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The NOVA SCOTIA MEDICAL BULLETIN

EDITORIAL

EDITOR FOR SALE

Some time ago, a distinguished physician received a letter from an official of a regional medical society. I quote from it, "I am sending you herewith the transcript of the paper you presented at our recent meeting. I requested a copy as some complaints had been registered concerning your specific reference to certain drugs in the latter part of your address. I presume you will wish to do considerable editing, in event the material is to be published in the Journal of Supine Medicine. I am sure you will agree that for publication you will wish to *delete portions which are derogatory in reference to the drugs you mentioned.* We would not consider such references in good taste, and would not wish to have such remarks published as part of our papers in The Journal of Supine Medicine." (The italics are mine). There is a good deal more to the story and, at the proper time, I will deal with it in the editorial columns in this journal. However, enough is revealed in the quotation to underscore one of the forms of dry-rot that threaten our professional institutions.

The recent exposure by the Kefauver Sub-Committee, of a long standing alliance between Henry Welch, the Director of the Antibiotics Division of the Food and Drug Administration of the U. S. government, a group of supposedly reputable medical journals and a number of major drug houses, should alert thinking physicians to the hazards of laxity and indifference in this aspect of our professional relationships. Dr. Welch encouraged the marketing of fixed combinations of antibiotics at a time when expert opinion condemned such mixtures on the ground that they were less effective than single agents in optimal dosage and that such practice was destructive of medicine's tradition of precise diagnostic practice. Incidentally, Dr. Welch is reported to have collected more than a quarter of a million dollars in private income from antibiotic journals financially dependent upon the makers of the drugs he was officially charged with judging.

Early this year, a most distinguished bloc of medical journals was sold to an organization that began its corporate existence selling mailing lists to industry. It is now a prosperous publishing-advertising-promotional combine that controls the entire operation from the inception of the promotional idea in the copywriter's mind to the delivery of the journal to your desk. I do not blame the drug industry in this for, here, it is in a peculiar position because the sale of its products is dependent on the decision of a professional body standing between the producer and the consumer. The drug makers must manipulate our therapeutics practices as a harsh fact of economic necessity.

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THE MEDICAL SOCIETY OF NOVA SCOTIA

NOVA SCOTIA DIVISION
OF
THE CANADIAN MEDICAL ASSOCIATION

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Honorary Treasurer	A. W. Titus
Executive Secretary	C. J. W. Beckwith

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Colchester-East Hants	H. R. McKean
Cumberland	D. R. Davies
Halifax	D. M. MacRae, J. W. Merritt & F. J. Barton
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Pictou County	M. F. Fitzgerald
Valley	D. MacD. Archibald
Western Counties	C. K. Fuller

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Chairman Public Relations Committee	F. A. Dunsworth
Chairman Medical Economics Committee	H. E. Christie

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Nova Scotia Society of Ophthalmology & Otolaryngology	H. J. Davidson
Nova Scotia Society of General Practitioners	A. G. MacLeod
Nova Scotia Chapter of College of General Practice	A. Titus
Nova Scotia Division of Canadian Anaesthetists' Society	C. H. L. Baker
Nova Scotia Association of Pathologists	J. H. Cooper

In this situation, the medical editor must maintain the independence of his editorial page at all costs. He may not be profound, far-seeing, completely informed or even unbiased in the exercise of his editorial duties but he must remain independent. Small potatoes like ourselves will never be bought outright but there are more subtle temptations to be "realistic", to "co-operate in improving our financial position", to be "reasonable and not offend our advertisers". My only answer is that, whatever the advertisers buy, they do not buy the editorial page. We can get along with industry without compromising our professional integrity or defaulting in our responsibility to protect the health of the public. Hugh Clegg, the editor of the British Medical Journal said, recently, that "a medical editor has to be a keeper of the conscience of a profession and if he tries to live up to this ideal, he will always be getting into trouble". Your editors have not reached that exalted plane but our opportunities and responsibilities are of a high order, none the less. Will you give us your advice, your support and your prayers now and in the future?

J. O. G.

POST-GRADUATE DIVISION, FACULTY OF MEDICINE
DALHOUSIE UNIVERSITY

SHORT COURSES IN HALIFAX

1. Psychiatry.....January 30 to February 1, 1961.
2. Infections and Infectious Diseases. February 27 to March 3, 1961.
3. Obstetrics and Paediatrics.....Late April, 1961.

REGIONAL COURSES

A series of six clinical meetings in your local hospital can be arranged on request (priority basis).

Transactions

2ND REGULAR MEETING EXECUTIVE COMMITTEE
9.30 A.M. SATURDAY, OCTOBER 15TH, 1960
AT HALIFAX

The second regular meeting was convened by the Chairman of the Executive Committee, Dr. D. I. Rice at 9.45 a.m.

There were three sessions—9.45 a.m. to 1 p.m.; 2.45 p.m. to 6 p.m. and 7.55 p.m. to 10.45 p.m.

Those in attendance were:—

PRESIDENT:	Dr. F. J. Granville (a.m., p.m. and eve.)
CHAIRMAN, EXECUTIVE:	Dr. D. I. Rice, (a.m., p.m. and eve.)
TREASURER:	Dr. A. W. Titus (a.m., p.m. and eve.)
EXECUTIVE SECRETARY:	Dr. C. J. W. Beckwith (a.m., p.m. and eve.)
REPRESENTING EDITOR OF THE BULLETIN	Dr. J. O. Godden (a.m., p.m. and eve.)

Representatives from Branch Societies:

ANTIGONISH-GUYSBOROUGH	Dr. T. W. Gorman (a.m., p.m. and eve.)
CAPE BRETON:	Dr. H. F. Sutherland (a.m., p.,. and eve.)
	Dr. J. R. Macneil (a.m., p.m. and eve.)
COLCHESTER-EAST HANTS:	Dr. H. R. McKean (a.m., p.m. and eve.)
CUMBERLAND:	Dr. D. R. Davies (a.m., p.m. and eve.)
HALIFAX:	Dr. D. M. MacRae (a.m., p.m. and eve.)
	Dr. J. F. Barton (a.m. and p.m.)
	Dr. A. S. Wenning (alternate — p.m.)
LUNENBURG-QUEENS	Dr. S. B. Bird (a.m., p.m. and eve.)
PICTOU:	Dr. M. F. Fitzgerald (a.m., p.m. and eve.)
VALLEY:	Dr. D. MacD. Archibald (a.m., p.m. and eve.)
WESTERN COUNTIES:	Dr. C. K. Fuller (a.m., p.m. and eve.)

Observers:

Rep. to C.M.A. Executive:—Dr. R. O. Jones (a.m. and p.m.)
Chairman, Public Relations:—Dr. F. A. Dunsworth (a.m. and p.m.)
Chairman, Medical Economics:—Dr. H. E. Christie (a.m., p.m. and eve.)

Minutes

The Minutes of the fifth and last regular meeting of the Executive Committee, 1959-60 were adopted as distributed.

BUSINESS OUT OF THE MINUTES—June 25th, 1960.

1. **The Scheduled Branch Society Meetings.** The Secretary reported that through the co-operation of the Branch Societies each of the nine Branches had held a meeting during the week of October 2nd, 1960. Three of these had been attended by the Chairman of the Executive, five had been attended by the Executive Secretary and one by the Past-President. Discussion relative to scheduled meetings of Branch Societies prior to Executive Committee meetings resulted in the following views:—

(a) That such meetings were of definite value and could be expected to develop in a manner which would result in increased interest on the part of the membership in the business of Medicine.

(b) That items of particular interest should be brought to the attention of Branch Societies rather than submitting the whole agenda of the Executive meeting as available at that particular date.

(c) Although some members felt that the meetings might be longer than two weeks in advance of the Executive meetings. No change in the plan was introduced.

(d) It was unanimously agreed that each Branch Society should include on the agenda of these scheduled meetings, a place for a report from the representative to the Executive Committee on the previous meeting.

The Secretary requested a review of the directive which required that the minutes of a Branch Society when received, be stencilled and sent to all Branch Society Secretaries. Resulting from discussion it was regularly moved and seconded:—

"That Branch Societies be requested to send an extract of the more important proceedings of each meeting and forward to the office of the Executive Secretary for stencilling and distribution to other Branch Societies for their information." Carried.

Group Disability Insurance

Dr. A. J. Brady, acting Chairman for the Special Committee presented the Committee report which informed the Executive of discussions which had taken place with Mr. R. F. Smith the Provincial Manager of the Union Mutual Life Insurance Company of Montreal. Mr. Smith had accepted an invitation to be present at this meeting. He gave a comprehensive background of the discussion which had taken place with the Special Committee as well as an outline of a proposed plan for consideration of the Society. These proposals led to a great deal of questioning by the members after which Mr. Smith was thanked for his presence and retired.

Further discussion by the Executive Committee resulted in the following resolution which was regularly moved and seconded:—

"That the Executive Committee is favourably impressed with the Union Mutual 14-day waiting period plan in point of principle, and that the representatives to the Executive Committee inform their Branch Societies of this; that the Branch Societies be requested to move resolutions to the Executive of the desirability of completing negotiations with Union Mutual. While this is going on the Special Committee on Group Disability to begin the preliminary negotiations with Union Mutual." Carried.

Mr. Smith has agreed to prepare an outline of the proposals and forward sufficient copies to be sent to the members of the Executive Committee and Branch Society Secretaries.

Report of Representative to Trusteeship Committee, C.M.R.S.P.

Dr. Crossman Young, alternate member to this C.M.A. Committee from this Division, reported very satisfactory progress in the affairs of this Plan. He stated that there had been a definite appreciation of the unit value of the investment portion of the Plan; that 64% of the seven million dollars contributed by C.M.A. membership has been allocated to investments and 36% has been allocated to the pension portion of the plan. He drew attention to a new operation identified as the "Canadian Medical Equity Fund" stating that the membership would receive notification of this in the mail. It was generally agreed that the C.M.R.S.P. is a plan which is working out to the satisfaction o all and that the membership should take advantage of it.

Dr. Young's verbal report was regularly moved and seconded for adoption. Carried.

The Chairman now returned to the agenda.

The Minutes of the 1st Regular Meeting of the Executive (1960-61) of June 30th, 1960 were adopted as distributed.

The Summary of Minutes of the Special Meeting of the Executive Committee September 10th, 1960 were accepted as minutes for that meeting and adopted as such.

Reports on Committees

Special Research Committee. Chairman Dr. A. A. Giffin.

Dr. R. O. Jones, a member of the S.R.C., was requested to present the report. It was regarded as of an interim nature recording the action taken at the first meeting of the S.R.C. on September 24th, 1960 and included a proposed budget for 1960-61. A request was made for additional secretarial services on a part-time basis primarily to assist this Committee in the discharge of its function and, to a degree, to assist the Executive Scretary.

A motion for adoption was regularly moved and seconded. After a comprehensive discussion this motion was unanimously carried.

It was also regularly moved and seconded:—

"That the S.R.C. be authorized to employ the medical assistant for its committee work as described in the report to the Executive Committee of its first meeting (September 24th, 1960)."

Committee on Medical Economics

The report for this Committee was presented by the Chairman, Dr. H. E. Christie and was regularly moved and seconded for adoption.

The report included proposed terms of reference which varied somewhat from those in the present by-laws. It also made reference to a resolution from the Annual Meeting 1960 ". . .: investigating the rates paid to physicians providing medical services for Federal or Provincial Governments on a full or part time basis . . .". The report included a recommendation that this item be referred to the Committee on Fees for study.

