the large number of cases in Great Britain there is a marked lack of cases on this continent. The similarity of these cases to Vitamin D intoxication is striking. British Cod liver oil has approximately twice as much Vitamin D as our preparation, and pre-cooked cereals are fortified with Vitamin D. In Britain proprietary milk products contain $3\frac{1}{2}$ times the amount of Vitamin D as used in this country. A committee set up to investigate this problem noted that the intake could be as high as 4000 I.U. or more, i.e. 10 times the normal requirement.[8] Of interest is that increases in fortification of British foods were effected just a few years prior to the first reports of this syndrome and an analysis of the foods revealed a higher content of Vitamin D than stated on the label—presumably to allow for deterioration.

Large doses of Vitamin A may result in loss of hair, painful swellings of the skin, convulsions and enlargement of the liver.

More recently evidence has been presented of the toxic effect on young newborn infants of giving large doses of Vitamin K, the anti-haemorrhage vitamin, not only to infants at birth,[9] but also to mothers just before delivery.[10]

In summary, one must consider whether yesterdays children were undernourished, or are todays children overweight or over-developed in comparison to the normal 19th century specimens, and hence destined as McCay's[11, 12] rats for an earlier death. Recent studies by Wolff[13] offer definite support for the contention that the observed advancement in height and maturation is a consequence of increased food intake rather than some hypothetical glandular factor. As yet there is no large body of evidence as there is for the adult to suggest that childhood obesity is harmful.

Today we are in an era of child care in which many former deterrents to good health have largely disappeared—an era which has witnessed significant advances in food technology, widespread use of promotional advertising and the general availability of potent dietary supplements, with a result that overnutrition is much easier to achieve.

Therefore, optimum nutrition will remain a challenge and future pediatric practice may well be concerned with the stress of overnutrition rather than nutritional deficiency.

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AN ANALYSIS OF DEATHS FOLLOWING CARDIAC SURGERY. Harrison, J. L Davila, J. C., Iaia, B. D., and Glover, R. P.: J. Thor. Cardiov. Surg., 39: 91, January, 1960.

A review of 67 consecutive closed cardiac surgical deaths, occurring over a 5-year period, is presented.

Major groups consisting of patients with acquired valvular heart disease are compared.

The data suggest that cardiac asystole, the cause of the operating room deaths, was associated with sudden or severe blood loss, definite periods of pre-arrest hypotension, increased myocardial irritability, and increased left ventricular end-diastolic pressure. The immediate post-operative deaths seemed predominantly related to post-surgical shock and, to a lesser extent, frank congestive cardiac failure. The delayed post-operative deaths were almost invariably related to the presence of frank congestive failure. In most cases the shock and the congestive failure (not merely terminal events) were related to one or a combination of the following: (a) failure of the myocardium, despite good mechanical correction of the lesion, (b) aggravation of a pre-existing lesion, (c) production of a new lesion, and (d) failure to correct the mechanical lesion.

The exact place, in the above scheme, of other factors, such as digitalis toxicity, rheumatic activity, pericarditis, and myocardial dilatation or hypertrophy is limited by lack of knowledge pertinent to these phenomena. Far-advanced tissue damage and anatomic derangements of the valves themselves, of the myocardium and of the pulmonary vasculature, are, at present, major insurmountable obstacles in the practice of cardiac surgery.

S.J.S.

# DRUG RESISTANT TUBERCLE BACILLI*

C. W. L. JEANES, M.B., Ch.B.**

*Ottawa, Canada*

The most dramatic progress ever made in the therapy of tuberculosis has been achieved in the past ten years by the use of specific anti-tuberculosis drugs. As a result of good drug therapy, i.e., adequate dosage for a sufficient length of time, the whole prognosis of the disease has been changed, there has been a great reduction in all forms of surgery, almost no thoracoplasties are now performed, resection is very much decreased, and artificial pneumothorax and pneumoperitoneum have become historic relics of the past. With this progress has come more rapid treatment and much more successful treatment.

The immediate response to drug therapy has been so good that it might be said that too much reliance is being placed on antibacterial drugs, especially when prescribed under domiciliary conditions or where it cannot be assured that the patient really does take the necessary combination of drugs. Unless drugs are taken continuously and in sufficient dosage, the tubercle bacillus will develop resistance to them. It is then useless to proceed with such drugs to which resistance has developed, and change to other drugs is essential. This is of course a basic and elementary principle which sounds simple and capable of always being fulfilled. There is accumulating, however, anxiety over the development of drug-resistant tubercle bacilli and some authorities now consider it to be the greatest problem in tuberculosis today.

Professor John Crofton has said that there is no case of active tuberculosis who cannot be made sputum-negative by adequate doses of chemotherapy given for a sufficient length of time and that, if a patient does develop resistance, then his treatment was inadequate.

This is, of course, a counsel of perfection, and we all know of and have had patients who, in spite of adequate chemotherapy, have developed resistant organisms. On theoretical grounds, resistance should never be a problem if a patient's bacilli are exposed to bacteriostatic concentrations of two drugs. What, therefore, are the causes of the finding of resistant tubercle bacilli?

1) Drugs prescribed too infrequently or in too small doses.
2) Drugs prescribed singly rather than in combination.
3) Interruption of treatment by:
    a) self-discharge
    b) non-coöperation
    c) hypersensitivity reactions and toxic effects
4) Tendency to domiciliary treatment with no control over the patient.
5) Surgical treatment of residual unhealed lesions, e.g., thick-walled cavity, too long delayed.

