VOL. XLII APRIL 1963 No. 4

The NOVA SCOTIA MEDICAL BULLETIN

EDITOR-IN-CHIEF
Dr. J. F. Filbee

MANAGING EDITOR
Dr. C. J. W. Beckwith

ASSOCIATE EDITORS

Dr. R. B. Nichols Dr. W. A. Taylor Dr. W. A. Cochrane
Dr. J. W. Reid Dr. W. E. Pollett Dr. S. C. Robinson

CORRESPONDING MEMBERS—SECRETARIES OF BRANCH SOCIETIES

Editorial

Good Obstetrics - - Or Bad?

"A paradox of obstetrics is that it is the very normality of pregnancy and parturition which has hindered progress, and which is still leading to mistakes and tragedies. In the great majority of cases mother and baby come safely through even if antenatal and labor care have been deficient. We are all apt to get careless or overconfident if we have got away with some risky procedure several times" – Professor A. S. Duncan, in making these comments (The Lancet, 1962, II, 733) points to the risk arising from the very human failing of *taking things for granted*. He goes on to point out that if a doctor examined vaginally all cases of antipartum hemorrhage in his practice, it could be only once in 30 years that he would cause further significant hemorrhage. Interestingly enough, he indicates that a doctor with roughly 3,000 patients in his general practice might expect one maternal death every 53 years and 2 breech deliveries a year. At this rate, the difference between a 5% fetal loss in breech cases and double that would be one baby lost in 10 years.

Hence the difficulty in assessing one's work. How does one know when he is going wrong? In the study of medical education and practice, carried out for the College of General Practice (The General Practitioner) – Clute, K. F. – University of Toronto Press, 1963, pp. 302 & 303), the author indicates that 84% of the Nova Scotia practitioners had a good prenatal schedule but that only 20% carried out a good set of preventive procedures at these scheduled visits. When a smaller number of Nova Scotia practitioners were assessed on 5 items, viz: initial history, initial physical examination, initial laboratory work, schedule for pre-and post-natal visits and follow-up investigation, *only a quarter had a score over 60%*, and half were below 40%. These figures, because of the limitations of the study, may not be fully representative, but they do indicate that all is not rosy.

Elsewhere in this Bulletin is an article on rural obstetrical practice. The author criticizes items in teaching and items in practice. Everyone may not totally accept his viewpoints, but the fact that he is concerned is all important.

THE MEDICAL SOCIETY OF NOVA SCOTIA

NOVA SCOTIA DIVISION
OF
THE CANADIAN MEDICAL ASSOCIATION

MEMBERS OF EXECUTIVE COMMITTEE

OFFICERS

President	D. F. Macdonald
President-Elect	C. L. Gosse
Immediate Past-President	R. F. Ross
Chairman Executive Committee	L. C. Steeves
Vice-Chairman Executive	J. E. H. Miller
Honorary Treasurer	J. F. Boudreau
Executive Secretary	C. J. W. Beckwith

BRANCH SOCIETY REPRESENTATIVES

Antigonish-Guysborough	T. W. Gorman
Cape Breton	D. H. MacKenzie, J. R. Macneil
Colchester-East Hants	H. R. McKean
Cumberland	J. C. Murray
Halifax	F. J. Barton, K. M. Grant, R. O. Jones
Inverness-Victoria	H. A. Ratchford
Lunenburg-Queens	A. J. M. Griffiths
Pictou County	C. B. Smith
Valley	J. A. Smith
Western Counties	C. K. Fuller

OBSERVERS

Representative to C.M.A. Executive Committee	D. I. Rice
Chairman Public Relations Committee	S. C. Robinson
Chairman Medical Economics Committee	H. E. Christie

CHAIRMEN OF STANDING COMMITTEES

COMMITTEE	CHAIRMAN	COMMITTEE	CHAIRMAN
Archives	C. M. Bethune	Medical Education	D. C. Cantelope
By-laws	J. E. Hiltz	Maternal & Perinatal Health	M. G. Tompkins
Cancer	J. E. Stapleton	Membership	J. A. Myrden
Child Health	R. S. Grant	Nutrition	W. A. Cochrane
Civil Disaster	S. B. Bird	Pharmacy	J. E. MacDonnell
Discipline	R. F. Ross	Physical Education & Recreation	J. M. Williston
Editorial Board (Editor)	J. F. Filbee	Public Health	S. D. Dunn
Fees	J. E.H. Miller	Public Relations	S. C. Robinson
Finance (Hon. Treas.)	J. F. Boudreau	Rehabilitation	G. J. H. Colwell
Health Insurance	D. McD. Archibald	Resolutions	L. C. Steeves
Insurance	A. J. Brady	Special Research	A. A. Giffin
Legislation & Ethics	D. F. Smith	Traffic Accidents	A. L. Murphy
Medical Economics	H. E. Christie	W. C. B. Liaison	A. W. Titus

BRANCH SOCIETIES	President	Secretary
Antigonish-Guysborough	G. L. Silver	R. Sers
Cape Breton	N. K. MacLennan	H. R. Corbett
Colchester-East Hants	C. C. Giffin	K. B. Shephard
Cumberland	D. C. Brown	J. A. Y. McCully
Halifax	K. M. Grant	G. J. H. Colwell
Inverness Victoria	H. A. Ratchford	W. MacIsaac
Lunenburg-Queens	F. W. Prince	W. I. Bent
Pictou County	L. M. Sproull	W. D. MacLean
Valley Medical	G. K. Smith	E. G. Vaughan
Western Counties	A. F. C. Scott	G. D. Belliveau

AFFILIATE SOCIETIES	PRESIDENTS
Nova Scotia Association of Radiologists	A. J. M. Griffiths
Nova Scotia Society of Ophthalmology & Otolaryngology	R. H. Fraser
Nova Scotia Society of General Practitioners	A. G. MacLeod
Nova Scotia Chapter of College of General Practitioners	
Nova Scotia Division of Canadian Anaesthetists' Society	C. H. L. Baker
Nova Scotia Association of Pathologists	J. N. Park

What is to be done? Two avenues are available. The first of these is self-appraisal. This cannot be done unless one has kept records. Impressions of one's own work are misleading. But one can, if he has the records, go over several years' cases and do an inventory. One of your editors spent many years in rural practice, and did a modest study of this kind (Robinson, S.C., C.M.A.J., 71:372, 1954). It was a most revealing experience.

The second method is to form in your hospital area a Maternal & Perinatal Health Committee. The Standing Committee of The Medical Society of Nova Scotia has never been asked to assist in such an undertaking and is bursting with desire to help any group to get off the ground. Such a committee will study, anonymously, all perinatal and maternal deaths in its area. As it does so, it soon comes to learn of the errors in patients' habits, in methods of practice, and about the defects in administrative organization and in equipment and its use. It sees what is wrong and can point out how to prevent future tragedies.

If any doctor be concerned about the quality of obstetric practice – rural or urban – nothing can be more useful than to take one or both of the steps described above. Hospital medical staff have a positive duty to ensure that this sort of quality control is carried out.

S.C.R.

Come to Braemar!

NOTICE TO MEMBERS

At the meeting of the Executive Committee December 1st., 1962 the following resolution was carried:

"THAT notice of motion be given to the Annual Meeting of The Medical Society of Nova Scotia that practitioners resident in the province of Nova Scotia be required to be members of The Medical Society of Nova Scotia before they can be participating physicians in Maritime Medical Care, Incorporated."

Come to Braemar!

110th Annual Meeting

THE MEDICAL SOCIETY OF NOVA SCOTIA

Braemar Lodge, Yarmouth Co., July 2-3-4-5, 1963.

PROGRESS REPORT

Dr. D. F. MacDonald, President of the Society and general chairman for the Annual Meeting, along with the different committee chairmen, are content with the progress so far.

Tuesday, July 2 and Wednesday, July 3 will be occupied with Business Sessions; Clinical sessions and social events will take place on Thursday, July 4 and Friday, July 5.

The clinical speakers will be Dr. Lott Paige and Dr. Guy Leadbetter; two prominent New England physicians who are doing work on tissue homografts. Both from the staff of the Massachusetts General Hospital, they will lead panel discussions on:

(1) Hypertension
(2) Common problems in pediatric urology
(3) Homologous transplants

We want all members to leave Braemar well rested from daily problems and so we will have a great variety of relaxing sports.

(1) Water skiing – Lake Ellenwood in front of Braemar Lodge is ideal for this.
(2) Deep Sea Fishing – Only 15 minutes drive either to Wedgeport or Port Maitland to some of the best fishing grounds in the Maritimes. All boats are fully equipped (except for "seasickness pills"!).
(3) Skeet Shooting – We have a newly constructed range in Brooklyn, only about 15 minutes drive from Braemar. Half a dozen shotguns will be on hand for those who do not wish to bring their own.
(4) Sail Boating – This will be on Lake Ellenwood in front of the Lodge.
(5) Golf – The Yarmouth Golf Course is known throughout the Maritimes and needs no boost.

Prizes will be awarded to winners of all these recreational sports.

SOCIAL FUNCTIONS include a Ceilidh on July 1; The Annual Ball on Tuesday evening, July 2nd; a Lobster supper on the Beach; the President's Reception and the Annual Banquet.

The ladies will be kept occupied and happy, we are assured by the Ladies' Programme Chairman, Mrs. D. F. MacDonald.

Plans are being made to have an X-ray machine on hand so that physicians can take advantage of this and get a (probably much needed) chest X-ray.

Applications are coming in daily. So to be sure of good accommodations do not put off till tomorrow what you can do right away!