After discussion the motion for adoption was put and carried.

Special Committee on Workmen's Compensation Board

This report was presented by the Chairman, Dr. A. W. Titus and was regularly moved and seconded for adoption.

The report included a review of the terms of reference and the preparation of a brief to the Royal Commission on the Workmen's Compensation Act. This had been submitted in 1957. The report of the Workmen's Compensation Commission is printed under the date of December 18th, 1958 and was considered by the Legislature in 1959. Efforts to arrange a meeting between representatives of the W.C.B. and The Medical Society of Nova Scotia, initiated in 1959, resulted in the meeting requested on October 6th, 1960. It was on this meeting that Dr. Titus reported. The Workmen's Compensation Commission had recommended adoption of four recommendations in the brief of The Medical Society of Nova Scotia. One of these is the formation of a Liaison Committee consisting of three members of The Medical Society of Nova Scotia and three members from the Workmen's Compensation Board. The formation of this Committee had been mutually agreed on at the meeting of October 6th and it was believed that this Committee would then explore the other recommendations as well as take under review other items presented by the W.C.B. and The Medical Society of Nova Scotia.

It was regularly moved and seconded:—

"That the Special Workmen's Compensation Board Committee, set up in 1957 be disbanded and replaced by a W.C.B. Liaison Committee, representative of the more industrialized areas of the Province, and, for continuity, to include one of the members of the former Committee." Carried.

It was also regularly moved and seconded:—

"That the Liaison Committee to the Workmen's Compensation Board consist of Drs. H. E. Christie, A. W. Titus and A. L. Sutherland." Carried.

After discussion the motion for adoption of the report was carried.

Committee on Public Relations

The Chairman, Dr. F. A. Dunsworth presented the report for his Committee. It was regularly moved and seconded for adoption.

The report examined the matter of "intercommunication within the profession" and recommended for consideration the development of a "newsletter" which would serve to keep the members informed on matters pertaining to the business of medicine which should not, because of their nature, appear in the Bulletin with its rather wide circulation. It was further proposed that if this "Newsletter" were to develop, it would be prepared and distributed in advance of the scheduled Branch Society meetings, i.e. four times per year.

The motion for adoption was carried.

Dr. Dunsworth produced a letter which he had received from the Supervising Producer, Public Affairs Department of the Canadian Broadcasting Corporation which had informed his Committee of a tentative schedule for a series of fifteen-minute programmes over C.B.H.T. on the subject "So Grows the Child." The assistance of The Medical Society of Nova Scotia was sought in the production of this series and the Executive Committee directed that the Public Relations Committee assist the C.B.C. in any way possible toward this end.

Committee on Civil Disaster

Dr. S. B. Bird, Chairman, gave a verbal report referring to a letter from Civil Defence which had requested the assistance and advice of his Committee in furthering plans for Civil Defence until such time as a full-time medical officer was appointed to Civil Defence. This was agreed to by the Executive Committee. Dr. Bird also reported that Dr. R. Weil would represent the medical profession at the Civil Defence Course at Arnprior in November. It was regularly moved and seconded that this verbal report be accepted. Carried.

Committee on Annual Meeting, 1961

Dr. F. J. Granville, President of The Medical Society of Nova Scotia, gave a verbal report in which he stated that one meeting had been held with the Executive Secretary; that the chairman of the various committees to do with the Annual Meeting will have been selected and a meeting of the chairmen, the Executive Secretary and himself would be held during the last week of November.

On motion the verbal report was adopted.

Radiology Standards Committee

This is a new Committee resulting from action at the Annual Meeting, 1960 whose Chairman is Dr. C. M. Jones. The report was introduced by the Chairman of the Executive Committee who stated that the detail entered into by the Committee had been desirable for present purposes.

Discussion resulted in the following resolution, regularly moved and seconded:—

1. "That the report of the Radiology Standards Committee be referred to the Health Insurance Committee.
2. That the Executive go on record as being in favour of recommendation No. 1, made by the Standards Committee.
3. That the Executive re-emphasize the terms of reference of the Standards Committee.
4. That the Nova Scotia Hospital Association and the N.S.A.R. get together and carry out an intensive advertising campaign to try to fill the vacancies which exist or will exist.
5. That the Hospital Insurance Commission be again informed by the Halth Insurance Committee of our stand re 'fee-service'." Carried.

Recommendation No. 1 is as follows:—

"That all demands for their services be met by the radiologists to the best of their ability and that the full fee, as approved by the Tariff Committee of The Medical Society of Nova Scotia, be paid for each and every service rendered."

The Executive Committee then directed its attention to five items of correspondence and five items of old business.

New Business

1. A request from the N.S.H.I.C. for recommendations for appointments to the Professional Technical Advisory Committee (P.T.A.C.) was acted on.

2. A recommendation from a member of the Society that a "Diabetic Day Service" be introduced as an insured service under the Nova Scotia Hospital Insurance Commission was approved by the Executive and the Nova Scotia Hospital Insurance Commission is to be so notified.

Resolutions from Branch Societies

Five resolutions from the Antigonish-Guysborough Branch Society and one from the Cumberland Branch Society were presented to the Executive and the necessary action taken.

Disciplinary Committee

An amendment to the by-laws which was adopted at the Annual Meeting, 1960 requires the formation of such a committee. A member of the Society selected by the Executive Committee was identified to be approached with the request that he act as Chairman of this Committee and select three members which would form the Committee itself.

The date for the next regular meeting of the Executive was named as February 4th, 1961.

On motion the second regular meeting of the Executive Committee 1960-61 adjourned at 10.45 p.m.

C.J.W.B.

OUR DEADLIEST MENACE

H. B. ATLEE, M.D.

Halifax, N. S.

At this late date the possibility of socialized medicine does not have to be argued: it is already with us in Saskatchewan. So let us waste no further time arguing the inevitable, and begin to ask ourselves what we are going to do about the evitable. What are we going to do about any scheme that either stabilizes our income at a mediocre level, or puts that income at the mercy of inflation, or—by placing us too firmly under the heel of a bureaucracy—will restrict our present freedom to expand and explore? Are we going to resist these with all the intelligence at our disposal, or, if we do have to accept socialization, how are we going to do so without suffering too greatly from that deterioration in human effort that seems the inevitable accompaniment of socialization?

On several occasions I have cried out about the necessity of tying any of the socialized fees that we now accept to the cost of living index to avoid inflation. Economists say that the capitalistic system won't run without inflation, so it looks very much as if a steady lowering in the value of the dollar is here to stay. There's one important way in which this can seriously jeopardize our future; fewer young men, especially fewer of the adventurous, free-wheeling type so essential to spurring us to new and original endeavours, will want to enter a profession where the demands keep expanding and the income decreasing. This trend is already showing itself, and I think we should give serious thought as to its why and wherefore.

Here we are on this continent, increasing in population so rapidly that it will double in the next forty years—yet the applicants for entrance to medicine are, not only relatively, but actually fewer. Can we do much more work per head than at present without a deterioration of effort? This is a serious danger and is already making its results manifest, especially among our elite. Even the teachers in our medical schools are so busy with the routine care of patients that they have less and less time for that process of rumination out of which comes ideas, less and less time for investigation, and—worse still—less and less time for teaching; and this because it is now necessary to see three times as many patients a day as it was twenty years ago to earn the equivalent dollar. What is equally disturbing is the increasing difficulty of recruiting from among our graduates, the proper calibre of men as teachers. In New York and Chicago, as well as Halifax, obtaining the right type of man for the most advanced graduate training grows steadily more difficult.

Why? I think we should ask ourselves urgently this most important question. If we start to wither at the top, what hope is there? If we start to wither anywhere, how can we possibly cope effectively with the increasing body of health problems that will grow out of our exploding population. If any large part of the reason for this is that our brighter and more resourceful young men are shying away from medicine because they fear socialization, then we should know this, since it would constitute a most powerful argument against socialization. If they are backing away because they fear the further effect of inflation on the set incomes of all our present insurance schemes, we should know that too.

Otherwise, what is likely to happen? Let us suppose that the admissions to medical study lessen and the population continues to increse at the present rate. It is obvious that we cannot effectively handle twice the population with half the doctors. Already, in order to deal with our present population, we have had to cut home-visiting to a minimum and get our patients to come to our offices where we can process them more quickly. Will we not presently have to do what the nurses have done, introduce the medical aide—a lesser breed socially and educationally—into our system? Make no mistake about it, this is what we are headed for if the present trends continue—and by present trends, I mean the increase in population and the decrease in doctors.

In fact, I feel quite sure that the medical aide is definitely on his way. Practically every factor in our present situation is making his (or her) advent inevitable. We will create him because we need his help, but he will prove a Frankenstein monster. Something like this will happen: because he will be a lower species, socially and professionally, we will high-hat him, forcing him back on his own kind, so he'll organize—as the nurses' aides have. Presently the continuation of present forces will bring about such an increase in his numbers that his ranks will outnumber ours. In that day his antagonism—feeding on the sense of inferiority we have forced on him—will prove the lower millstone—socialization being the upper—between which we'll be crushed. Not a happy situation—but one, let me repeat, that the logic of events will almost certainly make inevitable.

But let us leave this more mundane matter of recompense and pass on to another that holds the greatest menace to our professional and personal integrity. There is still a tendency among free men to regard the bureaucrat and his bureau with a touch of amusement. We speak of him with irony, even with contempt. But the bureaucrat is no laughing matter, as anyone who makes out an income-tax form knows. For the bureaucrat, humble perhaps in his beginning, grows like a djinn from Aladdin's lamp, until finally he stands above the law. He can beat the hell out of you, but you can't touch him short of a revolution.

Socialization is a system requiring an unusually large number of bureaucrats to set up the rules and see that they're applied. Presently, coming as they inevitably do under Parkinson's law, these create work for other bureaucrats, until finally there is clamped on the system a swarming group of little men, dedicated to the letter rather than the spirit of the regulations—at which point the men working under them are no longer free. For as the head bureaucrat sits in his office with his feet on the desk—he has two main thoughts in his mind: (1) How an I tie up this troublesome loose string with a new regulation: and (2) How can I regulate matters so that the people working under me can do the least to embarrass me? Of course not all bureaucrats are like this, but the bureaucrat who isn't is likely to find himself in trouble sooner or later with the politicians or board of directors who employ him. So you can put it down as Atlee's law, that all bureaucrats who live dangerously will one day get a kick in the stern; ergo, bureaucrats neither live dangerously nor permit those working under them to live dangerously.

And here we come to a very grave human situation: when men and organizations cease living dangerously they start to die. It is this tendency of the bureaucrat to influence the men working under him to hedge on every difficult problem, to take the safe rather than the risky course, to avoid any belief or undertaking that might be politically unpopular, that constitutes the greatest menace with which socialization threatens a profession like ours.

This could affect in a deleterious way the future of such a vulnerable specialty as psychiatry. I think that we can safely predict two things about the future of that specialty: (1) It is going to become increasingly important in the life of every doctor as the stresses and strains of modern living increase, and (2) since it deals ultimately with morals and moral ideas, fresh adventures in this field are highly likely to conflict with some of our religious and educational theories. What bureaucracy, controlled ultimately and supported financially by government, would find itself free to continue to sanction such unpopular ideational adventures? But what might prove particularly true in the case of psychiatry, would apply in a lesser degree, to every experiment our profession undertook that held any potential danger, or could create resistance on the part of a public not fully enlightened to the possible gains. As the Italian poet, Quasimodo said in a recent interview: "When politics is pre-eminent Man disappears. He becomes but a number." By "politics" he meant government—and to the degree that socialization permits government to control our ideas and our actions, to what extent do we disappear as truly useful human beings. What Quasimodo meant is illustrated by what happened to the writer Pasternak in Russia, what inevitably happens when government interferes with the outstanding man's right to express himself.