The vast majority of all sputum conversions should occur by the sixth month. After this time those who remain positive will tend to be developing resistant organisms and of those positive at the end of a year, 95% will have resistant organisms in the sputum.

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**Secretary, Canadian Thoracic Society, Ottawa, Ontario.

*Presented at the Annual Meeting, Canadian Thoracic Society, Halifax, Nova Scotia, June 3rd, 1959

It has been apparent to all in recent years that an increasing number of new cases of tuberculosis are being found to have resistant tubercle bacilli in the sputum.

In 1957, Professor Heaf in Cardiff reported that, of the new cases diagnosed in Wales in that year, in 21% the tubercle bacilli were resistant to streptomycin, 12% to PAS, and 27% to isoniazid.

Because this appears to be a very real and increasing problem, the International Union against Tuberculosis has recently instituted an international enquiry into the incidence of drug resistant tubercle bacilli.

Four sanatoria in Canada were asked to co-operate, Beck, Laval, Mountain Sanatorium and Toronto Hospital, and appreciation is expressed to Drs. Ewart, L'Esperance, Sharpe and Wicks and their staffs for providing the required information.

These sanatoria were asked to report on the sensititivy of tubercle bacilli to the standard drugs on at least 100 consecutive patient admissions in 1957. Some of these were newly diagnosed cases and others were re-admissions, some had had chemotherapy and some had had none.

Information was requested on 1) the number of patients who remained consistently negative during the first two months after admission, 2) the total number with positive sputum, direct and on culture, and 3) for those positive, the sensitivity to streptomycin, PAS, Isoniazid, or all three.

The results submitted concerning 218 sputum-positive patients have been analyzed with the following results:

| | |
|---|---|
| Resistant to streptomycin | 28% |
| Resistant to PAS | 6% |
| Resistant to isoniazid | 14% |
| Resistant to all three drugs | 4% |

These figures indicate quite clearly that a very significant number of resistant tubercle bacilli are now appearing. The significance of such resistance requires much further study. Isoniazid-resistant organisms and the increasing number of atypical bacilli now being found are subjects of controversy, but there is no doubt that streptomycin-and PAS-resistant organisms retain their full virulence.

It behooves us all to do everything in our power to prevent the development of resistance by:—

1)Giving adequate doses of proven-efficacy drug combinations for sufficient length of time.
2)Ensuring that the patient does take these drugs.
3)Never using one drug alone for initial treatment.
4)Not delaying surgery too long when the indications exist.
5)Doing resistance studies on all patients at regular intervals, and
6)on newly diagnosed or re-admission cases, if there is any reason to suspect resistance, giving three drugs together until the resistance results are known.

It would be a tragedy if our very hard earned weapon against tuberculosis, the drugs, ceased to be of value because of a great increase in the incidence of resistant tubercle bacilli.

## COLLEGE OF GENERAL PRACTICE

The annual meeting of the Halifax-Dartmouth Branch, N. S. Chapter, College of General Practice was held at the Nova Scotian Hotel on Feb. 14, 1960. Supper was served and a most successful and productive meeting was held by the twenty-three members present. Dr. S. G. B. Fullerton acting as chairman in the absence of the President, Dr. W. M. D. Robertson, gave an outline of the past year's activities and noted the accomplishments of several of the members, among which were the following:—

Dr. Fullerton was successful in winning a Schering Bursary and spent 2 weeks on a Medical course at the Montreal General Hospital.

Dr. D. F. Smith was our representative at a Symposium on Cancer Detection held in New York City by the American Cancer Society.

Drs. Brady, Miller, Stott and Phillips formed a panel on virus infections at the Annual Refresher Course.

Drs. Still and MacGregor were appointed to the staff of the V.G. Hospital and also to University Teaching Staff.

The following officers were elected for the year:—

| | | |
|---|---|---|
| President | — | Dr. S. G. B. Fullerton |
| Vice-President | — | Dr. M. L. Smith |
| Secty.-Treasurer | — | Dr. P. C. Gordon |
| Membership | — | Dr. W. M. McRae |
| Education | — | Dr. H. C. Still |
| Hospital | — | Dr. A. J. Brady |
| Public Relations | — | Dr. D. F. Smith and Executive |

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THE PROBLEM OF UNILATERAL AMBLYOPIA. Locke, J. C.: Canad. Med. Ass. J., 81: 7; 570, 1959.

The author, Professor of Ophthalmology at McGill, emphasizes that some three to six per cent of the adult population suffer unilateral amblyopia (amblyopia ex anopsia, "lazy eye") which has its onset in the first six years of life, being remediable if treated during this time. Most cases develop in association with strabismus (turned eyes) but another large group is due to unequal refractive errors in the two eyes, and these can only be found by testing the visual acuity. A four-fold attack on the problem is suggested:

1. Increased awareness of the problem by the general public.
2. A greater appreciation by the medical profession of the magnitude of the disability and the numbers of people affected is needed.
3. Pre-school vision screening programmes.
4. Continued research and the application of the latest treatment methods for established cases should be intensified.

J.H.Q.

### Canadian Public Health Association

## ANNUAL MEETING

### Nova Scotian Hotel, Halifax

### May 31st, June 1st & 2nd

The program is of unusual interest to all doctors. Wouldn't you like to drop in to hear about the "*Maternal and Perinatal Mortality Study*" by M. G. Tompkins, M.D., or the "*Trends In the Organization And Financing of Medical Care*"? The latter is to be discussed by Doctors A. D. Kelley, Executive Secretary C.M.A.; Stanley W. Marten, President of The Canadian Hospital Association; Joseph Willard, Research and Statistics Branch of Department of National Health and Welfare; Burns Roth, Deputy Minister of Health, Saskatchewan; Mr. Edward Goldberg, Research Department, United Steel Workers of America and Miss Elizabeth Reed, R.N., Acting Director in Chief for Canada V.O.N. If you would like to listen, drop in about 10:00 a.m. on Tuesday, May 31st.