General Practice in Canada

THE RELATIONSHIP BETWEEN THE CANADIAN GENERAL PRACTITIONER AND THE HOSPITAL SERVICES*

By Norman G. Glen, M.B., ChB., D.(Obst.) R.C.O.G., M.C.G.P.
Amherst, N. S.

I have pleasure in bringing to this Conference the greetings of the College of General Practice of Canada.

At the outset I wish to stress that the following account of how General Practice or Family Doctor Care is provided in Canada is presented as my own personal view. I have experienced nine years in Canadian General Practice - initially in a Clinic in a small town in Alberta; subsequently in solo practice in rural Nova Scotia; and for the last seven years in solo practice in a Nova Scotia county town. I have excluded from this paper any detailed reference to the financial aspect of practice in Canada as it would appear that this will be covered in other sessions at this Conference. Briefly, however, the Canadian G.P. receives his remuneration mainly by fee-for-service, either direct from the patient or from the patient's Insurance Company, and to a lesser extent by salary or "checkoff". Salaried General Practitioners may be found in some small isolated places where a community may form an organization to provide a home, office and salary for a doctor. In some towns which have been established by an industry remote from civilization a salaried company doctor often provides general medical services to the families living in the town. The "checkoff", which I believe is peculiar to mining towns, is a scheme whereby a premium is "checked off" from each miner's pay packet for the doctor. In return the latter renders general medical services to the miner's family. However, most G.P.'s choose the fee-for-service method of remuneration. The Provincial Medical Society in each Province issues periodically a schedule of appropriate fees for each service.

A G.P. proposing to commence practice in Canada, provided he satisfies the licensing requirements of the Province wherein he desires to settle, has free choice of location and type of practice. Practice goodwill is not purchased nor sold - the doctor merely "squats". Sometimes an incoming doctor will purchase the residence, or office, or equipment of a predecessor, but this is variable.

Similarly, where more than one doctor practises in a community, the patient has free choice of doctor at all times - there is no control by registration, "panel" or other means.

Continued on Page 104

---

*Presented at the Medical World International Conference on "Organizing Family Doctor Care", London, England, October 25th, 1962.

Delegate of College of General Practice of Canada.

Editor's Note:

This article was received with accompanying letter suggesting that "this paper may contain some material which the editor of the Bulletin might think would be of interest - possibly from the section entitled "Education for General Practice", and the subsequent section on "The General Practitioner's Relationship to the Hospital Services". Much of the earlier part of the paper is really only applicable when given on the other side of the Atlantic and would not be of much interest here".

However the Editors believe that this most interesting account of Medical Practice in Nova Scotia would be both of interest to readers and worth preserving. We therefore publish his paper in its entirety.

GENERAL PRACTICE IN CANADA — Continued

Definition:

What do we understand by the term "General Practitioner"? The following definition, which has received the provisional approval of the Board of Representatives of the College of General Practice of Canada,[1] indicates what is expected of a G.P. in that country: "A General Practitioner is a legally qualified physician and/or surgeon who is thoroughly trained in the art and science of diagnosis, and to provide a certain basic pattern of medical, surgical, obstetrical and psychiatric care for any patient. He has added to this basic training those extra skills that are necessary to serve his community adequately. Having accepted, prepared for and maintained these responsibilities, he may extend his scope in any direction limited only by his capabilities, his energy, and his desires. Thus equipped, he accepts responsibility for the prevention and management of his patient's health problems, providing availability, continuity, coordination of necessary consultant and ancillary services, and the relationship of illness to life situations".

Varying Types of General Practice

In the above definition it will be seen that the General Practitioner undertakes "... to serve his community adequately". In a vast country such as Canada the community to be served varies considerably with geographical differences. Equally variable are hospital facilities and relationships. This matter is referred to in more detail below. In extremely remote areas, such as the far North, the G.P. has to cope with his problem with very primitive or no facilities. He may travel to his patient by aircraft or, in winter, by dog team. This type of practice, however, is very much in the minority - most of the population (and their doctors!) live in quite civilised conditions!

The amount of surgery done by the General Practitioner is very variable. The further away from the large city the doctor practises, the more general surgery he is expected to do. In the small town the G.P. may remove tonsils and appendices, look after his own fractures, etc., but refer the more complex surgical problems to the city. In rural areas the amount of surgery expected of the G.P. is more related to whether or not he has adequate facilities in a rural hospital, whether there is anyone to give anaesthetics, and the distance to a surgical centre. Another factor pertaining to the practice of surgery by General Practitioners is that this is more common in the older age group. The younger G.P.'s are more inclined to refer their surgery, where possible, to surgeons.

I have also discovered, to my sorrow, that elementary dentistry in the form of exodontia is expected of the rural General Practitioner in Nova Scotia, at any rate. Many country folk would not think of bothering a dentist in town with their toothache - the family doctor is expected to extract the tooth!

Types of General Practitioners

As the types of General Practice carried on in Canada are variable so are the types of those rendering the service. They may be roughly classified as follows:

(a) "Pure General Practitioners". By this I mean the General Physician who strays but rarely into specialized fields such as Surgery, Anaesthesia, etc. However, practically all G.P.'s do their share of Obstetrics and the consequent Paediatrics.

(b) General Practitioners with a special interest: Many G.P.'s particularly in urban areas, take a special interest in some field and secure additional training and experience in it. In this way in a small town one G.P. may emerge as an Anaesthetist; another as having a special interest in Psychiatry, another in Paediatrics, and so on.

(c) Specialists (eg. Surgeons or Internists) who also practice as General Practitioners: This is a feature of practice in Canada, particularly outside the cities or immediate area of a Medical School. Specialists are not purely Consultants - many of them work in General Practice also, and will accept patients directly as well as by referral. Probably 1500 to 2000 Canadian doctors in General Practice are also certified in a specialty.

Routine of Practice

My own typical day in General Practice in Canada serves as an example. My morning is spent in one or both of the local hospitals. There I may assist at, or give anaesthetics for, major surgery or perform my own minor surgery. I attend my In Patients - Medical, Surgical and Obstetrical - in the Wards, and see in the Out-Patient Department those patients whose treatment is better given there than in the office. (For example, plaster casts, catheterization, aspirations, etc.). Domiciliary obstetrics, incidentally, is rarely practiced in Canada when hospital facilities are available - almost all confinements are conducted in hospital, by the attending doctor, whether G.P. or Specialist Obstetrician. Midwives are virtually unknown. I may also take part in a meeting of some committee of the Hospital Staff as part of my duties.

During the afternoon and some evenings I see patients in my office, and home visits are done during the evening or during any time available between the morning hospital work and afternoon office hours. Incidentally, an inefficient aspect of practice is that requests for house calls may be expected at any time. Were the public generally educated, as in Britain, to request house calls whenever possible early in the day, this service of the family doctor in Canada could be rendered much more efficiently. This is now being introduced in some areas.

During the evenings when I do not have office appointments there may be a Hospital Staff meeting or a Medical Society meeting. Like G.P.'s the world over I have my share of night work - obstetrics, anaesthesia or assistance at emergency surgery, accidents or medical emergencies in the hospital (our local hospital is not large enough to be blessed with Interns or Residents!) and emergency house calls.

Organization of Office

The General Practitioner's office (or "Surgery"), of which I believe mine is typical, usually contains a Waiting Room with accommodation for his receptionist, a Consulting Room, one or more Examining Rooms, some facilities for simple Laboratory Work, and a Wash Room. Some General Practitioners also provide X-ray Services, Electrocardiography, B.M.R., Simple Physiotherapy, etc. In my own practice the latter facilities are unnecessary as they are available to my patients free of charge at the local hospital as out-patients under the Provincial Hospital Insurance Act.

Secretarial Assistance is essential and most practitioners have a Secretary-Receptionist or Nurse-Receptionist. In my own case my secretary greets my patients in the Waiting Room, makes appointments, answers the telephone,

does my filing, typing, bookkeeping, billing and the bulk of the Insurance Reports and Claim Forms, of which there is a considerable volume. The amount of paper work connected with General Practice in Canada is very considerable and it would be impossible to render efficient service without secretarial assistance. A good secretary also makes tea!

Except in some rural areas where the patients don't (or won't) take to the idea, patients coming to the office are seen by appointment only, except, of course, in cases of emergency. Appointments are given every 15 minutes, and I find that as a general rule this period for each patient averages about right. A new patient with other than simple problems, may, of course, take 30 minutes or an hour - but usually this is balanced out by other brief services, such as immunization, a change of dressing, etc. From time to time one seems to run into a series of long cases in one session and then of course one's later appointments are thrown hopelessly off schedule. This, however, does not seem to happen too often and I would recommend an appointment system as being by far the most efficient method of running office hours, both for patient and doctor. An appointment card stating the date and time of the next appointment is given each patient who is to return for follow-up or subsequent treatment and only a minority fail to keep their appointments. Much use is made of printed instructions regarding diets, prenatal and postnatal advice, etc. This saves time and many phone calls! Some of this material is made available by drug firms. Many G.P.'s make use of such office machines as dictation machines and bookkeeping or billing machines.

In rural areas the G.P. often dispenses his own drugs but this is uncommon in towns or cities where the patient takes his prescription to a drug store.

As in most civilized countries the General Practitioner travels by car. In the Canadian Winter this is at times impossible when snow drifts block the highways or a blizzard makes any form of travel almost impossible. However, modern snow clearing equipment very quickly has the highways open again after each storm and in emergency the snow plows will take a doctor to a patient during a storm or conduct an ambulance to the hospital. In rural areas particularly the General Practitioner needs a vehicle which can cope with extreme driving conditions and several rural G.P.'s of my acquaintance use jeeps or trucks on occasion, particularly during the Spring when travelling on dirt roads is very difficult. On the prairies I know of G.P.'s using snowmobiles when snow conditions are particularly bad.