So, if we are going to allow ourselves to be socialized, we should not only have an awareness of the dangers facing our integrity in such a move, but should be prepared, if we desire to retain any real degree of freedom of action, to discipline ourselves to an unrelenting vigilance and courage so that we can resist from the beginning the earliest and most tentative attempts of the bureaucracy to expand its dominion over us.

Then, I think we should decide to what extent we are willing to be socialized. There are two phases to medical socialization. There is, first of all, the phase that can be summed up under the title, Medical Insurance. Then, there is the other phase, arising out of the philosophy that who pays the piper calls the tune; where government begins to interfere in and attempt to rearrange all sorts of medical matters—varying all the way from what is happening in Britain to what is happening in Russia. Although Premier Douglas' scheme is ostensibly medical insurance, it partakes enough of phase two to open the tent to the camel. It undoubtedly will act as a guide to other Canadian governments.

We have already accepted the philosophy of medical insurance in Maritime Medical Care, which is a degree of socialization. If government took over medical insurance, we would simply be exchanging the bureaucracy of Maritime Medical Care for that of the Department of Health. A government-run system of medical insurance, consolidating all the present schemes, would be in the public interest in that it would not only spread the costs of medical care so widely that no individual is crucified by an unlucky overload of sickness, but would include *every* individual in the community within its scope. Could we reasonably object to that without not only appearing illogical but even increasing the already existing public resentment against us?

Make no mistake about it, such resentment exists. How much of it is justified and how much the result of envy, I am not prepared to say. But as I listen to the various arguments I am certainly conscious of that note of envy—the mean desire of the man getting less to pull the man getting more down to his level—to cut him down to size. This note of envy is particularly evident when Trades Union spokesmen deal with our status. Or radio commentators. The other day one of these sages of the airways said over the

radio that we doctors had had it our own way long enough and should realize that we now have to accept the control of socialization. His tone was antagonistic.

If the entire country decided to become socialized, our profession would naturally have to go along with it. We would then all be in the same boat. But why should our profession be asked to place its neck under a heel that the other professions and the rest of the community are not ready to bow to? The argument that medicine should be socialized because everybody needs a doctor is equally true for groceries and electricity. The argument of the inequity of costs can be taken care of with proper insurance schemes, but beyond that what need is there to separate us as goats from the sheep? I am not arguing here that universal capitalism is better than universal socialism: I am suggesting that, since this is to all intents and purposes a capitalistic nation, the majority of the community has no right to force a minority to accept socialism and be forever after at the mercy of the voting power of that majority. I wonder how loud the lawyers or the Teamsters Union would howl to high heaven if it were proposed to do to them what they are proposing be done to us. But of course there is no danger of that—the lawyers control our parliaments and our parliaments, with the exception of Joey Smallwood's, are frightened to death of the Teamsters.

This rank injustice is an argument that I think we could use with much better effect than some that I have been listening to from Saskatchewan. We have better arguments than that, much better. We can, in addition to citing the injustice of socializing us while the rest of the community remains capitalistic, assure the public that, beyond shadow of doubt, socialization will cause a deterioration in our profession. When a man feels that the recompense he gets no longer matches the effort he is making, he slackens down on that effort. Very few people resist this rule, which gives rise in union circles to featherbedding and the five-day week, and other such limitations of human effort that have played so far such a small part in the life of medical practitioners. We can, furthermore, assure the public that socialization will not decrease the cost of medical care, it will actually greatly increase it.

Perhaps I can best illustrate not only why the costs of government-run monopolies tend to rise, but how the whole system of bureaucracy inherent in government control works to restrict our freedom, and to hamper us with rules and regulations, by reciting the following mythical fable of socialized medicine.

Sam Magee is a bureaucrat in a provincial Department of Health anywhere—Russia, for instance. This particular morning he is sitting at his desk staring grimly at a file of correspondence touching a matter that has caused him a great deal of annoyance and harrassment lately.

Some months ago, his secretary came in with some forms—one of Sam's outstanding accomplishments is that his department has instituted more new forms than any other in Canada—and placing them before him said: "I wish these doctors would write more clearly. We're having the worst trouble deciphering signatures. Here's one that looks like Dlorah Eelta. I can't find a Delorah Eelta in the directory."

Sam looked at the queer signature for a moment—saw that it came from Secum-Ecum, and burst out resoundingly: "The bastard has signed his name backwards! I'll settle his hash—take a letter."

But not only does his irate letter get no reply—the forms continue to come in signed Dlorah Eelta. Finally, Sam writes the delinquent stating that unless he signs his name properly, he won't get his monthly cheque.

By return mail comes this letter: "Dear Dr. Magee: I have consulted legal advice and am informed that, while it may annoy you, there is nothing illegal in signing one's name backwards. Large groups of the human race write from east to west instead of west to east—and surely what is permissible to the peasants of a backward country like Syria, should not be denied a member of the noble medical profession of Canada. In any case, since my lawyer says I am within the law, this is to inform you that if you don't pay my next month's salary— which God knows inflation is making a miserable pittance— I will sue you personally for it and send this correspondence to the Winnipeg Free Press (thank God there's still something free in Canada). This would make you look pretty ridiculous, wouldn't it? Yours truly, Dlorah Eelta."

One would have to be pretty hard-hearted not to sympathize with Sam in dealing with this unregenerate Secum-Ecum character, but the sympathy would be wasted. Being a bureaucrat, Sam knows what to do. He picks up the correspondence and heads for the minister's office. He finds the minister sitting at his desk staring out the window at the horizon which, this being a prairie province, is as far away as his gaze, for the minister is also having his troubles. What is irking him—in fact what is bothering him more than he would admit—is a 'phone call he has just had from Bill Corona, the big typewriter and office specialty jobber. Not only did Bill contribute very generously to the party in the last election, he contributed to the minister's own battle in a tightly contested constituency. Bill is complaining about the fact that in the last three months the government hasn't bought more than $3,000 worth of supplies from him, which as he put it "is goddam chickenfeed in this man's business."

So when the minister sees the file of correspondence in Sam's hand, he says wearily: "Sit down, Sam, and take the weight off your rules and regulations."

Sam sits down and presents his problem. For a moment the minister almost bursts out laughing, but since he knows that a sense of humour can lose more votes than a weekend with a floosie, he curbs himself.

"What would you suggest, Sam?" he asks.

Sam is right there with the answer: "I'd like to do something really useful about this, Mr. Minister. At the same time I'd like to settle this whole matter of doctors' illegible signatures on our forms. They've got to learn that government forms are important. How about an order-in-council that all medical signatures must not only letter from west to east, but must be clearly and legibly signed—otherwise a fine of fifty bucks. That'll show the so-and-sos we mean business."

A gleam suddenly comes into the minister's eye: Does this crazy situation offer a chance to kill two birds with one stone? He leans back in his chair and lights a cigar. "You know, Sam," he says, "That might be a bit tough on a lot of poor writers in a hurry. Even my own signature's not so legible when I'm rushed. I agree about the west to east business. Slap a hundred dollar fine on that if you like. But I've been thinking a lot lately about the medical profession. They seem to be getting a bit restive—inflation is eroding their incomes—and the first thing they'll be after me for a raise which the premier won't want to agree to. Not until he has implemented that promise in the

last election to provide special rest rooms for teenage girls in all our high schools. But here's a thought: suppose we make it a rule that every signature has to be written over a typewritten one, and—"

"But a lot of them haven't got typewriters, Mr. Minister," Sam interposed uneasily, "and that'll just make them madder at us."

"But that's where we come in, Sam," the Minister replied. "Our department will put up $60.00 on the price of every typewriter. A Corona can be bought for $75.00. What doctor could pass up getting a Corona for fifteen bucks? Make out an order-in-council to cover this and I'll ram it through the next cabinet meeting. I backed Malarkey for his increased roads subsidy, and McPedagogue for those crazy rest rooms for teen-age girls. The sons-of-guns can't refuse me a piddling little request like this, especially in view of the goodwill it'll create in your profession."

And of course the sons-of-guns can't. If they could taxes would have to stop going up—they might actually go down—and Parkinson's law would be proved wrong—which is unthinkable.

Now while the above is mythical it is also typical. It is typical in three ways. It shows first the manner in which the bureaucrat deals with the difficult ones—the Dlorah Eeltas—by smothering their individuality with red tape. It shows how governments squander your money and mine to maintain their pork barrel. And it shows how those working under a bureaucracy can be fobbed off with a gewgaw when what they need is a raise of pay—like the old bread and circuses that played such an insidious part in the decline of Rome.

The same sort of thing goes on in government circles every day and all over the world—but the more so the greater the socialization. Even the most superficial students of political economy (and the combination of those two words is a laugh) will agree that I have in no way exaggerated—can cite episodes to match it in every detail. Last week's TIME magazine quoted three such—here is one: The Air Force needed 116 fuel-pump screws that were worth 5 cents apiece, but the cost of extra handling and air-special delivery ran the cost up to $1 apiece. Later, when the Air Force came to pay for 272, 710 identical screws, Government purchasing agents agreed to a price of $1 apiece." So anyone who thinks that the socialization of medicine is going to lower the cost of medical care is living in an idiot's paradise. The only thing that will cost less will be doctors.

Where should we take our stand on this matter of socialization? I am certain that our commitment to the philosophy inherent in Maritime Medical Care makes it impossible for us to refuse to accept a government-financed medical insurance plan where government takes on the payment of the doctor drugs, nurses, and hospital. But how much further than that can we surrender our freedom without losing that vital liberty of action and experimentation without which we cannot maintain to its fullest in the future, our past progress against disease? Make no mistake. if government introduces medical insurance, it will try to socialize us further, Premier Douglas' plan makes that quite clear. So, if we don't want to surrender further why don't we let governments and public know now how far we feel we can go with safety to our professional integrity, beyond which we cannot go without danger of serious deterioration and beyond which we will not go without fighting.

Personally, I believe that we should draw the battle line clearly and definitively. We should say to governments and the community: "We will accept government medical insurance, if you will tie whatever fees are mutually agreed on to the cost of living index so that inflation will not wreck us. But

if you encroach further than that on our rights as free men we will fight to the bitter end with every legitimate weapon at our disposal, including the strike."

And then we should agree among ourselves that THIS IS IT. This is the point at which we must remain united from top to bottom. This is where we must maintain a front more impregnable than any of our brothers in any other country have ever done in the past.

Well, that's my gospel. Perhaps I am being over-pessimistic. Perhaps all the grim consequences of socialization which I have confronted you with will not occur. I can only say that they always *have* occurred, and so far men have not yet discovered how to accept the benefits of socialization and at the same time prevent that loss of freedom without which they become less than men. It is for that reason that I deplore our present apathy towards this wave of the future that threatens to engulf us. It is for that reason I believe it constitutes the greatest menace our profession has faced in modern times. If we are going to accept further socialization, we should already be planning and disciplining ourselves against its dangers. If we don't want further socialization, we should be organizing ourselves against it much more rationally and resolutely than our brothers in Saskatchewan. Above all, we should not remain indifferent.

MALIGNANT DISEASE IN THE AGED: REVIEW OF 16 YEARS' EXPERIENCE IN A MODERN MEDICAL FACILITY FOR THE ELDERLY. Elias, E., and Lesnick, G. J., Am. J. Med. Sci. 239:554, (May) 1960.