For those interested in Psychiatry, the place is the Ballroom; the time 2:30 p.m., May 31st. Two Panels: (1) "*Role of Public Health Personnel in a Community Mental Health Program*"; (2) "*Behaviour Problems in Children*".

In Salon E, at the same time, you might like to hear Dr. D. M. MacLean from the Hospital For Sick Children, Toronto, discuss "*Arthropod Viruses in Ontario.* With Special Reference to the Powassan Virus". Dr. J. C. Sinclair, F.R.C.P.(C) Department of Medicine, Banting Institute, will be along to bring us the story of "*Infectious Hepatitis in the Uranium Camps at Blind River*". Did you lose any money in Uranium lately? Dr. Sinclair has some excellent slides. Wouldn't you like to see where the money went? All this along with very pertinent observations on that bane of our existence-Infectious Hepatitis.

And POLIO: There is a most interesting story on the "*Epidemiology of the Outbreak in Newfoundland*" with Dr. J. W. Davies et al. Dr. R. J. Wilson from Connaught Laboratories will elucidate on "*Antibody Response With Single and Multiple Antigens*". Our own Dr. C. E. van Rooyen will bring us his "*Preliminary Observations on the Use of Trivalent Attenuated Oral Poliomyelitis Virus Vaccine in Halifax*". This is a fabulous subject, the implications of which (oral vaccine) may well revolutionize many facets of medicine. You just can't afford to miss it, nor its corollary on Wednesday, June 1st at 10:40 a.m., by Dr. Herman Kleinman from the State of Minnesota Department of Health, speaking on "*Field Trials with Oral Poliomyelitis Vaccine.*"

On Wednesday morning also, Dr. W. A. Cochrane will discuss "*Overnutrition in Infancy and Childhood*". Can't you just see that proud mother sitting across the desk from you, holding that fat puffy baby? You so want to tell the mother that this baby needs your help just as much as an undernourished child. Bill has some helpful hints for you. Dr. Stanley Rands plans to outline the new Saskatchewan plan for "*Community Psychiatric Services in a Rural Area*". Dr. R. J. Weil will discuss "*Psychological and Psychiatric Aspects of Spontaneous Abortion*". He and his group have done some admirable research work on this subject here in Halifax.

Space is limited, however I cannot help but whet your appetites with some interesting highlights from the sections on Wednesday afternoon:

Dr. W. I. Morse and Dr. D. L. Hirsch—"*Obesity: Emotional and Metabolic Factors*".

"*Progressive Patient Care*": This is a new and somewhat controversial method of hospital care. Would you like to have it adopted in your hospital?

Dr. F. Murray Fraser (President of College of General Practice) will discuss "*Physician Sponsored Medical Care*".

Dr. Arnold Branch will discuss "*Recent Developments in Antibiotic Therapy*".

Thursday morning too has its interesting highlights: An excellent Panel is being worked upon "*Radiation Hazards, Present and Future*".

Dr. J. C. Muhler, University of Indiana, will discuss "*Stannous Fluoride Topical Application*".

Dr. Oscar Auerbach will have the honour of the final paper. He is Professor of Pathology, Veterans Administration Hospital, East Orange, N. J. He will discuss "*Anatomical Changes in the Lung in Relation to Smoking and Cancer of the Lung*". This will be an outstanding contribution. Seats will be at a premium.

See you all at the C.P.H.A. Convention. Bring your wives. The entertainment program will be just as exciting as the technical program. Can't you just taste the lobster at the Shore Club at Hubbards: the grand finale.

J. J. STANTON, M.D., D.P.H.
Program Chairman.

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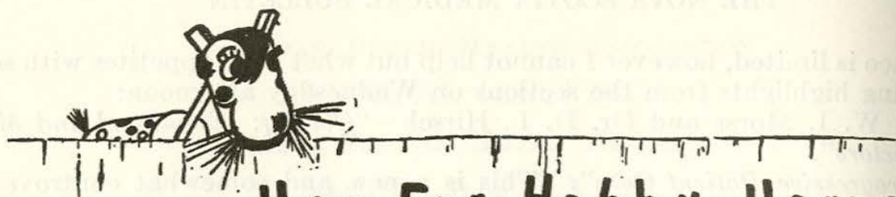
Psychosis and Addiction to Phenmetrazine (Preludin). Evans, J.: Lancet, 2: 152, 1959.

Preludin, a drug similar to amphetamine and ephedrine is a sympathomimetic agent with euphoriant stimulating qualities. It was first used in 1954 in the treatment of obesity. Since then it has been given in asthma, in Parkinsonism and as a euphoriant. This drug may be taken initially as an aid in weight reduction and then continued for its stimulating effect. Twelve cases, ten females and two males are reported in this paper. All found that the number of tablets taken had to be increased in order to obtain the same affect. All the patients except one had taken over ten tablets a day for many weeks. The amount taken did not appear to have a close relation to the severity of the illness. These twelve cases developed addiction to this drug producing a psychotic illness. The clinical picture cannot be distinguished from amphetamine or bromide psychosis, or alcoholic hallucinosis. Restlessness, pressure of talk, disturbance of mood, delusions and hallucinations are present without clouding of the consciousness. It is the author's opinion that Preludin should be placed on a restricted list so that its abuse can be prevented.