The proportion of home visits to office appointments in Canada is much less than in Britain. Most patients' families have cars and even quite ill patients may be brought to the office. Country folk think nothing of driving 20 or 30 miles to the doctor. The G.P. must be prepared to drive similarly long distances on home visits, but if repeated visits at such a distance would be required, the patient is usually admitted to hospital.

In this country of vast distances communications are of importance to the rendering of good service. In addition to the telephone, a Telephone Answering Service, either provided through the Telephone Company or by the Doctor's private arrangement, is a great help and relieves the long-suffering Doctor's wife of some burden. In my case my Telephone Answering Service is able to contact me when needed in hospital, on my rounds, or when off duty, and to take messages for me. This ability to get a message to the Doctor in an emergency is something which is appreciated by the patients one serves. My Telephone Answering Service is also able to make office appointments.

Another communication-aid which has recently become available in Canada and which has been incorporated into my practice organization and that of several of my colleagues is the Radio Telephone. The local hospital telephone switch-board operator has a Radio Telephone set from which she is able to contact the participating doctors with similar sets in their cars, and during the summer season, at their summer cottages at the local sea shore. This device, as well as increasing efficiency of communication with the doctor at any time, also contributes in no small measure to the doctor's peace of mind when he may be at the shore for some relaxation but wishes to keep in touch with some obstetrical case or patient about whom he is anxious.

In many areas where there are several G.P.'s, week-end duty rosters are arranged so that a doctor is available in emergency when his colleagues are getting some relaxation. This is often announced to the public by a notice in the local newspaper and the public is advised that the doctor on emergency call can be reached through the local hospital. This service, I understand, is one which is more common in areas other than the large cities, where it may be very difficult for the patient to find a doctor for emergency service at the week-end.

The above comments on practice organization apply mainly to individual and small group practices as I have seen them in Canada. In some areas, and these are increasing in number, General Practitioners and Specialists may group together to practice from one centre. This centre is often entitled a "Medical Arts Building" or "Clinic", and in some cities this may be a very large building containing many individual Doctors' Offices. Often it may be situated in the down-town business district of the city, or convenient to the hospital. In such a building individual doctors (G.P.'s and/or Specialists) may form a company to operate the building and to which each doctor using it pays rent. In the building may be provided as elaborate ancillary service as the participants desire - Laboratory, X-ray Services, Out-Patient Operating Rooms, Physiotherapy, as well as the usual consulting and secretarial facilities.

In some groups of this type the participating doctors work as a "Firm" - pooling their incomes and expenses. In a local town a "Clinic" of a Surgeon, Obstetrician, Internist and 2 G.P.'s operates from a clinic building and local hospital, and employs salaried G.P.'s in the outlying surrounding rural areas.

Whereas it seems to me that most of these Medical Buildings or Clinics are located separate from the local hospital, the opposite is true in some places. I know of one Clinic or Group Practice, whose offices are located in a wing of the local hospital. This is certainly a convenient arrangement for the doctors but it may be considered undesirable for some patients for psychological reasons.

Access to Diagnostic Aids

The Canadian G.P. has direct access to X-ray Services and to Laboratory Services, generally at the local hospital, or in the case of more complicated tests, by mail at the Provincial Laboratory. The Canadian Red Cross Blood Transfusion Service carries out Rh investigations free of charge and provides blood for transfusion when requested. Pathological, Cytological (eg. Papanicolau smears), and Bacteriological Services are provided, in Nova Scotia, by the Province.

EKG is available at my local hospital and EEG at larger centres. The G.P. has access to these facilities.

Access to Consultant Services

The services of Consultants in various fields are available upon referral of patients in the usual way. Most consultants are located in the larger centres, although some smaller towns have Consultant Surgeons, Internists, Ophthalmologists, etc. Psychiatric consultant service is more difficult to obtain - private Psychiatrists are few, expensive and located generally in the cities. However, the establishment of Mental Health Clinics in the smaller towns is proceeding apace and we look forward to much improved Psychiatric Consultant Service in the future. Provincial Governments provide the services of Medical Officers of Health to advise on Public Health problems and, in my district at any rate, the General Practitioners offer the return services of manning Immunization Clinics organized by the Department of Health.

A useful Consultant Service which is available in Nova Scotia is an Emergency Obstetrical Team which, upon request, will be flown out from a University centre by the R.C.A.F. to the aid of the practitioner struggling with an obstetrical emergency. The team includes a consultant obstetrician and consultant anaesthetist.

Access to Hospitals

This is variable and is discussed in more detail below. In my own case I have access to all the facilities at the local hospital, as I have already mentioned.

Access to Ancillary Services

The following Ancillary Services are freely available to the Canadian G.P. when they are provided.

Ambulance Service may be absent in rural areas - many patients are conveyed unsuitably to doctor or hospital on the back seat of a car or in a truck or station wagon. In other areas, and this is very common, the local undertaker provides ambulance service - usually in a proper ambulance vehicle but sometimes in more sinister fashion in a vehicle primarily designed for another purpose. This must be a good business method as it is rare for the patient conveyed to hospital by the ambulance provided by one undertaker, and should his ailment prove fatal, to be buried by a rival undertaker! In cities, Hospitals, the Police or the Fire Department often provide ambulance service and in other areas such bodies as the St. John Ambulance Brigade. In this country of vast distances Air Ambulance Service is often used and one reads frequently in the newspapers of "Mercy Flights" by airplanes or helicopters of the R.C.A.F.

Nursing assistance to the G.P. is available by nurses of such orders as the Victorian Order of Nurses, who operate in a similar fashion to the District Nurses in Britain but are governed by a voluntary body rather than the local authority, and are financed by voluntary contributions. Provincial Departments of Health offer a Public Health Nursing Service. These nursing services are of great help to the G.P.

Dental Services are provided by qualified dentists in urban areas but there is a great shortage of dentists. As mentioned above, in many rural areas dental health is not good and dentistry is largely confined to extractions by the

local General Practitioner. An aspect of the relationship between dentists and the G.P. in Canada, which is different from that in Britain, for example, is that general anaesthesia is used much less for dental extractions than in Britain. It is fairly unusual for a general anaesthetic to be given in the dental chair here and in some centres, such as my own, where a General Practitioner Anaesthetist is interested in dental anaesthesia, it is usual for the dentist to come to the doctor's office where the latter has anaesthesia facilities.

Research in General Practice

The College of General Practice of Canada is active in encouraging General Practitioner research. This includes research into the nature of general practice, sound health care measures, such phenomena as solo and group practice, also scientific studies of special clinical conditions and problems. In the latter regard, current research projects include a nation-wide testing of infants for phenylketonuria. The College has sent information on the characteristics of this disease and a simple testing kit to all members. Other G.P. research activities are concerned with the complications of measles, histoplasmosis, tuberculin skin testing, blood cholesterol levels and diabetes.

Education for General Practice

(a) Undergraduate

It is my feeling, and that of the College of General Practice of Canada, that at present Undergraduate Medical Training is not conducted in a fashion which is to the best advantage of the future General Practitioner. In a recent submission to the Canadian Royal Commission on Health Services[3] the College made the following points in this regard. "Adequate emphasis should be placed in Medical Schools on General Practice as a separate and distinguished branch of Medical Practice, rather than allowing it to continue as being regarded as the absence of specialty. It is unrealistic for medical students to go through their medical training without coming into contact at some stage with general practice conditions and the clinical techniques and philosophy of General Practitioners. . . ." Progress is being made in Canada towards fulfilment of the recommendations of the College that a thorough review of the whole medical curriculum be carried out; that more emphasis be placed in Medical Schools on General Practice as a major branch of medical practice and that an essential feature of this orientation be instruction in family medical care by experienced family doctors; and that medical students spend some time under the preceptorship of a selected General Practitioner as part of their final year curriculum. This preceptorship program of the College is becoming well established in Canada and works as follows:[4]

> "The College of General Practice solicits voluntary preceptors from among its best and most exemplary members. These General Physicians open their homes and their practices to the recently graduated or about-to-graduate student. For a period of about two weeks, the student spends every working moment with his mentor. He sees the realities of practice, its problems and rewards, in the most effective and telling way."

(b) Internship and Residency Training

The College of General Practice of Canada feels that the competent family doctor of to-day should be able to provide good medical care for 85% of the ills and injuries of people. His experience and training qualify him to

know when and where to get good attention for the remaining 15%. He should be able to act as a family counsellor and in the capacity of general manager of the illness of his patient.[5]

In view of the above, it is the feeling of the College that in hospital training for General Practice the usual Junior Rotating Internship should be followed by a second year's internship which may be called Residency in General Practice. This second year of training however, should be different from that leading to a specialty - it should be specially designed to meet the needs of graduates intending to enter general practice. Suggested content for this special training is three months medicine including dermatology, three months obstetrics and gynaecology, three months general and emergency surgery and fractures, E.N.T. and urology, one month anaesthesia, and two months paediatrics. During the residency emphasis should be placed upon the assumption of responsibility by the resident in his daily contact with patients and the attending staff. If the resident has not already done a preceptorship it should be included in his residency year.