The incidence and results of management of malignant disease in a home for the aged are reviewed in this study. Sixteen per cent of patients dying in a home had evidence of malignant disease prior to death or at postmortem examination. Three-fourths of them died of malignancy. Tumors of the gastro-intestinal tract comprised 49.6%; the genito-urinary tract, 16%; the lungs, 11.9% and the breast, 10.9%. Diagnosis was established prior to death in two-thirds of the patients. In a little over one-third of the patients, diagnosis was established early enough to permit treatment with some hope of success. Treatment gave significant palliaton in two-thirds of those treated and resulted in cure of the disease in one-fourth of those treated.

This study indicates the need for simple screening tests, such as blood and stool examination, and frequent weight measurements in older individuals. In the opinion of the authors, the excellent response to therapy in many of the patients emphasizes the value of early aggressive therapy even at advanced ages.

S.J.S.

SYMPOSIUM ON OEDEMA

PART V. THE MECHANISM OF ASCITES

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Ascites is the accumulation of fluid in the peritoneal cavity; the abdomen becomes converted into a bag of fluid (askos; a bag). The fluid can be either a transudate or an exudate. The exudative types of ascites are due primarily to carcinomatosis or tuberculosis. The transudative types are associated with cardiac or renal disease or with portal vein obstruction commonly associated with liver disease. This paper will deal mainly with liver disease, portal obstruction and the pathogenesis of ascites due these causes.

It was Starling in 1896[1] who suggested that the interchange of fluid between the blood and the tissue spaces is controlled by the balance between the capillary blood pressure forcing fluid into the tissue spaces and the osmotic pressure of the plasma proteins retaining fluid in the vascular compartment. In applying this hypothesis to the development of ascites, the portal capillary pressure, (C), helps fluid to pass into the peritoneal cavity whereas the osmotic pressure of the plasma proteins, (P), checks it by retaining fluid in the portal capillaries. Each of these factors is influenced by the intra-abdominal hydrostatic pressure, (A), and the intra-abdominal osmotic pressure, (O). Thus the forces causing fluid to pass into the peritoneum are C + O and preventing it P + A. Ascites develops when the pressure C + O exceeds P + A. It is apparent that the two most important factors contributing to the formation of ascites are the plasma colloid osmotic pressure and the portal venous pressure.

The plasma colloid osmotic pressure is not usually measured directly but is calculated approximately from the plasma protein level by the formula.[2]
Colloid osmotic pressure (mm H_2O) = K (3.56 Alb. + Glob.) K = 16

The plasma albumen level largely governs the colloid osmotic pressure and a lowered plasma albumen level is usually a pre-requisite for ascites formation. The critical level has been estimated at 3.1 grams albumen and this is sometimes called the ascitic threshold.

The ascites of subacute hepatitis may be even more closely related to the concentration of the serum proteins than that of portal cirrhosis; in the former raised portal venous pressure is a less important factor. Ascites does occur with plasma albumen levels above 3.1 gm. and this may be partly explainable by the influence of other important factors particularly a very high portal venous pressure.

The etiology of portal hypertension associated with liver disease and the influence of the portal hypertension on ascites formation is controversial at the present time. There is considerable evidence which indicates that the portal hypertension is not due to the hepatic fibrosis alone but may be related to hepatic arterial influence on the portal system. In 1907 Frederick C. Herrick did a series of experiments which showed this.[3] He found that in the normal liver an increase in arterial pressure up to 100 mm. of Hg. did not affect the portal pressure; however, in cirrhotic livers, the effect on the portal pressure was noted at 30 mm. of Hg. This, he believed, was evidence of the mutual influence between portal and arterial pressure within the liver and is an important explanation of the rise in portal pressure in portal cirrhosis. He also found that the actual blood flow, both arterial and portal, is increased in cirrhosis.

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Increased communication between portal and hepatic circulation increases the influence of the arterial over the portal pressure and this, rather than fibrosis, leads to the portal hypertension. Recently Madden et al[4] by injecting specimens with colored latex have shown that it is the outflow tract that is reduced and that this contraction is the cause of the portal hypertension.

Granted that there is portal hypertension; what evidence is there that this alone will cause ascites? Bolton in 1909[5] showed that experimental obstruction of the portal vein will not produce oedema unless there is hypo-osmolarity. This is illustrated by a patient who with evidence of portal hypertension, does not have ascites until he has a hemorrhage which precipitates it. That the degree of obstruction is important was illustrated by Bolton who did a series of experiments in cats and showed that:

(1) Unless the diameter of the inferior vena cava in the chest was constricted to 3/5 of its normal size ascites would not be produced.

(2) If the vena cava was completely occluded, death occurred within a few hours or if the cat lived long enough ascites developed (usually blood stained).

(3) If the portal vein was completely occluded, the animal died; but there was 6 - 10 cc. of bloody fluid.

Whipple and Sperry[6] on the other hand demonstrated the partial occlusion of the inferior vena cava did produce ascites without hypo-osmolarity. Thus, in such conditions as constrictive pericarditis and Budd-Chiari syndrome ascites accumulates without hypo-albuminemia.

It can be seen that there is conflicting evidence regarding the importance of portal hypertension alone being a cause of ascites. However, in the presence of hypo-albuminemia portal hypertension does serve to localize the oedema to the peritoneal cavity.

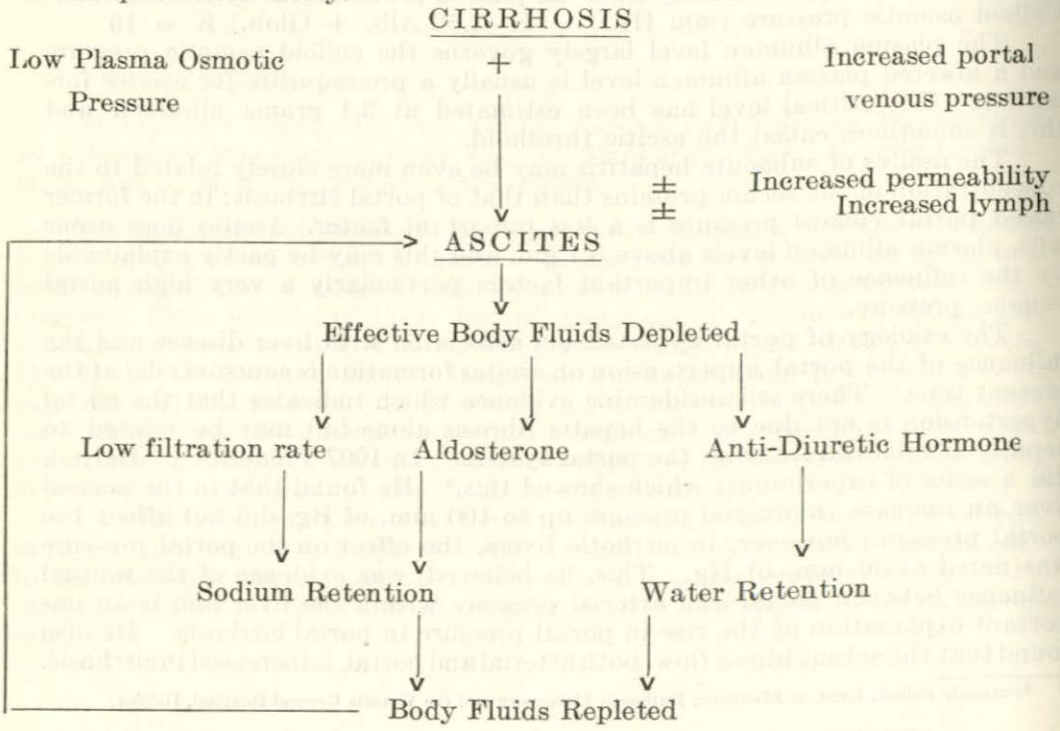

Fig 1—THE DEVELOPMENT OF ASCITES IN LIVER DISEASE

There appear to be at least two other factors involved in the production of ascites. It has been shown that there is increased permeability for albumen in patients with cirrhosis. Human albumen labelled with radioactive iodine is seen to diffuse rapidly from ascites to the blood stream and vice versa. The same applies for the peritoneal fluid and half the fluid is exchanged in one hour. It is postulated that due to poor nutrition the peritoneal permeability is increased.[7] Because the ascitic fluid has a high protein content similar to that of hepatic lymph, the lymphatic system has been involved as well. It has been suggested that the engorged liver forms ascites primarily by pouring lymph into the free peritoneal cavity. There is some experimental evidence to support this.[2] If a cellophane band is placed around the thoracic inferior vena cava of the dog, the hilar and subcapsular lymphatics are usually dilated and the hilar lymphatics are usually increased in number. When the hepatic lymph channels are cannulated a greatly increased lymph flow is found. Lymph has also been observed oozing from the liver. The importance of this is intensified if one considers the increased portal pressure due to the decreased hepatic venous bed.

Once the ascites is formed, there are several factors which tend to maintain and increase the condition.[2] In the first place there is a definite decrease in sodium excretion by the kidney, sweat, saliva, and even colonic secretions. Serum sodium levels are lower than normal as well. These changes are probably due to the effects of increased aldosterone secretion. Large quantities of aldosterone are found in the urine of patients with ascites due to cirrhosis and this is increased after paracentesis when the need to conserve sodium is accentuated. If bilateral adrenalectomy is performed, these patients have a sodium diuresis suggesting that aldosterone secretion plays an important part in the maintenance of the ascites. The mechanism appears to be as follows:

First: Fluid passing into the peritoneal cavity causes a contraction of extra cellular fluid volume; this in turn stimulates the production of aldosterone and thus sodium is retained. Another factor which tends to maintain high serum aldosterone is the fact that this substance is degraded in the liver and in liver disease there is a decreased degradation.

Secondly: The actual renal blood flow may be changed. It has been reported to be reduced by some observers and to be normal by others. It is suggested that a reduced flow is related to a low plasma volume and to the effect of increased abdominal pressure upon the renal veins.

Thirdly: Estrogens have a salt-retaining action in animals and are degraded in the liver. Administration of oestradiol in patients with cirrhosis and ascites causes retention of sodium and water and this may play some part in the secondary sodium retention found in ascites.

Fourthly: Anti-diuretic hormone, by increasing tubular re-absorption of water, has been postulated as a factor in ascites formation. By crude methods increased amounts of a substance resembling A.D.H. have been demonstrated in the urine of cirrhotic patients.

Conclusion

The two essential factors for the development of ascites in liver disease are:

1. The failure of hepato-cellular function, hence a lowered serum albumen and decreased degradation of steroids.

2. Portal hypertension due probably to a decreased hepatic vein vascular bed and an increased influence of the hepatic arterial flow.

With the development of ascites, there is depletion of effective body fluids leading to (1) secondary hyperaldosteronism
(2) increased A.D.H. activity
(3) possibly decreased glomerular filtration
(These mechanisms are summarized in Chart 1.)

REFERENCES

1. Starling, E. H. J. Physiol., 19: 312, 1896.
2. Sherlock, S. Diseases of the Liver and Biliary System, Charles C. Thomas, Springfield, 2nd ed., p. 110, 1958.
3. Herrick, F. C. J. Exp. Med., 9: 93, 1907.
4. Madden, J. I., et al: Surg. Gynec. Obstet. 99: 385, 1954.
5. Bolton, C. J. J. Path. Bact., Lond., 14: 40, 1909.
6. Whipple, G. H., and Sperry, J. A. Bull. John Hopkins' Hospital, 20: 278, 1909.
7. Mansin, H., and Lowell, A. J. Clin. Invest.: 27, 145, 1948.