J.O.G.




THE CHIEF JUSTICE AND THE HYPOTHESIS

The Chief Justice had recently been appointed chairman of the board of directors of the Nichole Foundation for the Prevention of Cancer. I first met him when I acted as moderator of a panel on Problems in Cancer Education which was arranged at the request of the Foundation. He came forward afterwards and complimented us on our contribution. His question during the discussion concerning power groups working against cancer prevention caught my attention. On the Sunday following the panel, I was walking in Point Pleasant Park with the children when we met the Chief Justice. It was an opportunity difficult to resist so I asked him for time to present in some detail the challenge presented by the rapid increase of lung cancer. He agreed and asked me to call within a few days.

At 2.30 one afternoon some days later, I hurried up the narrow staircase in the east wing of the Law Courts to keep my appointment. A clerk waited for me in the hall and before I could catch my breath I was ushered into the presence of the Chief Justice. He was seated behind a large low desk clear except for a blotter, desk calendar and a few papers. The dimly-lit room was lined with law books and reference works and I found nothing familiar in it to reassure me. In the bookcase near the door and the hall tree were a number of novels with legal themes including Anatomy of a Murder and that excellent biography of Edward Coke—The Lion and the Throne. The Judge finished instructing his secretary then rose and came around the desk to help me out of my coat.

I was in considerable awe of this man. I was still in high school when World War II broke out but I have strong memory of the comfort my father took in the reflection that there were four Nova Scotians to help run the country in the war which we faced. This man was now part of our nation's history. Furthermore despite my lack of contact with the profession of law I had an impression during my formative years of high ideals, lofty purposes and a resolute independence of mind in my reading of the works of giants of law such as Oliver Wendell Holmes Jr., Louis Brandeis, and Learned Hand.

Despite my anxieties the book-lined room and the quiet dignity of my host seemed to insure that good evidence would be given an impartial hearing. The hypothesis that regular cigarette smoking is the principal cause of the marked increase in cancer of the lung is one of the most controversial in modern medical history. When the complex structure of supporting facts is cleanly and directly presented there appears a pattern of steady uninterrupted growth during the past two decades. The inter-related elements of evidence must be fitted with precision to the main theme and with emphasis appropriate to the weight of each in the total hypothesis. The impact of the story of the search for the etiology of lung cancer on a free and ready mind must be profound.

I took pains to make plain to the Chief Justice that absolute proof is rare in that compartment of applied biology we know as the practice of medicine. Because incomplete and partial evidence is an inescapable condition of medical practice we value more highly than most professions that potent weapon of inquiring minds: *the good hypothesis.* The scientific method demands of us the willingness to back a sound hypothesis to the limit until further knowledge replaces it with a better one. Huxley's famous remark is to the effect that "we must sit down at the feet of truth as a little child and be willing to follow it wherever it may lead or we will discover nothing". Many of my cautions were unnecessary. The Chief Justice was prepared to examine the evidence on its own merits. He did not try to pretend that the whole thing was somehow a joke that could be disposed of if we would all have a good laugh over it. He did not pick on some irrelevant detail and insist for example that fumes from lighter fluid or matches were as likely a cause. In short the Chief Justice assumed I had done my home work and that the twenty years of careful research (being presented) had examined other possible or probable explanations before backing the present hypothesis.

The educator perseveres in the hope that careful and patient exposition will bring conviction to the free and ready mind. Conviction may ultimately give rise to concern and a willingness to personal action. The Chief Justice saw the course of action that would be the most profitable in the prevention of cancer of the lung but recognized that knowledge does not bring with it the power to get the desired results. Research has shown what needs to be done—the riddle of How is the most pressing problem in cancer today.

In brief, an overwhelming weight of evidence lies on one side of the argument. We have all the facts required to support the need for sharp modification of the smoking habit. But the knowledge that the effects of 20 years of regular cigarette smoking will kill one of each eight heavy smokers does not help most individuals make the choice between smoking and non-smoking. Future success in the prevention of cancer of the lung depends upon the political response of man to scientific facts. Here political is used in its widest sense meaning "pertaining to the action of individuals, parties or interests that control the affairs of the state." (Webster).

When a panel of experts, lay and medical, meet in committee at a national level their recommendations on this problem will only reflect in part the scientific evidence brought before them. The opinion of any group is moulded by the many pressures to which fallible individuals must accommodate themselves. It is for this reason that a dozen variables in the personal characteristics and past experience of the committee members studying the hazards of cigarette smoking are important although they are impossible to evaluate.

This reservation is important when examining the response of influential bodies, governmental and professional, to the challenge of lung cancer. To the strength of the smoking habit and the incomparable facility of man to rationalize in favor of his own desires must be added the primitive resistance to new ideas which is an eternal characteristic of our history. The threat posed by constant change is personal, rather than external and distant, when it endangers the sanctity of our personal habits. Those in whom this instinctive rejection of threatening facts takes place rarely recognize its operation in themselves. We can but pray for strength and impartiality. In Aequanimitas, Osler refers to this dilemma: . . "the condition of mind-blindness (exists) in which the truth is not recognized though it stares you in the face. It is one

of the great tragedies of life that every truth has to struggle to acceptance against (the) honest but mind-blind . . . Science, the cold logic of which keeps the mind independent and free from the toils of self-deception and half-knowledge (is the antidote)."