(c) **Postgraduate Training**

The facilities for enabling the G.P. to keep up-to-date and to receive postgraduate training are excellent in Canada. Universities and teaching hospitals offer a wide variety of courses for General Practitioners - refresher courses, concentrated courses in special subjects, and individual courses for the special needs of any individual doctor. An example of the latter was my own experience of being enabled to take a three months part-time residency in anaesthesia at the Victoria General and Children's Hospitals in Halifax a year ago. Through the College various bursaries and scholarships, which are donated by drug firms, are available to assist practitioners to take postgraduate courses.

As well as doctors being able to go to courses, the courses also come to the doctors! Regional courses, held in the practitioners' own local hospital, are run by such bodies as the Postgraduate Division of Dalhousie Medical School. In these courses members of the teaching staff hold a series of teaching sessions, usually monthly, in the local hospital, at which local doctors present their own cases of interest and of teaching value.

Tape recordings of lectures on subjects of value to the General Practitioner by renowned teachers in the various subjects, and, more recently, long playing records, are available through the College of General Practice.

It will be seen that there should be no difficulty for the interested G.P. in maintaining his education. In fact, so good are the facilities that the College of General Practice of Canada has as one of its requirements for continuing membership the completion of one hundred hours of approved postgraduate study in any two year period.[6]

Fellowship in General Practice

At the annual meeting of the College of General Practice of Canada held in Vancouver in March, 1961, it was decided that there is to be a "Fellowship" (or perhaps "Diploma" or "Master") in General Practice. It is proposed that this shall be awarded by the College to candidates with certain basic qualifications, such as ten years experience, upon payment of a Fellowship fee, the presenting of a medical audit for one year, the submitting of a prescribed number of case histories, as well as a written and oral examination. It can be seen that, in so far as members of the College of General Practice of Canada are concerned at any rate, the standard and status of the G.P. are well maintained.

When the Fellowship is introduced this should give further recognition to the fact that one can be a specialist in General Practice just as in one of the specialities. Interest and participation in postgraduate education is increasingly an activity of the General Practitioner in Canada.

The General Practitioner's Relationship with the Hospital Services

(i) The Patient's Choice of Accommodation and Doctor in Hospital

When hospital admission is advised in Canada, the patient may choose the type of hospital accommodation he wishes - Private or Semi-Private room, or a Public Ward bed. The choice is limited of course by the nature of the patient's illness and the types of accommodation available at the time. In most provinces Ward accommodation is now provided "free" by Government Hospital Insurance schemes. Should the patient choose to be admitted to a Private or Semi-Private room he or his private insurance company pays the difference in rates between the Ward rate and that for this preferred accommodation. However, if a patient's condition warrants a single room he gets it "free" and, should all the Ward accommodation be full and his condition be urgent he is admitted to a Private or Semi-Private room "free".

In the teaching hospitals the Public Ward patients do not have choice of doctor and it is these patients that are used for teaching purposes and whose treatment is carried out largely by the residents under the direction of the teaching staff. However, no medical fees may be charged these patients while in Hospital. The patient who chooses Private or Semi-Private accommodation in the teaching hospital has choice of doctor and is charged by that doctor for his services.

In the smaller, or non-teaching hospital, all patients are Private patients, whatever their choce of accommodation, and they are charged medical fees for the services rendered them in hospital, other than those of the Radiologist, Pathologist, etc., which are provided by Government schemes. Some of these Private patients, of course, will be indigent or in difficult financial circumstances and these are treated charitably by doctors in Canada. No one is refused treatment for lack of means.

(ii) The G.P.'s Access to Hospital Facilities

The G.P.'s ability to treat his patients in hospital is variable, as is the nature of his practice, with geographical differences whether his is a remote or rural area, small town or city.

(a) **In remote areas** (eg. in the far North) there are usually no hospital facilities and the doctor is forced to treat his patient where he lies or to airlift him to civilization. In some areas there are small Mission Hospitals such as the Grenfel Missions in Labrador. These are General Practitioner staffed.

(b) **In rural areas** there may be a small community hospital of, say, 12 or 15 beds, or an Outpost Hospital such as those operated by the Canadian Red Cross in some small places in Nova Scotia. These may have one or two General Practitioners on the staff and are equipped for the care of obstetrical, medical, and minor surgical cases. They often have simple X-ray apparatus but usually no laboratory facilities. Any G.P. practicing in the neighbourhood may make application for staff privileges and acceptance is usually automatic.

(c) **In small towns (and certain city hospitals)**: These conditions offer the best hospital relationships for the General Practitioner in Canada

at the present time, and are those under which most Canadian G.P.'s work.

These hospitals are termed "open" to the G.P., who may practice therein to the limit of his privileges. Upon making application to the Hospital Board for membership on the Medical Staff of the hospital, the doctor states his qualifications, experience, special training in any field, etc., and following consideration by a committee of his colleagues on the Medical Staff, the Credentials Committee, the extent of his privileges is laid down. For example, my own hospital privileges include medicine, obstetrics (other than Caesarean Section), minor surgery, and anaesthesia. In my local hospital other doctors have surgical privileges, privileges for the performance of eye, ear, nose and throat surgery, radiology and so on. Some General Practitioners develop special interests and their practices may develop in such a way that they do more than average gynaecology or psychiatry, for example. In my own case, as I have an interest in anaesthesia and had some additional experience in this field previously and have, as mentioned above, had the opportunity to take some postgraduate training in this field, I have been granted anaesthetic privileges.

The free association and working together of the G.P.'s and Specialists in the hospital is a happy situation and a good one for maintaining the interest of all concerned. The informal discussions which take place daily in the local hospital are a continuing form of postgraduate education, a point emphasized by Cronhelm.[7] Each hospital provides a medical library for the use of the medical staff, and access to this is an asset.

The patient, while in hospital, has his treatment directed by his own family doctor who calls upon the services of specialists if required. Most medical cases are treated entirely by their family doctor in the hospital, as are the simpler fractures, abortions, minor surgical conditions, and so on. Even when the services of a specialist are required the patient's own family doctor still supervises the overall care, in consultation with the specialist.

The standard of medical care given the patient in hospital is maintained and guarded in several ways. In Nova Scotia all aspects of the care given to patients is reviewed regularly by a Standards Committee of the Hospital Board. The establishment of such a committee is one of the requirements of the current Nova Scotia Hospital Insurance Act. A Medical Sub-Committee of this Standards Committee watches the standard of medical services rendered in the hospital. A Tissue Committee, appointed by the Medical Staff, compares the pathological, preoperative and postoperative diagnosis of all cases in which tissue is removed at surgery. At regular department meetings in departmentalized hospitals, or staff meetings in those which are not departmentalized, the clinical work, particularly cases of special interest and deaths, are reviewed at regular intervals. Another committee of the medical staff reviews the records kept by the members for completeness, evidence of sound practice, and so on. In addition to these policing activities within the medical staff of the hospital itself, the Canadian Council of Hospital Accreditation, through its inspectors, watches closely all matters pertaining to the standard of patient care in Canadian hospitals, including the standards of the doctors using the hospital, and, according to the findings of the inspectors, may or may not accredit any given hospital.

Other activities of the G.P. on the hospital staff include work on one or more of the Medical Staff Committees, such as those mentioned, above and, in hospitals with schools of nursing, the instruction of student nurses.

(d) A number of large hospitals in the cities at present are "closed" to G.P.'s. This situation applies especially in Montreal and the teaching hospitals in Toronto and some other centres. The medical staff of these hospitals is organized into Departments - for example, the Department of Surgery, of Internal Medicine, of Neurology, of Anaesthesia, of Paediatrics, and so on. The members of each Department elect at regular intervals a Head of the Department, who is responsible for the clinical work done in his Department, and an elected Chief of Staff supervises the activities of all Departments.

As a general rule only those with special qualifications may become members of the medical staff in any Department, and this effectively bars the city G.P. from hospital privileges. It therefore becomes necessary, when hospital treatment is needed for his patient, for referral to a staff member of the appropriate Hospital Department. The General Practitioner and his patient then drift apart until the patient is discharged from hospital and is referred back to the family doctor by the attending specialist. At this point a serious breakdown in efficiency of communications often occurs. In the case of the Public Ward patient it may be weeks or months before a communication from the hospital regarding his progress, treatment and medications on discharge is received by the family doctor. In the meantime, naturally, the patient expects the family doctor to know all about him and to advise him from time to time. In the case of the Private or Semi-Private patient, matters are somewhat better and the attending specialist usually, but not by any means invariably, reports back to the family doctor reasonably promptly. This state of affairs, both from the point of view of the patient and from that of his family doctor, is unsatisfactory. It is not conducive to efficient overall care of the patient as an individual, although the technical aspects of his treatment in the narrow context of the pathological condition which ailed him may be very good. From the point of view of the G.P., he finds himself excluded from some of the more interesting and instructive phases of his patient's illnesses, and the patient is separated from the ability to turn to the family doctor as counsellor and friend in what may be one of the periods of his life when he needs this help most.

From the point of view of medical education, too, and as mentioned previously, the absence of the G.P. from the teaching hospital is bad for the developing outlook of the future G.P.'s in training there. Also, when the patient is about to be discharged the recommendations of the specialist attending him may be quite impractical for the particular patient outside the hospital environment, and these recommendations should be tempered by the G.P.'s special knowledge of his home, family and financial conditions.