A Comparison of Isoniazid-Cycloserine with Isoniazid-PAS in the Therapy of Cavitary Pulmonary Tuberculosis. X. A Report of the Veterans Administration-Armed Forces Cooperative Study. Storey, P. B., Am. Rev. Resp. Dis. 81:868, (June) 1960.

The data from a large cooperative study of the clinical effectiveness of the two drugs cycloserine and isoniazid used together are analyzed in this paper. The efficacy of this regimen was measured against that of isoniazid and para-aminosalicyclic acid (PAS) given concurrently to a control group of patients with cavitary tuberculosis in fourteen cooperating hospitals.

In several respects, results in the isoniazid-cycloserine-treated group tended to show that this regimen is less efficacious than isoniazid-PAS. These results are: A higher incidence of roentgenographic evidence of progression of the disease, 7 per cent as compared with an incidence of 2 per cent among the control group; a much higher incidence of clinical failure to respond satisfactorily to treatment, which necessitated change in drug regimen in 12 per cent of the cases as compared with 2 per cent in the isoniazid-PAS-treated group; a lesser incidence of cavity closure; a lower incidence of appearance of bacteriologic "conversion" of the bronchopulmonary secretions; a more rapid emergence of bacterial resistance to isoniazid with a greater over-all incidence of resistance to isoniazid.

Although (in general) well tolerated, the regimen is not without its own toxicity as evidenced by the occurrence of one convulsive seizure, one instance of optic neuritis, 3 hypersensitivity reactions, and perhaps 13 instances of mental aberration or behavioral change. In the isoniazid-PAS group, there were 9 hypersensitivity reactions, including one death from acute yellow atrophy. The great bulk of PAS toxicity was associated with gastrointestinal irritation.

S.J.S.

PREVENTABLE FACTORS IN PERINATAL MORTALITY*

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The Maternal and Perinatal Mortality Committee is administered by the Medical Society of Nova Scotia under the same chairmanship as the Maternal and Child Welfare Committee for the Province of Nova Scotia and is supported by a Federal-Provincial Grant.

The purpose of this Committee is to determine the perinatal mortality and, more important, to determine the methods by which the mortality can be reduced. With this in mind, the Committee has been extremely critical in its search for preventable factors which could alter the outcome of many cases. Many times, in retrospect, one can easily see difficultes that existed and can make clear decisions about preventive measures.

The Committee would like to stress the fact that the names of the patients and the physicians involved are unknown to the committee at the time of the discussions so that the opinions expressed are entirely impartial.

The following are four cases, taken from the files, which have been studied in the past year and a half and represent a few of the more common obstetric and paediatric problems:—

Case No. 1

This patient, who was Rh-negative and gravida 6, para 1, was delivered by caesarian section of a stillborn infant at 34 to 35 weeks gestation. This woman's fourth baby was treated by means of an exchange transfusion and is living and well. With the exception of the first baby, which was premature, all the others were full term, weighing 8 lbs., or over and lived from only a few hours to 3 days. The expected due date for this pregnancy was December 7th. The prenatal course was normal up to the October 3rd visit, when the patient had a blood pressure reading of 130/70 (normal 110/70). Her weight, had increased in one month from 180 lbs. to 196 lbs. Urinalysis showed that the albumen was 4+. The patient was sent home on a salt-free diet, chlorthiazide 500 mgs. daily and bed rest. This regime was not followed by the patient. On the next office visit the patient's weight remained the same. Blood pressure was 140/80 and the urine albumen still 4+. Because of her negative Rh status and persistent toxaemia she was sent to hospital where an assessment for the need of premature delivery was to be made.

On admission the patient's blood pressure was 130/84. Foetal heart rate was 132. The chlorthiazide was continued and Seconal, gr. 1½ given. An obstetrical consultant saw her and stated that the uterus was enlarged to about 8 months gestation. The baby was a good size and the consultant recommended that "the baby should be delivered 3 to 4 weeks early, but since the mother is now toxic suggest a caesarian section immediately. The time for the operation was set at 11:30 a.m. next day. The foetal hart was recorded at 120 at 10 p.m. but could not be heard the following morning. However, considering that the baby might still be living, a low transverse caesarian section was done under spinal anaesthesia with Pentathol induction. The baby was stillborn and showed gross signs of erythroblastosis foetalis in the form of hydrops foetalis, enlarged liver and spleen and an extremely large and oede-

*An abstract from the report of the Maternal and Child Welfare Committee of the Medical Society of Nova Scotia 1959. Dr. M. G. Tompkins Jr. Chairman.

matous placenta. At autopsy the spleen and liver showed marked focal areas of extramedullary haematopoiesis. The abdominal cavity contained a large amount of brownish fluid. No other pathological findings were reported. The following conclusions were reached by the Committee:—"This is a preventable obstetrical death, the preventable factors being as follows:

1. A physician error in judgment in that, initially, the patient was seen in a severely toxic state and was sent home.
2. A physician error in judgment on the part of the consultant in that a caesarian section was advised and done, as an elective procedure, with no foetal heart present. It was the feeling of the committee that this was needless from both the foetal point of view and the maternal aspect.
3. Toxaemia is a very serious disease which progresses rapidly in a short period of time. It is the feeling of the committee that toxaemia can be best treated in hospital. There is no place for the casual treatment of toxaemia. Transient toxaemia has been observed in erythroblastosis foetalis with impending death of the foetus. Although toxaemia had little to do with the death in this case, it should have warned of the dangerous state of the foetus. If caesarian section had been done earlier, this stillbirth might have been prevented.

Case No. 2

This is a neonatal death in a premature infant within 10½ hours of birth. The birth weight was 2 lb., 14 oz. The mother, age 27 years, has had 3 live births—2 living children. A premature infant weighing 3 lbs., died after 9 hours. This woman has had 2 miscarriages. She has been a victim of mild asthmatic attacks for many years and during this pregnancy the patient had an attack during the month prior to delivery. She was treated with aminophylline and ephedrine with good results. The patient made only one prenatal visit to her doctor, in her 6th month. Her blood pressure, urinalysis and weight gain were normal, her haemoglobin was 70% and the Rh factor was positive.

The patient went into labour on November 18 and was admitted to hospital at 12:20 a.m. after 3 hours of labour she delivered spontaneously in the bed at 1:45 a.m., with the interne in attendance. It was a breech presentation. Demerol 50 mgs. and seconal, gr. 1½ were given one and a quarter hours prior to delivery. The baby was placed in an incubator with moist oxygen. The nurse in attendance records that the infant's colour was poor following birth and that breathing was in gasping respirations. Suctioning of the airway was needed. The attending physician states he did not consider the baby was in as poor condition at the time of birth as the hospital record indicated. He stated that the breathing and crying were spontaneous and that there was no evidence of asphyxia. Five hours following birth the progress notes state that the baby was cyanotic and had gasping respirations. Ten and a half hours following birth, the baby expired. No consultation was held and no further treatment ordered.

The physician stated that he saw the baby eight or nine hours after birth when the colour and response to stimulation were as good as he would expect for a baby so small. He also stated that he was surprised that the respirations were as good as they were and that he expected the baby to die. No autopsy was requested by the physician. He stated that he did not consider it necessary in such a small premature.

The following conclusions were reached by the Committee:—Without an autopsy a clinical diagnosis was inconclusive. The Committee would like to stress the importance of an autopsy, not only in this case but in all cases. This is essential if some of the mysteries surrounding these deaths are to be solved. Failure to request an autopsy on all deaths and stillbirths is inexcusable in most cases. This case was considered to be a preventable paediatric death for the following reasons:—

1. Inadequate prenatal care on the part of the mother.
2. A physician error in judgment. The committee considered that a rather passive attitude was taken by the physician regarding the care of this baby. Even though the outcome might not have been altered, the baby should have the benefit of a consultation and more extensive therapy considered.
3. The ready acceptance of a hopeless prognosis on the part of the physician is a very dangerous attitude and cannot be justified in this case. Unfortunately this attitude is noted much too frequently. The Committee feels that if neonatal mortality is to be improved the profession must begin by practising this basic concept of vigorous, hopeful therapy.
4. No baby over 1000 gms. (2.2 lbs) should be considered previable, with a diagnosis of prematurity as the cause of death.

Case No. 3

This 39 year old white multipara gave an obstetrical history of a miscarriage with her first pregnancy followed by 6 live births. She had considerable ankle oedema during her last pregnancy. The expected date of delivery of the present pregnancy was on Dec. 4th. Patient visited her physician every month from the 3rd month onwards. The only abnormality during this prenatal course was a mild deficiency anaemia with the hemoglobin level below 10 gms. Iron was given by mouth but the anaemia was not corrected. In the 7th month (October) she showed signs of toxaemia. The blood pressure had increased from 140/80 to 150/90. The urine showed a trace of albumin and her weight had increased by 12 lbs. in one month. Mild ankle oedema was present. The treatment prescribed was bed rest, a low-salt diet, chlorthiazide and phenobarbital. She was to return in one week, but did not report to the doctor until two weeks later when labour had started. The blood pressure and urinary findings were unchanged, the oedema of the ankles was still present, but the patient had lost 5 lbs., in weight. Of significance, however, was the onset of occipital headaches and the presence of "silver streaks" in front of her eyes which began after her visit in October. She also stated that she had not felt foetal movements for over one week. The haemoglobin level was now 6.2 grams. The patient was immediately admitted to hospital. No foetal heart sounds were heard on admission. After 4 hours of labour a macerated stillbirth (4 lbs., 10 oz.) was delivered. There was no autopsy of the foetus.

On review of this case by the Committee the following conclusions were reached.:—This was a preventable obstetrical death presenting these factors:

1. A physician error in judgment existed in the handling of the anaemia. The failure of treatment with iron by mouth should be followed by other measures such as administration of intramuscular iron.
2. A physician error in judgment was assessed in the handling of the toxaemia that had occurred at the time of the office visit in October. It has been

previously stated that patients with toxaemia are best treated in the hospital. If unusual signs or symptoms occur they must be treated immediately. The onset of the headaches and the silver streaks should have warned her physician of impending eclampsia and/or death of the foetus. Also, it has been observed that toxaemia subsides when foetal death occurs, as happened in this case. Therefore it was the opinion of the Committee that if the patient had been referred to hospital at that time (October) a live birth might have resulted.

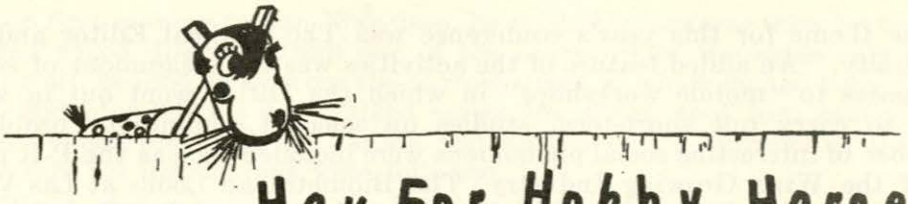
Case No. 4

This primiparous woman had her last menstrual period on Dec. 4th. Her previous medical history was not relevant. At about the 6th month of pregnancy she was admitted to hospital because of vaginal bleeding. She had had no previous prenatal care. The bleeding subsided after a period of bed rest and she was discharged the following day. A radiological examination of the pelvis showed a normally situated placenta. The next day, however, she was re-admitted because of the onset of labour pains. Soon after admission to hospital moderate vaginal bleeding occurred and she was taken to the case room where her membranes were ruptured. Following this procedure, a premature female infant weighing 3 lb., 7½ oz. was delivered.