The Chief Justice and I spent almost two hours examining various aspects of the developing story of the hypothesis linking cigarette smoking and lung cancer. It was a very enjoyable and encouraging experience for me. The evidence was quickly apprehended and with the exception of occasional questions regarding source I was able to develop the presentation without digressions. In retrospect even if we could be assured of a safe cigarette by 1961 we still have desperate need for improved techniques in mass education. Our present experience, arising from attempts to encourage an increasing number of adolescents to refrain from smoking, will be valuable when the profession has to persuade large numbers of adults to revolutionize their diets or alter their ways of life in other respects. A physician interested in the prevention of cancer, coronary artery disease, osteo-arthritis and similar chronic disabling illnesses has no choice but to be keenly concerned in the development of techniques that will bridge the gap between scientific knowledge and the eventual modification of unsound personal habits.

Yours, for a fair hearing

BROTHER TIMOTHY.

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THE EFFECT OF CHILDBEARING ON THE COURSE OF RHEUMATIC HEART DISEASE A TWENTY-FIVE YEAR STUDY. Maynard, E. P. and Grover, V: Ann. Int. M. 52: 163, 1960.

The authors obtained a follow up on 97.4% of 455 cases over a twenty-five year period at the adult cardiac clinic of the Brooklyn Hospital. They elaborate on the difficulties of drawing statistically valid conclusions from their findings. For example, at a given age mortality is much higher for nonparous than for parous women, and decreases with increasing parity. They feel that the possibility that pregnancy in itself exerts a beneficial effect on the course of rheumatic heart disease, cannot be ruled out or investigated on their data, but that there is no evidence that pregnancy has a detrimental effect. They feel that the more favorable experience of the parous women in this series, probably results from the tendency of the non-parous not to become pregnant. It is emphasized that each case must be considered individually, as the incidence of cardiac failure and death is much higher during an individual year containing a pregnancy than in another comparable year in that same person's life.

L.C.S.

## PERSONAL INTEREST NOTES

### Cumberland Medical Society

Dr. W. R. Morrison, who has been in hospital in Montreal, has returned to his practice.

### Halifax Medical Society

March 23, 1960—Fifth Regular Meeting at H.M.C.S. Stadacona. The clinical programme included, "Two Unusual Cases of Jaundice" presented by Surg. Capt. H. R. Roberts, R.C.N., and "Fractures of the Hand" presented by Squadron Leader J. R. Baker, R.C.A.F.

Dr. F. M. Fraser was installed as president of the College of General Practice (Medicine) of Canada at the annual meeting in Montreal on March 2, 1960.

The Fourth Annual Scientific Assembly of the College of General Practice was held in Montreal on March 3, 1960 and among those attending were Drs. F. M. Fraser, D. I. Rice, H. I. MacGregor, and H. C. Still.

The recent sectional meeting of the American College of Surgeons in Boston was attended by Drs. J. A. Noble, E. F. Ross, and G. W. Bethune.

Dr. H. L. Scammell, Executive Director, Alcoholism Research Commission for Nova Scotia visited research and treatment centres in Toronto, Hamilton, and London, Ontario during February.

Two recent editorials in the Halifax Mail-Star have protested the system in present use at the Victoria General Hospital which "does not permit those patients who are admitted to Public Wards to be attended by their personal physicians. They must accept the services of staff doctors and internes, who although competent, are nevertheless, strangers to the sick. Whatever the merits to this rule, it becomes grossly unfair when it is remembered that, at the increasingly busy Victoria General, choice of accommodation is not always open to the patient. A person may be willing to pay for the privilege of a semi-private or private room, where he could be attended by his family doctor or a specialist of his own choosing. Often, however, such space is not available and he is placed in a public ward where he is cut off from the services of those professionals he knows and trusts."

### Nova Scotia Society of Internal Medicine

Despite the threat of a major snowstorm, a meeting of the Nova Scotia Society of Internal Medicine had a record registration on Friday and Saturday, March 4 and 5, at the Cornwallis Inn in Kentville. Under the presidency of Dr. L. C. Steeves this was the first full-scale meeting of the Society and included both scientific and business sessions. The Secretary-Treasurer, Dr. Hugh MacDonald, was responsible for the general arrangements and Dr. Douglas Denton took care of the local details in Kentville.

The meeting got under way at 3:00 p.m. on Friday with Dr. S. T. Laufer in the chair. The first presentation was by Dr. J. F. L. Woodbury and was entitled "Serum Proteins in Rheumatoid Arthritis". The complex reactions underlying the various diagnostic tests and the immunologic factors were outlined. The exact interpretation and understanding of the mechanisms of the diagnostic reactions may help to clarify the etiology of rheumatoid arthritis.

This paper was followed by "Tuberculosis—1960", given by Dr. J. Earle Hiltz, Superintendent of the Nova Scotia Sanatorium. The speaker described the modern management of pulmonary tuberculosis and the very marked drop in mortality rate over the past fifty years. The morbidity figures, however, show no comparable improvement and Dr. Hiltz made a strong plea that we contine to treat the tuberculosis problem very seriously.

On Saturday morning Dr. Eric Cleveland presented a paper on the treatment of ambulatory depressed patients with Tofranil. The work was carried on in the Fundy Psychiatric Clinic by Dr. Cleveland and Dr. Frank Townsend, and consisted of a detailed study of the out-patient management of 85 depressed patients. The results have been encouraging and in many cases appear to represent an advantage over electro-convulsive therapy. The next paper was "Epilepsy—1960", presented by Dr. Hugh MacDonald. The speaker aroused the interest of his audience with his first slide*, and was followed intently through the present day concepts of the etiology, classification, pathology, pathogenesis and treatment of epilepsy.