For these reasons the College of General Practice of Canada recommends (a) the appointment of General Practitioners to the staff of the larger hospitals, both teaching and non-teaching (see above); (b) the development of residences in General Practice (see above); and (c) the establishment of Departments of General Practice in all departmentalized hospitals.[8]

The Department of General Practice in the hospital should be an organized segment of the medical staff, similar to the other staff departments and with a Head of Department selected in the same manner as the heads of other departments. But, "it shall not have a clinical In-Patient Service, and no patients shall be admitted to the Department. However, it may be responsible for conducting the Out-Patient Clinic in whole or in part . . . . . ." Members of the Department of General Practice, however, should have ". . . .privileges

in the clinical services of the other departments in accord with their experience and training on recommendation of the Credentials Committee. . . ", as explained above. "In any service in which any General Practitioner shall have privileges, he shall be subject to the jurisdiction of the Chief of the Clinical Service involved". This concept of a non-clinical (with the exception of the Out-Patient Service) Department of General Practice in the hospital may seem a little confusing, but it is workable and such departments have been, and are continuing to be, established in large hospitals across the country. This phase of reintegrating the G.P. into the larger hospitals is progressing quite rapidly across the country, and at the present time there are nearly 100 large hospitals in Canada with Departments of General Practice, including 10 or 12 in University Hospitals.[9]

The Influence of the College of General Practice of Canada on Canadian General Practice

The College has approximately 2,350 members and this is approximately 22% of the estimated 10,500 doctors now engaged in General Practice in Canada.[10] The influence of the College, however, is far greater than one would anticipate by the above figures. It has done much to raise the status of the sincere General Practitioner in the eyes of his colleagues and of the public, and also a lot towards ensuring that the G.P. continue his medical education throughout his life and maintains high standards. This activity will be highlighted when the Fellowship in General Practice is introduced. The College has also done much towards improving the access to hospital facilities by the G.P. when these have been lacking,[11] to encourage research in General Practice, and improve the under-graduate education for the future Canadian General Practitioner,[12] as mentioned above.

Summary and Conclusion

The main disadvantages of the existing method of providing family doctor services in Canada are unavoidable, owing to the huge size of the country and the low density of population in the less populated areas, to which may be added the rigors of the climate. From the patient's point of view, in rural areas he may be many miles from medical help in an emergency, and in cities, particularly at week-ends, it may be difficult for him to obtain emergency medical care in the home if his own family doctor is not available. From the doctor's viewpoint, distances and climate are factors to be reckoned with, particularly for the immigrant G.P., but these are taken as a matter of course eventually. The closed city hospital is a great frustration to the city G.P., who may also be troubled by the patient who "shops around" from doctor to doctor, and by the quite highly competitive nature of practice in the city. The latter may give rise to a certain amount of showmanship in office decor and facilities, and approach to the patient, and the small town or rural G.P. removed from the "rat race" of the city, I think tends to get his coronary later than his city colleague! The paper work associated with General Practice in Canada is very considerable, although some measures such as the recent introduction of standard insurance forms acceptable to most insurance companies, are helping to prevent further increase.

The advantages of Canadian General Practice from the point of view of the patient are that a high quality service is generally available to him, rendered by family doctors who are well trained, up-to-date, enthusiastic about

their work, and whose interest is maintained by a stimulating medical environment in association with their colleagues both within and without hospital, and by profuse provision of facilities for continuing postgraduate education. The family doctor attends many fewer patients than he does in Britain, for example, but has more time to spend on each, and is able to do much more for them himself.

As early as 1920 it was recognized that the organization of the health service of a nation should be based upon the family as a normal unit and on the family doctor, and that personal service was essential for the proper and efficient treatment of individual persons, and further that this could only be rendered to them by a family doctor who has continuous care of their health[13] These conditions pertain generally in Canada, particularly for the family doctor practising in the small town.

Scott, who has addressed this Conference earlier, has stated that "the quality of General Practice in a given point in time depends on three factors: (a) existing medical knowledge; (b) the circumstances in which the family doctor practises - the diagnostic and therapeutic tools at his disposal, the amount of time he can give to his patient, the organization of hospital and community services, both medical and social, and the administrative arrangements prevailing at that point in time; (c) the personal attributes of the doctor himself, his technical skills, and his knowledge and insight - factors which are to some extent controlled by our methods of selection of medical students, the way we train them, and the doctor's postgraduate training and experience. These three factors, of course, interact on each other in varying degrees, but, if the personal qualities of the General Practitioner are reasonably adequate, his basic training sound, and his continuing education assured, and if the circumstances in which he practises are adequate, i.e., if we can provide him with adequate time, tools and training, then any advance in medical knowledge, skills or techniques, will automatically result in an advance in the quality of service provided by the family doctor.[14] These ideal conditions are largely available within the family doctor service as it is rendered in Canada. Further, in the majority of areas where the Canadian G.P. has access to hospital facilities, the family doctor's service even more closely approaches the ideal.

I wish to thank my colleagues Dr. Donald Brown of Amherst, Nova Scotia, Dr. D. R. Davies, of Oxford, Nova Scotia, and Dr. W. V. Johnston, of Toronto, Ontario, the Executive Director of the College of General Practice of Canada, for their helpful advice and criticism in the preparation of this paper.

REFERENCES

1. Proceedings of the Board, Journal of College of G.P. of Canada (1962) 9. 12
2. Brief to Royal Commission on Health Services, College of G.P. of Canada, May, 1962. 20.
3. Ibid. 14.
4. Ibid. 14.
5. "Essentials of Approved Residencies in General Practice," the Committee on Residency Training, College of G.P. of Canada (1959) 2.
6. "What You Should Know About the College of Geneeral Practice of Canada".
7. Cronhelm. Brit. Med. J. (1961). 1. 194
8. "Manual on General Practice Departments in Hospitals", Committee on Hospitals of College of G.P. of Canada, March 1960.
9. Johnston, College of G.P. of Canada (1962). Personal communication.
10. Brief to Royal Commission on Health Services, College of G.P. of Canada, May, 1962, 8.
11. Ibid. 3.
12. Ibid. 2 and 14.
13. "Interim Report of the Consultative Council on medical and Allied Services", quoted by Fulton. Practitioner (1960) 184. 642.
14. Scott, R. Practitioner (1961) 187. 557.

Para Medical Organizations (7)

Nova Scotia Speech and Hearing Assessment Clinic

The matter of a dearth of services in this Province for the treatment of young deaf children was brought to the attention of a local service club by one of its members in 1958, suggesting that this could be a suitable "service" project for its attention. The Halifax branch of Zonta International was ideally suited to such a project, since its membership is drawn from executive and professional women, and includes the Medical and paramedical fields – paediatrics, psychiatry, psychology, social work and nursing.

Following an intensive study and exploration period, several points emerged, viz.:

1) Diagnostic services were non-existent in the area. It was impossible to have a young child's hearing loss assessed in range and degree, leading to prescription of proper hearing aid. Indeed there was no general acceptance of the idea of hearing aids for the very young child although it was accepted practise elsewhere.

2) There were no pre-school classes for early auditory training although these too, were accepted practises in other centres.

3) There was lack of actual knowledge of just what constituted a good or adequate modern program for helping those with a hearing handicap – such as the need to begin offering help at the earliest possible age – or in denying the old notion that the *deaf* had also to be *mute*.

Zonta Club undertook to do what it could toward changing some of these ideas, or at least arousing some civic concern.

In 1959, interested parents and a wider circle of professional workers in the health field were approached. A series of meetings were held in the former School for the Deaf. From these, the Hearing Handicapped Association of Nova Scotia was formed.

Speakers, films, study sessions, visits to and from other centres, fostered the conviction that there was a great deal of work to be done, and before any rehabilitation plan could be set down, a child's medical situation had to be fully evaluated. Medical members of the Association by this time included several specialists from the staff of The Children's Hospital, and from the Pediatrics Department of Dalhousie Medical School.

After considerable study, the membership became convinced of the merits of the "oral" method. Mothers began trying the John Tracy Correspondence Course with their child, a course designed especially for the young deaf child in the home.

In 1960 a summer class was organized with 4 pupils 3 to 4 years of age. The adjustment of the children to this group experience made it seem imperative to continue the class if possible. In September, Dr. Chester Stewart, Dean of Medicine, made space available for it at the Dalhousie Public Health Building. The money for some sort of honorarium to the teachers had to be found, and this responsibility was undertaken by the Association. A small Board was appointed to operate the class and to receive the monies. This Board was composed of 2 representatives from the Association, 2 from Zonta

Club, 2 from the Department of Paediatrics and one from the Dean's office. Dr. N. Barrie Coward, Professor of Paediatrics, became Chairman.

The little class began as a pilot project, to demonstrate what might be done with 3-year-olds. The numbers of prospective pupils steadily increased and brought major problems in transportation and finances. The increase also pointed up the urgent and desperate need for a diagnostic and assessment clinic where the medical evaluation could be done EARLY, PROPERLY, and LOCALLY! Dr. Coward assumed responsibility for working toward this clinic, staunchly supported by fellow paediatricians from the original group as well as colleagues who were becoming interested.

Up to this time, diagnostic work on a child stopped when it reached the need for audiometric testing. A few families could afford to travel to Boston or Toronto, or more recently to Montreal, but there were dozens waiting.

From our referrals to the Speech & Hearing Centre at The Children's Hospital in Boston, our problems caught the attention of the Clinic's director, Adam J. Sortini, Ed.D. In the fall of 1961 he offered to come to Halifax for 2 or 3 days to run a clinic for us for 3 to 5 year olds, with no professional fees. (Results were published in the Canadian Journal of Public Health, November 1962). At this Clinic, appointments were set for approximately 60 children. It was amazing to see the great number of parents, from Yarmouth to Sydney, who came in with a child but with no appointment. There was ample evidence that we MUST have a clinic, and the Committee moved ahead with renewed vigor.