The baby's condition at birth was considered good despite mild respiratory distress. This subsided after 2 days of treatment with moist oxygen in an Armstrong incubator. Feedings of glucose and water were given after 48 hours and prematurity formula started after 72 hours. No difficulties were encountered until the 4th day of life when generalized jaundice was noted. The total serum bilirubin was 17.2 mgs. %, with 16.4 mgs. % of indirect and 0.8 mgs. % of direct bilirubin. No Rh or ABO incompatibility was found. The baby seemed well until the 6th day of life when she became listless, vomited dark greenish material and had laboured respirations. Clearing of the respiratory pathways by suction and oxygen by mask produced temporary improvement. However the baby soon became unconscious, cyanotic and expired on the 7th day of life. The pertinent necropsy findings were prematurity (weight 2 lb., 15½ oz.) with severe jaundice and gross and microscopic evidence of kernicterus. Recent publications suggest that in the absence of incompatibility of blood groups, the cause of hyperbilirubinaemia is probably immaturity of liver function as manifest by a failure in the conversion of indirect to direct bilirubin.

The following conclusions were reached by the Committee. This was a preventable paediatric death.

1. The family was at fault since the mother had had no prenatal care. It is surprising how often this factor is present in cases of infant mortality that have been reviewed by this Committee.
2. There was a physician error in judgment which is, perhaps, of academic interest only. If an exchange transfusion had been carried out on the 4th day of life when the baby's condition was satisfactory, kernicterus might have been avoided. However it may be argued that in a premature infant, especially one who weighs 3 lbs., or less, the risks of the exchange procedure may be greater than the risk of kernicterus. It also may be argued that the relief from hyperbilirubinaemia is only temporary following an exchange transfusion. In the light of our present knowledge the indications for exchange transfusion in a premature infant, in the absence of blood group incompatibility are still not clear.
3. This case illustrates the value of an autopsy with respect to diagnosis.



Hay For Hobby Horses

The Pink Champagne Pump

Last April, the Society of Amateur Medical Editors held its annual meeting at the Iron Horse in Maiden Lane, San Francisco. I went out as the representative of the East Coast enclave of this ancient and honored society. Benje and Jim Tallgrass had been named delegate and alternate at the last annual meeting but found it wise to be unavailable when this year's meeting came around. I was drafted at the last minute and the following is a belated report of some of the high points of this trip. The Society of Amateur Medical Editors are known to each other as the Dittos and among the elect, the muttered shibboleth "Ditto" and the flourish of a heavy red pencil, such as those used to deface manuscripts, will open barred doors all over the nation.

PAUL MASSON
CHAMPAGNE CELLARS, SARATOGA, CALIFORNIA
Foreground: Champagne fountain, reflecting pool, Reception Rotunda and spiral ramp leading into the Winery.

The theme for this year's conference was The Medical Editor and the Community. An added feature of the activities was the assignment of several delegates to "mobile workshops" in which the Dittos went out in small groups to carry out short-term studies on selected community problems. A number of interesting social phenomena were included such as the P-R problems of the Wine Growing Industry, The Biometrician Looks at Las Vegas or The Cultural Values of Classical American Burlesque and A Freudian Appraisal of the San Francisco Cable Car. The assignment to these social phenomena were randomly distributed among the delegates by a unique double-blind method which made use of a short-sighted secretary who was primed with a pint of vodka before she commenced distribution of the numbered slips. Three of us, Bob Novaque of Philadelphia, John Cole of Dallas and myself drew the wine-growing industry of the Santa Clara Valley and the Las Vegas evaluation as our opportunities to relate to the community. We had a 48-hour period from Wednesday noon to Friday noon to carry out our studies. A very unhappy team which included my friend Willis Fafnir of Toronto, were required to investigate the following advertisement from one of the San Francisco papers:—

Jane Lawrence Agency
ESCORTS
PRospect 5-6125

VISITOR? ALONE?
Go dining . . . dancing . . . or
explore this fascinating
city in the company of a
GLAMOROUS YOUNG LADY!

I have no idea how Willis proved to his ever-loving wife that this investigation was carried out purely in the interests of science.

San Francisco is a delight, with many more hills than the fabled seven of Rome. It is a city with a personality that impresses itself upon the visitor immediately. I have heard travellers attribute distinct personalities to Montreal and New Orleans but this is the first time I recognized the phenomenon for myself. Like other hicks, the delegates from Philadelphia, Dallas and Halifax hung from the side of the Powell Street cable car as it climbed up the sheer slopes of Knob Hill then over Russian Hill to careen down the opposite side through Chinatown to drop us off at Fisherman's Wharf. The guide book says that when you talk about transportation in San Francisco, first come the cable cars, those toy-like little trolleys powered by a cable that runs in a slot between the tracks. Obviously San Francisco and cable cars were made for each other. During the visit in 1889, Rudyard Kipling said of the cable cars something which is still just as true "They turn corners almost at right angles, cross other lines, and for aught I know may run up the side of houses." We also did a few of the sights as a warm-up to our cross-cultural studies of the wine industry and the gambling capital of America. The Hungry I was the basement that gave Mort Sahl to the world. During our visit it featured a Boston comic, named Ned Harrington, Jr., who did an impression of a Southern senator nominating Orville Faubus for President. "I tell you-all that that great American, Orville Faubus, is a per-see-cuted saint." The Senator went on to outline in considerable detail what would happen to the United States "if Jack Kennedy gets hisself elected." It was a devastating parody, if a bit disturbing in its undertones. As we saw San Francisco at lunch hour and in the evening, we were met everywhere with good humour and disinterested kindness by the citizens of that city. One of my hosts said

that on first moving to San Francisco, he made his business trips by tram-car. He had asked direction from one of the operators of the cable cars and, on getting off, headed away from the narrow street to which he had been directed. The conductor left his car, walked across the street, took him gently by the shoulder, lead him back up the hill and walked to the entrance of the street to be sure his instructions were followed.

We started our study of the P. R. problems of the wine-growing industry by joining a guided tour leaving San Francisco on Wednesday at 1 p.m. We drove down the Santa Clara Valley on a clear afternoon with the temperature hovering around 80° in the shade. The entire peninsula southwest of San Francisco is a series of communicating valleys surrounded by bare, steep brown hills. Before World War II this was one of the greatest fruit-growing areas in America producing large quantities of grapes, prunes, figs and the like. However, it is rapidly being engulfed by the population explosion from the urban center of San Francisco. The area is adding over half a millon to its population each year and the wine groves are disappearing under the bulldozers to make way for housing developments and shopping centers. Our first project in community research was carried out in the champagne cellars of Paul Masson in Saratoga, California (see illustration). Without committing my co-authors, I can assure you that Mr. Masson's public relations techniques were superb. Our guide was a tall brunette, with straight brows, a cool glance and a striking profile. Bob was much subdued by her crisp manner and called her the Western Amazon because she hailed from Nebraska. He hung on her every word. Our guide shepherded us through the huge chambers where, at a constant temperature, the wine was held in 10,000 gallon oak or redwood casks for aging. We followed it as it was transferred to glass-lined vats before blending. Just before it passed to the bottling machines, the wine was pumped through filtration beds. The colours throughout the plant were light pastel shades and the small pump that fed the wine into the filtration beds was a shocking pink. Incidentally, the manager of this filtration unit is the object of special interest to the medical scientists of nearby Stanford University. He has been persuaded to pledge his brain to the medical school on his death. The staff is most anxious to have an opportunity to study a filtering man's thinker.

At the end of the tour our guide passed us into the tender hands of the bar men in the patio of the champagne cellar and we were invited to sample the many products of Paul Masson's art. Our hosts only poured us a few drams at a time so it took patience and persistence to get anything more than a gentle glow. Bob, still enamoured of our charming guide, trotted back and forth to the bar with our glasses, and in between paid his respects by toasting his Amazon's classic brow, junoesque profile and superb carriage. He was probably marked down by the social scientists who examined his reports on the grounds that his study on the public relations policy of the wine industry was too subjective and concentrated on a limited sample. Bob could reply that the samples were limited in the experiment through no fault of his own.

As I understood it, the purpose of these mobile workshops was to counter the ancient and well-recognized tendency of medical editors to seek seclusion, to tend toward excessive puritanism and to favour a remote and refined (if not impractical) view of the world's problems. The organizers of the annual meeting of the Society of Amateur Medical Editors were successful in getting us out into the world. I will spare you even a brief report on part II of our

assignment, The Biometrician Looks at Las Vegas, until the January issue. In closing I will favour you with a story left over from the trip. The first of the Astronauts had landed on an unknown planet. He was greeted by the inhabitants who were large people over eight feet tall and covered from top to toe with fur. They told him they were called the Furries and offered to take him to their leader. He was taken to a great cavern and lead before a crystal throne on which was seated a great fur-covered being with a pointed head. From the tip of his head grew a large hypodermic syringe. On being greeted by the Astronaut, the leader said with considerable pride, "I am the Furry with the syringe on top."

With the utmost seriousness, I am, yours,

Brother Timothy.

GALLSTONES AND PREGNANCY: THE COMPOSITION OF GALLBLADDER BILE IN THE PREGNANT WOMAN AT TERM. Large, A. M., et al. Am. J. Med. Sci. 239:713, (June) 1960.

In this study, bile aspirated from the gallbladders of 28 pregnant women at Cesarean section and compared with the bile aspirated from the gallbladders of 10 normal women yielded no evidence to suggest alteration in the constituents of gallbladder bile or change in the function of the gallbladder during pregnancy which might yield to the formation of gallstones.

Bile samples obtained via T-tube from a 27-year-old woman during the course of her pregnancy likewise failed, when analyzed, to reveal any change which might lead to stone formation.

S.J.S.

DISSECTING ANEURYSM OF THE AORTA. Erb, B. D., Tullis, I. F.: Circulation, 22: Pages 315-325, August 1960.

The authors report an extensive review of the literature covering 107 references from 1760 to the present, indicating an incidence of one case in three hundred and ten hospital autopsies including a fourteen month old child and a centenarian; the peak incidence being in the fifth and sixth decades with men affected twice as frequently as women. Pathology, etiology, and clinical features are covered, with many useful clinical points. The value of intense pain at the onset and characteristic involvement of multiple systems having in common a single blood supply, is emphasized. They deal with medical management as "preoperative," closing with the statement "dissecting aneurysm of the aorta now is a surgical emergency that requires early accurate diagnosis and early surgical treatment if the natural survival rate 10% is to be improved."

L.C.S.

BOOK REVIEW

HONOUR A PHYSICIAN. Auld, P., Hollis and Carter, London. 270 pp.

This is a book about a general practitioner at work in the industrial north of England, under the National Health Service.

Dr. Charles Gatwood returns from war service to enter practice under the National Health Service. Gatwood as an individual physician with ideals and a sense of duty toward mankind, welcomes the Scheme as a great socialistic advance for the betterment of the general health of the whole population.

The books tells of Gatwood's experiences at the patient's bedside and in the office. Beginning with the inauguration of the N.H.S. in 1948 and continuing for the first ten years of the Service, Philip Auld relates in a particularly interesting and conversational manner the thoughts and feelings of the doctors, patients and the authorities. He shows the sad disillusionment of the G.P. and how the position of the physician in society is undermined. The weak points in the system are brilliantly exposed.