The final scientific presentation was given by Dr. John Bethune, and bore the broad title of "Bone—1960". Dr. Bethune first used all his exuberance and wit to lead his audience through the complex of bone chemistry, to say nothing of the Haversian canals. The second part of this excellent review was concerned with modern views of the nature of the various metabolic diseases of bone and pointed up the problems still with us in their diagnosis and treatment.

Two business sessions were held, one on each day, and were concerned with such matters as membership in the Society and fee schedules of Maritime Medical Care, Blue Shield and hospitals under the Hospital Insurance Act. The Society strongly endorsed the principle of adherence to the fee schedule of The Medical Society of Nova Scotia.

The sessions were very well attended by the members and we were pleased also to have two visitors from our sister society in New Brunswick. Every paper was followed by a vigorous discussion and time was the only limiting factor.

On the social side, the ladies had a coffee party and get-together on Saturday morning, and on Saturday evening a cocktail party followed by a banquet and dancing rounded out a very successful gathering. There was also the common pleasure which one finds in taking a few days away from the daily grind, and this relaxation was easy to find in the comfortable atmosphere and excellent service of the Cornwallis Inn.

R. L. A.

## Births

Dr. and Mrs. A. Arneil, a son, Halifax, March 7, 1960.

Dr. and Mrs. Patrick Campbell (Doris Black), a daughter, London, England, March 5, 1960.

Dr. and Mrs. Robert C. Stewart (Barbara Hume), a son, Roderick Alexander, at Colchester County Hospital, Truro, February 28, 1960.

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*We understand that Dr. MacDonald is prepared to show this slide again to selected groups capable of grasping its intricacies, whenever suitable arrangements can be made. (Ed.)

## Coming Meetings

April 27, 1960—Halifax Medical Society—Annual Business Meeting—Dalhousie Public Health Clinic.

May 7, 1960—Halifax Medical Society—Annual Dinner Dance—Lord Nelson Hotel.

May 31-June 2, 1960—Canadian Public Health Association—48th Annual Meeting—Halifax, N. S.

June 13-17, 1960—Canadian Medical Association—93rd Annual Meeting—Banff, Alberta.

June 27-29, 1960—Medical Society of Nova Scotia—107th Annual Meeting—White Point Beach, Nova Scotia.

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## Obituary

We regret to report the death of Dr. Daniel Neil Chisholm, on February 8, 1960, at Port Hawkesbury, N. S., where he had practised Medicine for a number of years.

### WILLIAM GERARD COLWELL
An Appreciation

Those of us who remember the slender youth who was so prominent in the halls of the medical school during the first three years of the 'roaring twenties', find it hard to realize that he graduated in 1924, so well remembered and oft remarked was he during the following years. Indeed he seemed hardly to have left us before he returned to take up the practice of obstetrics and gynecology in 1928. Those intervening years were spent in training for his specialty in Boston and Montreal, and these were, for Halifax, the early days of long time post-graduate training, that now so commonly precede the laborious brushing together of the crumbs of practice. One remembers, too, how scanty were those crumbs through the 'hungry thirties', and how many a man had to turn his hand to unfamiliar work to earn his bread.

It was Bill who introduced many of us to organized medicine in Halifax. I well remember the occasion of the first annual dinner meeting of the Halifax Medical Society which took place a month or so after I had opened an office in Halifax, and a shy and diffident stranger it was who heard with joy Bill's cheerful voice on the 'phone that evening—"Going to the dinner?" "Come along with me." So was I introduced to the bun throwing contests which marked those otherwise memorable dinners, with their long post-prandial exercises in the pasteboard arts. Truly organized medicine needs many such friendly apostles to encourage and welcome newcomers into the fold. Friendly indeed he was. In all those years I did not meet him anywhere but, that the same bright greeting was his warm salute! Nor have I heard him speak ill of any man, even the shortcomings of our weaker brothers he observed with tolerance and regret.

For over thirty years a faithful and energetic worker and teacher, his hospital, his medical school and the people of this province owe him and others like him a debt they hardly acknowledge, let alone repay? The hours of his labors in the wards and theatres of his hospital, the days of his demonstrations and teaching in the clinic rooms, grew into, and devoured the years of his life. He was a true Professional of the highest type, not hiding his shortcomings in the snivelling shadow of the Cross, but offering honestly and unabashed

the best of his high art and skill in exchange for his livelihood. Would that medicine knew more of his able and honest breed!

One would have expected that the much deserved and well earned Chair of his specialty would have brightened and honored his later years. But such was not. To his friends at this sore hurt came Robert Browning's lines from the 'Incident of the French Camp,' where the great Napoleon, noticing his bleeding courier, exclaimed:

"Your're wounded!" "Nay", his soldier's pride
Touched to the quick, he said:
"I'm killed, Sire!" - - - - -

Institutions, in their self-seeking, are more often blind than malicious, when, with their opaque eyes they pour the deadly poison of distrust into the very crucible from which should bubble the urge and ambition that holds the young teacher toward the highest goal. Indeed loyalty is a strangely wayward salt that passes it's ions in purest form from where it stands in fair and equal concentration on either side of the membrane of service.

Loyalty to his friends was a sterling trait in Bill's character, and those of us who worked with him played with him, and matured with him feel a very deep sense of loss in the passing of so close a friend and colleague.