In January 1963, this Clinic opened its door. Truly, there are many hurdles still to be faced, but it is here at last. Watch for its official opening!

The new Nova Scotia Speech and Hearing Assessment Clinic is located at 1318 Robie Street in Halifax. The Medical Director is Dr. Arthur Shane, and Dr. Helen Hunter is the Consultant Paediatrician. Both are well known in Halifax.

The Committee was most fortunate too, in interesting Dr. Sortini to come as Administrator, Speech Pathologist and Audiologist.

Dr. Sortini is a pioneering type of individual intensely interested in the needs of young children with speech and hearing problems. He was the first audiologist at the Boston Children's Hospital and was responsible for the development of its Speech and Hearing Centre. In his twelve years of service that Centre has gained wide repute.

As consultant, lecturer, and writer, Dr. Sortini is well known on the American scene. He has already been warmly welcomed to Canada by the Speech and Hearing Association of Toronto.

In summary then, we find that in the past 3 years, several important steps have been taken in this Province toward improving services for children with hearing problems. Chief amongst these are:

1) The fine new residential Interprovincial School for the Deaf in Amherst, already involved in active plans for an improved program for the older child.

2) An Association of informed citizens – the "Hearing Handicapped Association". Its objectives embrace the needs of all age groups, but just now it is emphasizing the importance of attack in infancy.

3) Pre-school classes that point out the need of many more such classes throughout the Province.

4) A Diagnostic and Assessment Clinic, which is basic to any remedial program.

This is a fair record of achievement for three years. The physician in Nova Scotia is in a strategic position to influence developments in the years just ahead, for it is to them that the parent concerned over a child handicapped with a speech or hearing difficulty will come and be referred by them to this local clinic.

BOOK REVIEW

ANTICOAGULANTS AND FIBRINOLYSINS

Edited by R. L. MacMillan and J. F. Mustard
The MacMillan Company of Canada Limited, 1961

This book contains the papers presented at a symposium held at Toronto early in 1961 as well as the discussions which followed them. As the role of anticoagulants in venous thrombosis is relatively well established, most of the material is directed towards the problem of arterial thrombosis. Participants included authorities in the field from the United States, Norway, England, Germany, France and Canada. The basic mechanisms of coagulation, thrombogenesis and fibrinolysis are covered in the subject matter as well as the effects of anticoagulants on blood coagulation. More practical topics include the choice of anticoagulant, the various methods for control of therapy, the type and incidence of complications, as well as the specific clinical applications.

The most obvious conclusion left by this symposium is that there is still very little agreement as to the role of anticoagulants in arterial thrombosis. It was generally agreed, however, that these agents are useful in preventing transient cerebral ischaemic attacks, and in the management of acute coronary insufficiency; that they are of questionable value in the treatment of acute myocardial infarction and in the prevention of subsequent infarctions; and that they are of no value in the established cerebral vascular accident, except when it is due to embolism, in which case further episodes may be prevented.

The book provides an up to date review of an important subject. However, much of the basic material will make heavy reading for all except those working in the field.

R.N.A.

Obstetrics in the Rural Area

D. R. MacInnis, M.D.
Shubenacadie, N. S.

Obstetrics in the rural area is and should be the field of the G. P. but unfortunately many a patient fails to receive more than a small part of what modern medicine can offer her. Anyone doubting this has only to talk with a cross section of young married women. Too high a percentage look upon their pregnancy as a time of uncertainty and depression and their labors as horrible ordeals.

There are three reasons for this: (a) The failure to question outdated methods that have been handed down from the past and are still being taught. (2) The lack of glamour in obstetrics which causes many men to treat it as unworthy of time and effort. (3) A blind following of teachers of natural childbirth.

Can we as a profession be proud of the fact that in some of our rural areas women receive no prenatal care at all beyond writing the doctor a letter letting him know when they are due? In other areas the doctor gives lip service only to the idea of prenatal care. These patients never receive a general examination or even a pelvic examination and such things as blood tests are unheard of.

When these patients come into labor they are under the care of the nursing staff alone. The doctor doesn't appear until a few minutes before delivery with no knowledge of the real or imaginary terrors that the patient may have suffered. Others who do happen to appear on the scene at an earlier hour often rigidly withhold sedation from a suffering girl in the belief that she will do better and be happier later if she has a so called natural childbirth. I think the average girl deserves a better deal than this.

No physician is so busy that he cannot take the time to do good prenatal care. The patient should first be seen at the second or third month of pregnancy and she should have regular appointments from then on and she should keep these appointments.

At this point some doctor will say you cannot get patients to come in for prenatal care. If he would only let it be known that he would attend no woman who appeared later than the fourth month and has the guts to stick to this rule he would have no problem. Unfortunately there are those in our midst who can never turn down any such call and will treat patients who have refused all prenatal care. Personally I consider the man that does substandard work thru a sense of duty and the man who does such work thru greed to be tarred with the same brush.

On the first visit a very thorough history and a general physical examination should be done and this necessitates a completely undressed patient. Some doctors are so concerned with the imaginary modesty of their patients that they try to examine them thru their clothing. Actually the average young married woman has no false modesty unless the physician created the impression in her mind that she should. Subsequent visits should include

blood pressure, urine, hemoglobin, weight and an abdominal examination. Also a pelvic if you desire and a check of any areas of complaint. Following this the patient should have a few moments to discuss any worries or fears she may have. The value of these few moments can be far reaching because the girl feels that she can confide in her physician during her pregnancy and if he has the time to listen will continue to confide in him about other matters. This is of little value to the obstetrician but of great value to the family physician.

The average G. P. acquired the belief somewheres during his training that it is dangerous to become too friendly with female patients. This perhaps stems from the fact that some of his best teachers were very ill at ease with women. Actually, this is a false impression. The average obstetrical patient is not amourously inclined and if she is one can easily fend her off without anyone losing their head. Accordingly the G. P. can get on a first name basis with his patients and permit them to consider him their friend as well as their physician.

We should definitely define the limitations of the average G. P. He should not handle any case which is likely to end up in difficulties or in which there is any risk to mother or baby. In such cases the patient should be referred to an obstetrician and there is no place in Nova Scotia that is so isolated that this cannot be done. Every G. P. should be able to handle the normal case as well as the specialist but no G. P. should desire to become proficient in abnormal obstetrics for this can only be done by taking unnecessary risks with his patients.

There is absolutely no excuse for a G. P. getting caught with anything in a labor that he did not know about beforehand. All severe abnormalities of the foetus should be recognised by at least thirty-six weeks and if incompatible with life the patient should be induced. Letting hyrocephalus and anacephalics go full term is poor obstetrics. The use of X-ray for diagnosis is wrong. The X-ray should be used to confirm the clinical diagnosis. Its routine use should be condemned. This includes placenta preveas all of which can be diagnosed at an early date if the physician would only look for them. In this same light delivering breeches is poor obstetrics. The breech that cannot be turned to a vertex possibly does occur but it must be a very rare case. For a man to take pride in his ability to deliver breeches is the same as being proud of his ability to drive when intoxicated.

Let us next consider the rectal examination. This bit of antiquated foolishness has absolutely no place in modern obstetrics. There is no contraindication to vaginal examination. A vaginal can be done at any time during the prenatal period, during labor and after labor with absolutely no risk if normal cleanliness is observed. Two fingers in the vagina will give more information than one in the rectum. If needs be you can slip the finger thru the cervix vaginally but you cannot do this rectally. From the standpoint of the patient vaginals are normal and without discomfort but rectals are disgusting and painful especially on repeated examinations or where haemorrhoids are present. I think that I can say without fear of opposition that the man who does rectal examinations in preferance to vaginal examinations is either very old or very foolish. I have seen malpositions, malformations of the foetus and prolapsed cords all misdiagnosed because the doctor was afraid to do a vaginal examination.

Many men have never sat thru a labor with any of their patients and consequently have little knowledge of what goes on during a normal labor. The primipara at least deserves the presence of her physician during the last few hours of her labor and by the presence I mean sitting with her and not sleeping elsewheres in the hospital. This is an opportunity to catch up on the reading that we fail to do at other times.

The exponents of natural childbirth have caused many of our labor rooms to be turned into horror pits by getting physicians brainwashed to the idea that childbirth with little or no sedation is natural and that is the method of choice in all cases. Nothing could be farther from the truth. It has been my finding that less than twenty percent of women are adaptable to delivery without sedation. The statistics showing figures of up to eighty percent success with unsedated childbirth are compiled by men who have been trying to make a name in this field and never set thru a labor with their patients. They ignore all adverse results and often the poor woman is too frightened to criticize the method. Any girl who has any unhappy memories of her labor or any fears of another pregnancy has been badly handled and has had poor obstetrics practised on her. The primipara should be able to honestly say "I didn't mind it a bit".

Except in cases of uterine inertia the use of all drugs by injection can be avoided. It is these narcotics and tranquilizers that depress babies. The doctor in rural practice needs only one thing and that is trilene. I have used it for thirteen years and in the last three hundred consecutive cases have used it exclusively. I do all my forceps deliveries and repair all my episiotomy under trilene alone.

Some patients use trilene for as long as twelve hours – it being my policy to tell each girl "you don't have to suffer – you can have the trilene just as soon as you want it – it is your decision as to if and when you take it". Some babies are sleepy but I have never been able to blame respiratory depression on trilene when used alone. Conversely I feel that combining narcotics and trilene is asking for respiratory depression in almost every case.