Dr. Gatwood also welcomed the N.H.S. because "any scheme which relieved him of the need to hold out his hand to his patients for money was assured of his uncritical approval." He felt that the details could be safely left to the British Medical Association. However, as his waiting room became more and more crowded—seventy-four patients in one office session—and when he realized that sixty per cent of his house calls were for trivial matters, which didn't require medical attention, he began to have his doubts. He still defended the general principles of 'the Scheme,' however, against the bitter criticism of the Service by his friends and colleagues.

It transpires that some patients seemingly take a delight in reporting the doctor to an Executive Council which is composed of lay and medical members. The Regulations and Terms of Service of the National Health Service are weighted against the doctor. He remains responsible for his patients even when on holiday and his practice is being looked after by a locum tenens. The government published these Terms of Service without consultation with the profession and the B.M.A. didn't object.

After two and a half years Gatwood was ready to admit that "it hasn't worked out as I'd hoped." However, he still had his deeply ingrained ideals and conscience and continued to give of himself, hoping that the public would change its attitude about getting something for nothing and therefore milking the Service for all it was worth.

Although it is depressing to read of the gradual degradation of the general practitioner and the emphasis placed on malingerers and the ignorant, the fresh air of accomplishment blows from time to time—Gatwood's emergency handling of the obstetrical case with a prolapsed cord; the patient with the perforated duodenal ulcer who delayed calling for the doctor because he didn't want to bother him unnecessarily. These things helped to keep Gatwood going in spite of his disillusionment.

Although the government made much of the preservation of the doctor-patient relationship when 'the Scheme' was launched, the doctor was soon to learn that because his services cost the patient nothing he was cheapened and downgraded in the eyes of his patients; Gatwood's assistant states, "I wasn't cut out to be a martyr. Too much tripe to make it worth the strain—especially when you get no thanks for it."

Dr. Gatwood from 1948, when he was all for the National Health Service, until 1958, by which time he was sadly disillusioned but still a doctor, continued to plod through the red tape, interference from petty officials and deep frustration. He was convinced that it was dangerous to be sick because so many people used the Service unnecessarily the doctor's time was wasted with trivia.

This book, although heavily biased against National Health Insurance in Britain, is very good reading for all doctors at the present time.

J. McD.C.

THE TREATMENT OF TOXIC NODULAR GOITER WITH RADIOACTIVE IODINE: 10 YEARS' EXPERIENCE WITH 436 CASES. Eller, M., et al. Ann. Int. Med. 52: 976, (May) 1960.

This study reports 436 patients with toxic nodular goiter who were treated with I^{131} in a total series of 1,603 hyperthyroid patients; the toxic nodular group included 127 patients with solitary nodules. One third of the treated patients were below the age of 40; three quarters of them were females. The patients with toxic nodular goiter were considerably older than those with toxic diffuse goiter. Ninety-two per cent of the patients with toxic nodular goiter were cured with radioactive iodine, and 8% were made permanently myxedematous; the percentages were identical for toxic diffuse goiter. About 40% of the nodular and 50% of the diffuse toxic thyroids were cured with a single dose of I^{131}. The patients with Graves' disease averaged 1.9 treatments each, while those with toxic nodular goiters averaged 2.2 treatments each. Patients with toxic nodular goiters required an average total administered dose of 10.3 mc. of I^{131} to cause a remission in the hyperthyroidism; those with Graves' disease needed 7.2 mc. This represents the differences in uptake and size of gland, rather than radiosensitivity. Solitary nodules in hyperthyroidism patients respond well to treatment with radioactive iodine. Substernal thyroids even very large ones, may be treated successfully with radioiodine; pressure symptoms due to goiter are not a contraindication to I^{131} therapy. All of this series of thyrotoxic patients had their hyperthyroidism controlled with radioactive iodine alone. The toxic nodular goiters averaged 53 gm. in weight before treatment and 37 gm. after treatment. The ability of a toxic nodular goiter to pick up radioactive iodine is only moderately less than that of a toxic diffuse goiter. Thirty-two per cent of the patients with Graves' disease and 18% of those with toxic nodular goiters showed exophthalmos in some degree. After treatment with radioactive iodine, eye signs improved but did not disappear, regardless of the type of thyroid gland the patient had. Eighty per cent of all patients had pulse rates in excess of 100 per minute before treatment; relieving the hyperthyroidism with I^{131} relieved almost all of the tachycardias. Atrial fibrillation was found in 25% of the patients with toxic nodular goiters and in 10% of those with Graves' disease; after I^{131} therapy, one-half to three-quarters of the fibrillators reverted to a regular rhythm. Before treatment with I^{131}, one-quarter of the patients with toxic nodular goiters showed some degree of congestive heart failure, as did 10% of those with Graves' disease; after therapy, there was a marked improvement in the decompensated patients. Angina pectoris also improved after I^{131} therapy. Diabetes mellitus associated with hyperthyroidism lessened in severity when the hyperthyroidism was relieved with I^{131}.

S.J.S.

PERSONAL INTEREST NOTES

In earlier numbers of this year's volume of the Nova Scotia Medical Bulletin, we have listed the composition (by profession) of the various provincial legislatures which have been up for election in this year, 1960. These were:

Nova Scotia Legislature: Page 228 (July 1960)
Saskatchewan Legislature: Page 228 (July 1960)
Quebec Legislative Assembly: Page 343 (October 1960)

We promise this will be our last excursion into the field of politics for this year, but for completeness, we include the results of the last two provincial elections which occurred in Canada this year, namely, the Provincial Election in New Brunswick, June 27, 1960; and that in British Columbia, September 12, 1960.

THE COMPOSITION OF NEW BRUNSWICK LEGISLATIVE ASSEMBLY
(BY PROFESSION)

	Liberal	Progressive Conservative*
Agronomist	1	
Automobile Agent	2	
Barrister	5	3
Businessman (Timber)	1	
Customs Officer (Retired)	1	
Druggist	1	
Electrical Contractor	1	
Employee (Fraser Co.)	1	
Farmer	3	2
Fish Wholesaler	1	
Fuel Dealer		1
Insurance Agent	1	2
Investment Dealer		1
Lumberman	1	4
Manager	1	
Merchant	3	
Physician	1	3
Plumbing Contractor	1	
Potato Broker		1
President (Concrete Products)	1	
Pulpwood Broker	1	
Railway Brakeman	1	
Railway Conductor (Retired)	1	
Railway Engineer		1
Real Estate Agent		1
School Teacher	1	
Theatre Manager	1	
Tug Boat Business		1
	31	20

*1 Resigned (Not Included)

THE COMPOSITION OF BRITISH COLUMBIA LEGISLATIVE ASSEMBLY
(BY PROFESSION)

	Social Credit	C.C.F.	Liberal
Accountant	2		
Barrister	3	2	2
Carpenter		1	
Chief Clerk		1	
Civil Servant	1		
Farmer	2		
Garage Owner	1		
Hospital Administrator	1		
Housewife	1	2	
Insurance Agent	3		
Insurance Broker	1		
Law Student		1	
Lumberman			1
Machinist		1	
Manager	1		
Merchant	1		
Metal Worker		1	
Minister	1		
Newspaper Editor	1		
Office Worker		1	
Pattern Maker		1	
Public Relations			1
Railway Engineer	1	1	
Rancher	1		
Real Estate	1		
Retired	1		
Salesman	2		
Sawmill Operator	1		
School Inspector	1		
Schoolteacher	2	1	
Shoe Service Owner	1		
Social Worker		1	
Storekeeper		1	
Store Owner	1		
Trade Union Representative		1	
Undertaker	1		
	32	16	4

Antigonish-Guysborough Medical Society

Dr. T. W. and Mrs. Gorman attended the reunion of the Royal Victoria Hospital ex-residents at Montreal recently.

Dr. T. B. Murphy and Dr. J. J. Carroll attended the Refresher Course at Dalhousie University from November 7-10, 1960.

Cape Breton Medical Society

November 23, 1960—The annual dinner dance of the Society was arranged at the Isle Royal Hotel, Sydney.

Dr. H. A. Giovanetti, one of our senior members has been a patient in St. Rita's Hospital.

Dr. M. G. Tompkins was tendered a testimonial dinner by the Glace Bay doctors on the occasion of his retirement from active practice in October.

Dr. Joseph Kereczsturi, radiologist to St. Elizabeth Hospital, North Sydney and Harborview Hospital, Sydney Mines, has resigned effective October 31, 1960, to accept a position on the staff of the Victoria General Hospital.

Dr. Michael Shannon, previously of Fredericton, N. B. was appointed his successor.

Dr. Liam MacKeough has taken papers for the Aldermanic Seat in Ward Three in the forthcoming civic election in North Sydney.

Halifax Medical Society

November 16, 1960—The monthly meeting of the Society was held in the auditorium of the Victoria General Hospital to hear a report on Maritime Medical Care Inc., and review the structure of the Nova Scotia Medical Society. The guest of honor was Dr. T. W. Gorman.

Dr. Frank Markus has recently opened an office for general practice at 1003 Gottingen Street, Halifax.

Recent additions to the staff of the Nova Scotia Hospital, Dartmouth were: 1. Dr. M. L. Almudevar, psychiatrist; 2. Dr. Oscar Pudymatis, Medical Department.

Dr. C. D. Chipman, Dr. W. K. House, and Dr. J. Filbee are on the executive board of the Halifax Picture Loan Society. This group, in its third year of operation brings original contemporary Canadian paintings to Halifax so that the membership may borrow them for periods of six weeks. This year's collection will total over a hundred canvases and includes exchanges with similar societies in Calgary and Edmonton.

Western Nova Scotia Medical Society

Dr. and Mrs. George Burton recently visited Yarmouth on vacation during the hunting season. He is at present doing post-graduate work in Montreal.

College of General Practice: Halifax-Dartmouth Branch

October 22, 1960—A scientific programme was held at the Victoria General Hospital auditorium. Papers were presented by Drs. W. A. Cochrane, J. G. Aldous, and J. E. Stapleton. A symposium on Laboratory Medicine "Pitfalls for the Practitioner" was presented by Drs. W. A. Taylor, C. E. Van Rooyen, H. C. Read, and L. C. Steeves. The scientific programme was followed by a business meeting and dinner.

Nova Scotia Society of Ophthalmology and Otolaryngology

November 7, 1960—A combined meeting with the New Brunswick Society was held at the Victoria General Hospital and followed by a reception and luncheon at the Lord Nelson Hotel. The usual large number of cases were presented at the out patient department of the V. G. Hospital followed by discussion and business meeting. Following dinner, papers were presented by Drs. D. D. MacFie and H. W. Kirkpatrick. Two films were presented, and comments on the recent meeting of the American Academy of Ophthalmology and Otolaryngology by Dr. R. F. Hand. A business meeting closed the programme.

Nova Scotia Association of Pathologists

November 10 and 11, 1960—A pathology workshop was held in Halifax for pathologists in Nova Scotia. Special guests included pathologists from all the Atlantic Provinces. Among the speakers was Dr. D. F. Cappell, University of Glasgow, Scotland, this year's John Stewart Memorial Lecturer. This is one of a series of workshops held at various laboratories in the province of Nova Scotia, enabling pathologists from all parts of the province to meet and discuss recent developments in the field of laboratory diagnosis.

Dr. N. Kerenyi, is leaving the Pathology Institute, Halifax, to take up the position of Associate Pathologist in the regional laboratory at Fredericton, N. B. Dr. Kerenyi, who was on the staff of the University of Budapest, left Hungary after the 1956 rebellion and has been in Halifax since that time. His loss will be severely felt by the local group of pathologists. He was certified this year by the Royal College of Physicians and Surgeons of Canada.