To his family goes our most sincere sympathy.

J. W. R.

## HARRY DOW O'BRIEN

An Appreciation

Harry O'Brien, born in 1903, the son of a doctor, died January 17, 1960. Left to mourn him: his wife, Jean Murray O'Brien, one son, John, a brother, Robert and a sister, Anna. Basic education in Nova Scotia schools and Dalhousie Univ. Medical Education: Dalhousie. Graduate of 1927. Early in his post-graduate life he became associated with Dr. John G. MacDougall a pioneer in surgery in Nova Scotia and one of the greatest surgeons and teachers of his time. Between the two there developed a very fine relationship which led Harry into a very rich experience.

He was appointed to the V. G. Hospital and to the teaching staff of Dalhousie Medical School where he served until the war. Then without waiting for the formalities of leave of absence he resigned and joined R.C. A.M.C. He served in England and went through the Italian Campaign as officer in charge of Surgery, No. 5 General Hospital. At the end of the war he returned with the rank of Lieutenant-Colonel. He was reappointed to his former positions at Hospital and University, and was serving those institutions up to the time of his passing. He was a Fellow of the American College of Surgeons.

During his professional life he served many offices. President of his local Medical Society, President, Provincial Medical Board of Nova Scotia, President of the Medical Council of Canada and was a member of the governing Board of the American College of Surgeons. His more recent appointment was part-time Medical Officer to the Hospital Insurance Commission. With all that, he kept himself in the forefront of medical knowledge and served his calling as a skilful and conscientious surgeon.

Such are the barest biographical details, and they indicate little more than the milestones in a very busy medical career.

How unfortunate that the record can do so little to paint a picture of the real man—the man as his colleagues knew him and will want to remember him; and how unfortunate, too, that so few if any of us are qualified to brush in the colours that would do justice to such a picture!

A thin little man, this colleague, whom it was good to know; a man who could be as mild and agreeably cooperative as any could be, but when principles were infringed or when bureaucracy became unduly irritable could be as peppery, rebellious and effective as they come: a man always with ideas—sometimes quite heterodox, but always refreshing—and with the ability and the courage to express them; a man to whom conformity for its own sake was a vice, and inimical to progress. Though kind and cooperative, quick to evaluate evidence and when indicated quick to concede a point with grace, the words that follow could well have been his:

"I praise thee for the will to strive
I bless thy goad of discontent";

for his endowments in that realm gave him character.

He had re-married only a few weeks before and though never robust, life for him seemed full and happy as with the promise of morn. How fitting it would have been, could he have continued his usefulness, were the shadows to have lengthened slowly, and were an evening of soft warm hues to have guided his pathway towards the night! But no! The call that has become so familiar to doctors in our time was for him clear and insistent and brooked no delay . . . . . . . . . . . .

The sadness of this tragedy was felt widely—wherever he was known; but the shock among his closer colleagues produced a most depressing gloom. In it one sensed a resentment, as if we would fling into the face of the Eternal Inscrutable a demanding "Why". But reason returns, and with it the realization that here is one conformity that though we spend our lives resisting it for others, is inexorable and inescapable for all. So in the abjection of defeat we can but salve our wounded minds with the ineffectual unguent of the poet:

"Out of the wind and the waves' riot
Out of the load foam
He has put into a great quiet
And a still home".

Requiescat in pace.

N. H. G.

## LETTERS

To the Editor:

Re: Dalhousie Medical Alumni Association

Most graduates of Dalhousie Medical School will have recently received a letter along with blank cheque forms for remitting annual and, where possible, life membership dues.

Since mimeographing that letter some two months ago, we should like to report further progress in our efforts to mould a strong Medical Alumni organization, to help develop many facets of the complex business of medical education on the Forrest campus, and to work along with the parent body toward an expanded and fuller life for medical students, graduates and the public they serve.

Our Association has now been duly incorporated under the statutes of Nova Scotia as a nonprofit organization, with all the privileges pertaining thereto including tax relief. We are most grateful to Mr. Gordon S. Cowan Q.C. for his generous help in looking after the details of this incorporation.

As will no doubt be surmised, a trend, beginning some 60 years ago towards attendance at Dalhousie by medical students from the Atlantic provinces has now reached the point where only a handful of such students seek their medical education elsewhere. This fact speaks volumes for our Medical School and illustrates the place it occupies in the lives of our Atlantic peoples.

We do not for a moment forget that large numbers of medical graduates from elsewhere have come and will continue to come to live among us, thus enriching our medical education and practice.

According to our Constitution these physicians and teachers are automatically eligible for Associate Membership in our Alumni organization on payment of dues, thus enabling us to work closer together in promoting our growth. A special appeal will be directed to this group in the near future.

One of the objectives of our youthful organization is to promote, when and where possible, frequent social gatherings of Alumni to keep all members informed of latest developments.

The first of these meetings since our inaugural gathering in June 1958 and the Annual Meeting in October 1959, will take place during C.M.A. Week in Banff. The plans are for a reception, dinner and short program for graduates and wives, where all those attending from the East will meet our many graduates in Western Canada and the U.S.A. This will take place at the Banff School of Fine Arts on Thursday June 16 at 6.00 p.m.

These arrangements are under the capable chairmanship of Dean Walter MacKenzie of Edmonton, with Dr. Donald Ramsay of the Calgary Associate Clinic acting as local Chairman.

All Eastern graduates are urged to communicate with our Medical Alumni office in Halifax, confirming their plans to attend. Westerners should communicate with Dr. Ramsay.