We should not hesitate to interfere with nature. Too many physicians feel that they should let nature take its course in obstetrics. This may have some value but I fail to see it. You must make a stand somewheres – either you must be prepared to interfere whenever nature seems to be going astray or else leave obstetrics alone altogether. You foresee the difficulties and try to avoid them happening during the pregnancy and when the foetus gets near term you watch all the closer and at any suspicion of trouble with the foetus you induce labor. No matter how limited your knowledge you can always find a pediatrician who will help you care for a premature infant but not even God can help you with a stillborn infant. Inductions are safe and almost always sure if one has three constant factors (1) a good pelvis (2) a cervix that is partially effaced and will admit two fingers easily (3) a foetal head that is well engaged. If all three are present rupture the membrane, use pitocin and all should be well but if you lack any one of the three induce only with the realization that it may fail.

In this type of obstetrics forceps can be considered almost normal procedure. With the head visible on the pelvic floor there seems little value in having it pound away there for another hour when it can be easily lifted out with forceps. This applies equally to anterior and posterior presentations. If one's assessments of the labor has been correct any posterior can

be delivered as such by low forceps or manually turned to an anterior. I doubt if the occasion need arise when the rural G. P. ever needs to do a rotation by forceps or needs to apply mid forceps.

In conclusion I feel that it is high time that the medical society publically stated what it considers to be good prenatal care and good obstetrics. Then and only then will the average girl in this province be able to know when she is receiving an acceptable standard of care.

I would hope also to see the day when every stillbirth and every infant dying within seventy-two hours of birth would be subject to investigation by the medical society.

---

*From the Bulletin of 40 Years Ago

The Medical Society of Nova Scotia Bulletin, March 1923.

From Cure to Prevention

More money is spent by a railway on train and track inspection than on wrecking crews. The average owner of an automobile does not wait until there is a breakdown, he is always on the watch for signs of motor trouble. The progressive factory manager does all that he can to guard against interruptions in production by solicitously looking after his machines.

Vastly more complex than any machine, the human body is in need of vigilant care and frequent examination, yet for the most part it is neglected until pain and disability sound an unmistakable alarm. Then the doctor is called in and too often is expected to do the impossible. Usually he is thought of as a wrecking crew instead of a train and track inspector. The doctor will be increasingly called upon to keep his patients well. The emphasis is shifting from cure to prevention.

Diffuse Exocrinopathy

Cystic Fibrosis

The disease commonly called cystic fibrosis, and sometimes mucoviscidosis, is due to an abnormality in the exocrine glands and the name exocrinopathy is suggested. The pulmonary lesion has the greatest significance.

Gradually it has become apparent that "cystic fibrosis of the pancreas" is not primarily a pancreatic disease; neither is it a cystic or a fibrotic disease The basic mechanism is a disturbance of the function of many of the exocrine glands of the body, structures that secrete their products externally onto an epithelial surface. The common denominator in this disease appears to be an abnormality in the composition of these exocrine secretions and clinical disease results when the secretions are sufficiently altered to cause dysfunction of the organ or organs involved.

The mucous glands of the tracheobronchial tree, the acinar tissue of the pancreas, the biliary canaliculi of the liver, the secretory tissue of the salivary glands, the sweat glands of the skin, and possibly other structures such as the gastrointestinal mucosa may be involved in this disease. After years of observation, D. H. Anderson who introduced the term "cystic fibrosis of the pancreas" now defines cystic fibrosis as a "congenital familial disease characterized by dysfunction of many of the exocrine glands."

The clinical disturbances are variable and related to the type of the secretions and the function of the exocrine gland involved. Apparently the secretions of the pancreas, liver, and tracheobronchial mucosa are too viscous, while the abnormal secretions of other organs, such as the skin and salivary glands apparently have normal viscosities.

CLINICAL ASPECTS

The disease is not uncommon. Its most significant clinical aspect is the pulmonary lesion, not pancreatic insufficiency. With growing appreciation of the pulmonary aspects of the disease, certain children with bronchitis, "chronic pneumonia," "whooping cough pneumonia" are now correctly diagnosed as having cystic fibrosis. The term mucoviscidosis, introduced in 1945, implied an increased viscosity in the secretions of the tracheobronchial tree, pancreas, and liver. The name had merit until P.A. di Sant'Agnese and associates discovered the electrolyte abnormalities of sweat in patients with this disease, but found no alterations in viscosity. While cystic fibrosis is still the accepted name, exocrinopathy would appear to be more suitable one.

The exocrinopathy of the mucous secreting glands of the tracheobronchial mucosa produces the most serious effects of the disease. The tracheobronchial tree contains numerous mucous glands in its submucosa. Their secretions are most viscous and are cleared from the tracheobronchial tree only with difficulty. Retention of the viscid material predisposes to infection and airway obstruction, either of which may predominate. During infections of the lower respiratory tract, the thick mucus results in prolongation of illness and favors development of serious complications.

Often cystic fibrosis may be suspected when a child fails to recover promptly from a "chest cold," "flu," or pertussis. Respiratory complaints—primarily cough, sputum production, and susceptibility to recurrent infections—may be minimal for years only to erupt at or after puberty into a progressive, relentlessly fatal respiratory disease.

John A. Prior, M.D., The Ohio State Medical Journal, October, 1961.

Abstracted by National Tuberculosis Association.

Before pancreatic insufficiency is detectable clinically, 90 per cent or more of the pancreatic exocrine function has been lost. If this degree of loss is present at birth, meconium ileus may develop, causing an intestinal obstruction and accounting for approximately 10 per cent of the deaths due to cystic fibrosis. Patients spared meconium ileus will usually die primarily of pulmonary disease.

The most commonly described cystic fibrosis patient is a child who between the second and twelfth month of life develops steatorrhea and chronic recurrent respiratory infections.

SWEAT GLANDS

Parents of children with cystic fibrosis have observed that their children may taste salty when kissed. These children may also have a white, gritty material on their foreheads after exertion, and they may not "do well" in a hot spell.

In 1954 di Sant'Agnese and co-workers demonstrated that the electrolyte depletion was the result of the secretion of sweat containing excessively high concentrations of sodium and chloride. By metabolic balance studies, they demonstrated that the skin was the only route of the abnormal electrolyte loss. They devised a diagnostic procedure, known commonly as the "sweat test," in which the subject is exposed to thermal stimulus and his sweat is collected for analysis of the electrolyte concentration. In cystic fibrosis patients the sweat concentration of sodium and chloride is elevated from two to three times that of normal. There is no demonstrable correlation between the degree of electrolyte increase and the severity of the associated disease.

The marked variation in the severity of the disease is based upon inherited factors. It may be that the genetic factor can occur unexpressed clinically, thus some relatives of patients have abnormally high sodium and chloride sweat concentrations but no accompanying indications of disease.

DIAGNOSIS AND TREATMENT

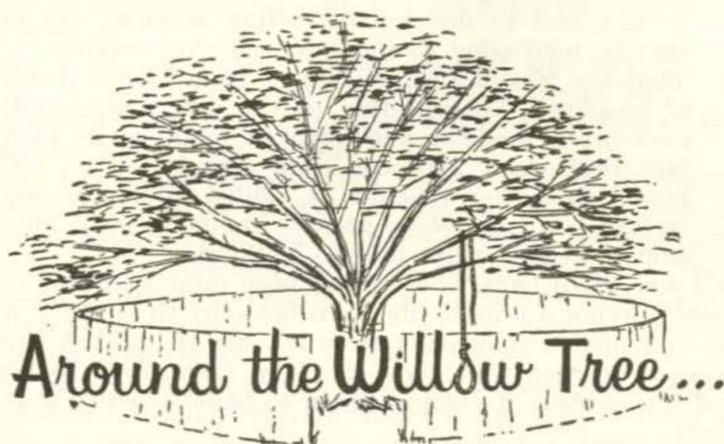
The laboratory diagnosis of cystic fibrosis is based primarily upon the sweat test, which is positive in 99 per cent of known cystic fibrosis patients.

As in many other diseases, cystic fibrosis was first reported to be a rare but highly fatal disease. Although usually considered a disease of children, active disease has been found in individuals in the third and fourth decade.

Since the pulmonary disease accompanying cystic fibrosis is responsible for most of the deaths, particular attention to the lungs is indicated. The viscid secretions may be rendered thinner by the use of expectorants such as the iodides. Pancreatic streptokinase and streptodornase may be helpful in liquefying secretions.

For the control of infection, intensive courses of broad spectrum antibiotics each month for four or five days continuously are often helpful. In some instances, virtually year-round antibiotic therapy may be necessary to effect significant improvement. Cultures should be made of the sputum at regular intervals. Changes in the bacterial flora may dictate changes in antibacterial therapy.

The Doctor's Column



Bushveldt Vignettes - - - October, 1962

Missão Evangélica do
BAILUNDO
Teixeira da Silva
ANGOLA

Dear Friends: –

In his famous speech to defend the freedom of the press, my fellow Nova Scotian, Joseph Howe, confessed that he was neither a prophet nor the son of a prophet. Me too!

Howe went on, however, to make some guesses about the future of our little peninsula and its people.

So, just for now, let's look the other way. I am not much of a "looker backer", but it might be worth while to try a bird's eye view of this little local venture of which we are a part. All the more so, because most of you who read this letter have also had a share – and some of you a very large share – in these schemes and dreams and hard work, humbly yet hopefully designed to fit into that which we boldly believe to be a divine plan.

Coming to Bailundo in 1957, the object was to develop a much more active health work as an integral part of the life and witness of the evangelical church which had begun in 1880 with the arrival of the first Congregational missionaries. (That, by the way, was many years before there were any other white people in this part of the country.)