University

A portion of Carleton Street, valued at $28,600. should be sold to Dalhousie University for $1.00, Halifax Finance Committee agreed recently. President Kerr pointed out that a considerable portion of the medical campus had been given up to the Grace Maternity Hospital to provide the City with a necessary service. If the University had retained that property they would not be pressed for space now.

Births

To Dr. and Mrs. Carmen d'Intino, Sydney, a son, Carmen Joseph, at St. Rita's Hospital, October 16, 1960.

To Dr. and Mrs. F. G. Dolan (nee Dorothy Sutherland, R.N.), a son, James, Grace Maternity Hospital, October 29, 1960.

To Dr. and Mrs. W. O. Elliott (nee Margaret Harlow, R.N.) a daughter, Sheila Margaret, at Brighton, Ontario, October 9, 1960.

To Dr. and Mrs. Patrick Kavanagh, a daughter, Laura Todd, at Grace Maternity Hospital, November 13, 1960.

To Dr. and Mrs. Herbert Lang, a daughter, Halifax Infirmary, September 24, 1960.

To Dr. and Mrs. Rex Langdon (Bernice Parsons) a daughter, Halifax Infirmary, October 16, 1960.

To Dr. and Mrs. J. H. Quigley, a daughter, Paula Lorraine, Grace Maternity Hospital, October 19, 1960. A sister for Michael and Robert.

To Dr. and Mrs. Thomas Theobald, (nee Doreen Hiffins, R.N.) St. Vincent's Hospital, New York City, a daughter, Michele Marie, October 25, 1960.

Marriages

Dr. Hugh Bacon (Dalhousie 1960) on the staff of the Nova Scotia Hospital, was married to Joanne Gould, Yarmouth on November 19, 1960.

Dr. Arthur Lesser was married to Elizabeth Loebel, Montreal, June 26, 1960.

Coming Events

January 16-20, 1961—The American College of Physicians, Post-Graduate Course Number 5: Mechanisms of Disease: Columbia Presbyterian Medical Centre, New York.

January 19-21, 1961—The Royal College of Physicians and Surgeons, Annual Meeting, Ottawa, Ontario.

January 22-25, 1961—The Canadian Association of Radiologists, Annual Meeting, St. John, N. B.

March 12-17, 1961—American College of Allergists, Graduate Instructoral Course, 17th Annual Congress at the Statler Hilton, Dallas, Texas. For information write, J. D. Gillaspie, M. D. Treasurer, 2141 14th St., Boulder, Colorado.

March 20-23, 1961—College of General Practice (Medicine) of Canada, Vancouver, B. C.

March, 1961—N. S. Division, College of General Practice: Business Meeting with social activities. Further details will appear in a later issue.

June 19-23, 1961—Canadian Medical Association, 94th Annual Meeting, Montreal, Quebec.

Obituary

Dr. Joseph Schwartz, 33, radiologist at St. Martha's Hospital, Antigonish and a native of New Waterford was killed November 10, 1960 when the small automobile he was driving struck a parked truck near Port Hastings. Dr. Schwartz, the only passenger in the sports car was killed almost instantly. He was returning to Antigonish from Inverness, where he had been radiologist for the community's two hospitals. Dr. Schwartz had only moved to Antigonish some eight months' ago, and he was considered to be a brilliant young man with a great future. He is survived by his widow, his mother, and several brothers and sisters.

Sympathy

To Dr. and Mrs. James H. MacLeod, Liverpool on the death of their 2½ year old son, Brian Dewar.

To Dr. Gordon Wheelock, Halifax on the death of his mother, Mrs. Frank Wheelock, Wolfville.

LETTERS TO THE EDITOR

To the Editor:

October 13, 1960

For many years there has been an apparent need for a Medical Services plan capable of covering persons aged 60 or over. Very little in the way of prepaid medical coverage has in the past been available to this group, and what has been offered has often proved to be far from satisfactory. The prepaid medical plans, and most insurance companies, have regarded persons in this age group as poor risks, and have therefore been reluctant to offer adequate protection.

In recognition of the apparent need, Maritime Medical Care has now formulated a plan which is presently being offered to the "over sixty group as the "Seniors' Health Plan." Essentially, the plan is designed to protect the patient against high costs of surgical and serious medical illness, and is therefore basically an "in hospital" plan. Home and office calls for medical conditions will not be covered, but medical care in hospital will be a contractual benefit. Surgical conditions will be covered in home, in the doctor's office or hospital. The necessity of providing the plan at a low rate has to some extent dictated the benefits available.

The Seniors' Health Plan has been offered to all the residents of the Atlantic Provinces who are over age 60. The response has been quite gratifying in that to date over six thousand applications have been received. These applications are presently being processed and subscribers to the plan supplied with identification cards. The number of applicants would appear to bear out the previously stated need for some type of medical coverage for this group.

As the utilization of services in regard to the seniors group is still a debatable matter, no statistics being available on which probable costs might be based, the Board of Directors of Maritime Medical Care has stipulated that this plan must be set up as an account separate and apart from the regular operation of Maritime Medical Care. To this end, separate statements covering submissions for this group will be issued, and accounts for this group will be subject to separate proration. It is thought that by this means Maritime Medical Care will be able to accumulate sufficient statistics to accurately determine rates which in future may be applied, or to increase or delete benefits, without disturbing in any way the regular Maritime Medical Care operation.

As the first plan in Canada to offer coverage of this nature to this age group, Maritime Medical Care feels that it has taken a needed step forward; with the Seniors' Health Plan, coverage has been extended to all age groups of our population.

Rates:	Single	$1.85 per month
	Married	$3.70 ,, ,,
	Married (Dependents)	$4.95 ,, ,,

Yours truly,

G. B. Shaw, M.D.,
Medical Director
MARITIME MEDICAL CARE INCORPORATED

To the Editor:

As you know, telephone calls requiring advice or prescription, which appears in the 1958 schedule of fees of the Medical Society of Nova Scotia as item D16 under Section D, was adopted as a Maritime Medical Care benefit on authority of the Board of Directors, effective July 1, 1959. Although this item could be regarded as outside the terms of Maritime Medical Care contracts, it was the feeling of the Board that its inclusion as a benefit might serve to materially reduce the apparent high incidence of home and office calls, as a telephone call might readily be substituted for some of these visits. Only those telephone calls actually requiring advice or the issuing of a prescription, as stipulated by the fee schedule and which might conceivably substitute for a home or office call, would be payable by the Plan.

During the first few months following the adoption of telephone calls as a benefit, the incidence of accounts submitted for this item, rose rapidly reaching a plateau in approximately five months. Accounts are presently being submitted at the rate of 1,000 per month and it is now noted that the service is being abused to some extent. Evidence of this is provided by the physician who submitted five accounts for five members of the same family for telephone calls made on the same day—diagnosis "pinworms." The scheduled additional fee for "extra patients" cannot be applied to this item.

Costs of Item D16 have been followed carefully and comparisons are presently being made to determine whether or not its adoption as a benefit has achieved the original object, i.e. a reduction in the volume of home and office calls. If the desired effect is not obtained and as telephone calls have been adopted on an experimental basis only, it is conceivable that they may be deleted as a benefit at some future date.

Yours very truly,

G. B. Shaw, M.D.
Medical Director
Maritime Medical Care Incorporated

NOVA SCOTIA MEDICAL BULLETIN

GENERAL INDEX

Vol. 39 – 1960

Abbreviations used:— Ab. for abstract; C. for correspondence; Ed. for editorial; Rev. for review.

RADIOLOGIST WANTED

Radiologist wanted immediately to service two hospitals in the centre of the Annapolis Valley. Hospitals are: Western Kings Memorial Hospital, Berwick, N. S., with bed capacity of 40 and extension under consideration, and Soldier's Memorial Hospital, Middleton, N. S., a new 68 bed hospital opening in Spring 1961, replacing the present 27 bed structure. These two towns are twenty miles apart, all paved highway. Income commensurate with qualifications. Address reply to:

The Superintendent,
Soldiers' Memorial Hospital,
Middleton, N. S.

MEDICAL TEACHING

The Anatomy Department needs part-time demonstrators in both Gross Anatomy and Micro-anatomy to teach either Micro-anatomy (Histology) or Gross Anatomy. Classes in Micro-anatomy are conducted in the morning and classes in Gross Anatomy in the afternoon. Graduates interested in teaching, or preparing for higher examinations in Medicine, Surgery or the Specialities would be welcome. Applications should be made to Professor R. L. deC. H. Saunders, Anatomy Department, Dalhousie University, Halifax. For appointment, telephone 423-7933.

C. B. Stewart, M.D.,
Dean of Medicine.

INFECTIOUS DISEASES—NOVA SCOTIA
Reported Summary for the Month of August, 1960

Diseases	NOVA SCOTIA 1960 C	NOVA SCOTIA 1960 D	NOVA SCOTIA 1959 C	NOVA SCOTIA 1959 D	CANADA 1960 C	CANADA 1959 C
Brucellosis (Undulant fever) (044)	0	0	0	0	24	11
Diarrhoea of newborn, epidemic (764)	0	0	0	0	5	13
Diphtheria (055)	0	0	0	0	1	0
Dysentery:						
(a) Amoebic (046)	0	0	0	0	0	0
(b) Bacillary (045)	0	0	0	0	134	124
(c) Unspecified (048)	3	0	0	0	66	13
Encephalitis, infectious (082.0)	0	0	0	0	13	12
Food Poisoning:						
(a) Staphylococcus intoxication (049.0)	1	0	3	0	60	0
(b) Salmonella infections (042.1)	55	0	13	0	55	0
(c) Unspecified (049.2)	3	0	0	0	5	134
Hepatitis, infectious (including serum hepatitis) (092, N998.5)	64	0	0	0	298	241
Meningitis, viral or aseptic (080.2, 082.1)						
(a) due to polio virus	0	0	0	0	109	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	5	0	0	171
Meningococcal infections (057)	0	0	5	0	9	14
Pemphigus neonatorum (impetigo of the newborn) (766)	0	0	0	0	0	0
Pertussis (Whooping Cough) (056)	19	0	1	0	357	586
Poliomyelitis, paralytic (080.0, 080.1)	0	0	1	0	135	429
Scarlet Fever & Streptococcal Sore Throat (050, 051)	223	0	102	0	517	490
Tuberculosis						
(a) Pulmonary (001, 002)	0	0	23	1	322	420
(b) Other and unspecified (003-019)	0	0	4	0	0	108
Typhoid and Paratyphoid Fever (040, 041)	0	0	1	0	16	21
Venereal diseases						
(a) Gonorrhoea — Ophthalmia neonatorum (033)	35	0	0	0	1302	0
All other forms (030-032, 034)	0	0	51	0	0	1512
(b) Syphilis — Acquired—primary (021.0, 021.1)	3	0	0	0	173	0
— secondary (021.2, 021.3)	0	0	1	0	0	0
— latent (028)	0	0	0	0	0	0
— tertiary — cardiovascular (023)	0	0	0	0	0	0
— „ — neurosyphilis (024, 026)	0	1	0	0	0	0
— „ — other (027)	0	0	0	0	0	0
Prenatal—congenital (020)	0	1	0	0	0	0
Other and unspecified (029)	0	0	0	0	0	182*
(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	3	0
Cholera (043)	0	0	0	0	0	0
Leprosy (060)	0	0	0	0	1	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	2	0
Trichinosis (128)	0	0	0	0	7	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

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