Finally, we are already looking forward to a "Calaigh" during Refresher Course Week (November 7-10), at which time our Second Annual Meeting will take place. This gathering is to be sparked by several class reunions.

One final word. Don't forget your dues! ! !

W. A. Murray, M.D. '43
President

## INFECTIOUS DISEASES—NOVA SCOTIA

### Reported Summary for the Month of January, 1960

| | NOVA SCOTIA | | | | CANADA | |
|---|---|---|---|---|---|---|
| | 1960 | | 1959 | | 1960 | 1959 |
| Diseases | C | D | C | D | C | C |
| Brucellosis (Undulant fever) (044) | 0 | 0 | 0 | 0 | 5 | 0 |
| Diarrhoea of newborn, epidemic (764) | 0 | 0 | 0 | 0 | 6 | 0 |
| Diphtheria (055) | 0 | 0 | 0 | 0 | 2 | 5 |
| Dysentery: | | | | | | |
| (a) Amoebic (046) | 0 | 0 | 0 | 0 | 1 | 0 |
| (b) Bacillary (045) | 0 | 0 | 0 | 0 | 395 | 0 |
| (c) Unspecified (048) | 0 | 0 | 0 | 0 | 23 | 0 |
| Encephalitis, infectious (082.0) | 0 | 0 | 0 | 0 | 3 | 0 |
| Food Poisoning: | | | | | | |
| (a) Staphylococcus intoxication (049.0) | 0 | 0 | 0 | 0 | 0 | 0 |
| (b) Salmonella infections (042.1) | 0 | 0 | 0 | 0 | 0 | 0 |
| (c) Unspecified (049.2) | 1 | 0 | 0 | 0 | 290 | 0 |
| Hepatitis, infectious (including serum hepatitis) (092, N998.5) | 176 | 0 | 73 | 0 | 642 | 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 | 0 | 0 | 0 | 0 | 24 | 1 |
| Meningococcal infections (057) | 3 | 0 | 0 | 0 | 18 | 0 |
| Pemphigus neonatorum (impetigo of the newborn) (766) | 0 | 0 | 0 | 0 | 0 | 0 |
| Pertussis (Whooping Cough) (056) | 19 | 0 | 17 | 0 | 690 | 515 |
| Poliomyelitis, paralytic (080.0, 080.1) | 0 | 0 | 0 | 0 | 47 | 3 |
| Scarlet Fever & Streptococcal Sore Throat (050, 051) | 142 | 0 | 237 | 1 | 3149 | 1743 |
| Tuberculosis | | | | | | |
| (a) Pulmonary (001, 002) | ** | 0 | 23 | 1 | 386 | 51 |
| (b) Other and unspecified (003-019) | ** | 0 | 0 | 0 | 106 | 19 |
| Typhoid and Paratyphoid Fever (040, 041) | 0 | 0 | 2 | 0 | 20 | 5 |
| Venereal diseases | | | | | | |
| (a) Gonorrhoea — Ophthalmia neonatorum (033) | 0 | 0 | 0 | 0 | 0 | 0 |
| All other forms (030-032, 034) | 55 | 0 | 26 | 0 | 1475 | 995 |
| (b) Syphilis — Acquired—primary (021.0, 021.1) | 0 | 0 | 1 | 0 | 0 | 0 |
| — secondary (021.2, 021.3) | 0 | 0 | 0 | 0 | 0 | 0 |
| — latent (028) | 2 | 0 | 3 | 0 | 0 | 0 |
| — tertiary — cardiovascular (023) | 0 | 0 | 1 | 0 | 0 | 0 |
| — ,, — neurosyphilis (024, 026) | 2 | 0 | 0 | 0 | 0 | 0 |
| — ,, — other (027) | 0 | 0 | 0 | 0 | 0 | 0 |
| Prenatal—congenital (020) | 0 | 0 | 1 | 0 | 0 | 0 |
| Other and unspecified (029) | 1 | 0 | 1 | 0 | 195* | 151* |
| (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 |
| Psittacosis & 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

*Not broken down

**Not available

# ANNUAL MEETING—1960

## HOUSING APPLICATION FORM

**The Medical Society of Nova Scotia**

**White Point Beach Lodge,**
**Queen's Co., N. S.**
**June 27th., 28th., & 29th, 1960**

DR. L. A. MacLEOD,
Liverpool, N. S.

Please reserve for me the following accommodations—

**A. Main Lodge**
Double room with bath—including meals—$10.00 a day per person.

**B.** Cottage with single bedroom for two people—including meals—$10.00 a day.

**C.** Cottage with two bedrooms for four people, including meals—$9.00 a day.

I WILL EXPECT TO ARRIVE JUNE .................. A.M. ............... P.M.

I WILL EXPECT TO DEPART JUNE.................. A.M. ............... P.M.

Name of persons who will occupy above accommodations:

Name (Dr. and Mrs.) ..............................................................................

Address ..............................................................................

In view of large attendance expected, no single rooms will be available at White Point Beach Lodge unless cancellations permit. If coming alone and willing to share a room please check here.................................... If you have a preference for some party to share a double room with (or couple(s) to share cottage with) please insert name(s) below:

I would prefer to share accommodation with

Name ..............................................................

Address ..............................................................

Name ..............................................................

Address ..............................................................

This form valid until May 15, 1960. After that date the committee assumes no responsibility for rooms.

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**Confirmation of Accommodations**

Dr. and Mrs.......................................................have reservations as follows for White Point Beach Lodge.

Cabin No......................................

Room No......................................

Date ..........................................