From 1947 until 1957, except when on furlough, I had had the mission and the village dispensaries here "under my wing" as I directed the work of Dondi Hospital and its public health activities.

In only a few months two factors became painfully clear:

First: That every effort to improve rural sanitation, to provide health education, to push immunization against tuberculosis, using B.O.G. and to develop midwifery services, etc.,meant a constantly increasing demand for *curative* services.

Second: That the 50 miles separating us from Dondi Hospital, the cost of gasoline, the condition of the dirt roads, and the already over-taxed medical and surgical facilities in Dondi, plus the fact that many patients were already 80 or 100 miles from home when they reached us, added up to the conclusion that *we had to do something positive* about surgery and hospitalization in general right here in Bailundo.

So there I was, right back where I had been (and still am) ever since we came to Africa! Living a double life, torn between the utterly urgent call to cure and the inescapable obligation to teach health, preach prevention and not only to convince men that they can help themselves to larger slices of life, but – and it's harder – to inspire them to believe that it's worth while to make the effort!

It's this kind of a two-way pull:

"I'll try to get to bed before midnight to-night. Early tomorrow I'll do just the things the nurses can't do here at the hospital. Then I'll drive 80 kilometers North-East to where Aaron Elephant will be having a mother and child welfare clinic. I'll have a good session with the mothers and Aaron will be so happy to have some help!). . . . . .Midnight plus. A jeep has roared by our bedroom window its search-light lighting up our 70-year old mud house, turned in the yard and roared out again. Just to make sure that all is "in order" . . . . . ."Maybe it's not quite as easy to get to sleep again after you're 60. .But there's the wooooing of the owl and the sigh of the wind in the tall jacaranda trees that tower over our low tile roof. . . .and bed feels *so good*!. . .Thank goodness there have not been many fleas lately. . .Sanitary science hasn't given us the answer to fleas in Africa yet. . .Well, some day. . Think of jiggers. They're almost gone. But even to think of them makes my toes itch. Oh, the miles and miles I rode on the bicycle 30 years ago with big slippers on my feet because they were so swollen from jigger infection!. . .There were the clinics for leprosy patients in the country between the Kukema and Quanza rivers, to visit and direct. There were the little bush dispensaries to supervise. . . . ." . . . .

Tap! Tap! Tap! at the window. A soft voice speaks out of the dark: "We need you, doctor. . .They've brought a parturient from out Bimbe way. Four days in labour. The foetal heart is alright but her pulse is fast".

And so the night is over at 4 A.M. There's a Caesarean to do. There is another case to see when the first is tucked in bed – or rather in 2 beds – a hospital cot and a basket! Too soon, tomorrow is here. Plans to teach

mothers and examine children and inspire health workers in the villages have to be cancelled. One is caught up again in the net of the needs of those already ill – those needs that, in all "only-starting-to-develop" countries stand between doctors and the masses who might suffer less than a tenth of the sickness they now endure, and from which they die, *if* there was adequate teaching, technical development, sanitation, nutritional betterment, immunization and prophylactic services.

Well, that's the way it is. A man should give thanks for the health and chance to live a double life and to do something at least to heal broken bodies *and* to offer more health and larger life to his fellows who have the same right to them as he has himself.

So, during five years the Bailundo Health Centre has been growing up.

As to what it *will be* to-morrow, or the day after. . . .well that depends on whether new recruits are found, sent and admitted, on whether new doctors are trained, on whether the church in this land can weather the storms that have been breaking upon it and all around it, on factors about the most of which one must remain silent. . now.

Of *two things* I am sure:

That the Father's will *is* life and good for all of human breath; and that the brotherhood shares in His fight with death that is slow (as in kwashiorkor) and death that is fast (as in cerebral malaria); the death of the mind that might have lived but has never had a real chance to live, and the death of the spirit that has longed to see but has known mostly darkness; the death that men did not will, but that they might easily conquer if they cared enough, and the death that men have wilfully imposed upon their fellow-men, and, being sure, I propose to keep on fighting,

Sincerely,

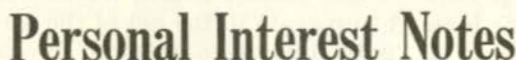
SIDNEY GILCHRIST, M.D.

"WANTED: General practitioner, preferably with some surgical experience, for Sawmill town of 1,700, with large surrounding district. Have modern 25 bed hospital, opened in 1957, with Lab. Technician, X-ray Technician, and services of Radiologist.

Town has High School, Elementary School, Golf Course and Curling Rink.

Only one doctor at present.

For additional information contact V. R. Briggs, Chairman, Board of Management, Tobique Valley Hospital, Plaster Rock, New Brunswick."



Personal Interest Notes

Antigonish-Guysborough Medical Society

Dr. N. P. Murphy attended the American Orthopsychiatric Annual Congress in Washington during March.

Dr. F. E. MacDonell attended a meeting of the C.M.A. committee on Pharmacy in Toronto recently.

On February 21st Dr. MacDonell's youngest daughter, Marguerite Antonia was born. We join in congratulations to him and wish also to express our sympathy with him in the death of his mother, Mrs. John E. MacDonell on March 11th.

Colchester-East Hants Medical Society

Dr. T. C. C. Sodero spent a vacation in Florida in February.

Dr. R. F. Ross also has spent a vacation in Florida and Nassau recently.

Dr. David Moore who has been doing graduate work in Halifax during the last three years has opened an office in Truro for the practice of Obstetrics and Gynaecology.

Halifax Medical Society

Dr. N. Fahmy announces the opening of an office at 152 Ochterloney Street, Dartmouth, (former office of Dr. L. A. Rosere).

Dr. H. B. Colford, Director of Child and Maternal Health for the Nova Scotia Department of Health addressed the joint meeting of the Nova Scotia and Halifax-Dartmouth Metropolitan Red Cross Homemakers Committee recently. He stressed the importance of maintaining immunization against tetanus, diphtheria, poliomyelitis and smallpox during childhood and adult life. Accidents in the 5-9 year age group rank first as cause of death in Nova Scotia as elsewhere.

Dr. Doris Hirsch, Halifax City Family Life Chairman, took part in a regional family life conference held in Halifax recently, sponsored by the N. S. Federation of Home and School Associations.

Valley Medical Society

Dr. A. A. Giffen was recently elected President of the Kentville Hospital Association at its Annual Meeting.

Congratulations

To Dr. John Merritt who early in March was appointed to the Board of Directors of the Nova Scotia Trust Co. Dr. Merritt, a Gold Medalist and Malcolm Honour award winner from Dalhousie is a Fellow of the Canadian,

American, and International College of Surgeons and presently is associate professor of Surgery at Dalhousie, and Chief of Service at both the Victoria General and Childrens' Hospital. He has never spared himself in anything furthering the cultural development of Halifax.

To Miss Joan Casey, second year Medical student at Dalhousie who has been awarded one of four Smith, Kline and French Scholarships for work and study in medically underveloped countries. Miss Casey will, during her next summer vacation join her brother, Dr. Tom Casey at Holy Rosary Hospital in Emekuku, Eastern Nigeria.

Dalhousie University

On March 27th was held the second of the Annual Research Days put on by the University. The object is to acquaint one's confreres with the Research which is being carried out by the different departments. A very interesting programme was presented which was well attended.

Births

To Dr. and Mrs. Ian Drysdale (née Janet Owen) a daughter, Heather Lynn, on March 18, 1963, at the Women's College Hospital, Toronto.

To Dr. and Mrs. W. Siddall, a daughter, Wanda Leigh on March 25, 1963.

To Dr. and Mrs. Donald Nicholson, (née June Meagher) a daughter, Mary Joanne at the Halifax Infirmary on March 13, 1963.

To Dr. Albert J. and Mrs. Shaw, their fifth child a daughter at the Halifax Infirmary on March 21, 1963.

Birthdays

Our congratulations and best wishes to Dr. James M. Corston, Halifax, on his 84th birthday, March 12, 1963.

Obituaries

We regret to record the death on March 19, 1963 at Whycocomagh, Inverness Co. of Dr. Gordon Daniel Timmins. Dr. Timmins died of a coronary attack at the age of 49. He was buried in Mt. Hermon Cemetery Dartmouth. For a number of years since graduating from Dalhousie he practised in Ship Harbour and Dartmouth. We extend our sympathy to his wife and daughter.

On March 15 in Sydney Cape Breton there died Dr. Freeman O'Neill, born in Sydney, 89 years ago. He was a graduate from Bellvue Hospital New York and practised first in Louisburg before coming to Sydney. He was Medical Officer overseas during World War I and after the war for Cape Breton Co. Later he was M.O. for the Cape Breton Highlanders which he organized and commanded. In World War II he served as Assistant M.O. of the R.C.A.F. He was a Knight Commander of the Order of St. John of Jerusalem. We extend our sympathy to his family.

On March 27, 1963 Dr. Leander Rupert Morse, aged 91 years died at Lawrencetown, N. S. He was a graduate of McGill University and had practised in the Valley throughout his career except during the war. He was a survivor of the Halifax Explosion and was one of the earliest certified radio-

logists in Nova Scotia and the first in charge at Camp Hill. He was associated with Dr. J. A. Sponagle in founding the Soldiers Memorial Hospital in Middleton.

Until 1950 he was associate with his sons in practise yet found time to give of his energies to many activities including his Alma Mater, Acadia and as a member of the provincial Medical Examining Board. We extend our sympathy to his wife, doctor sons, and the other members of his family.

Coming Meetings

There will be no Victoria General Staff clinical meetings during the month of May. We hope to publish some of the papers delivered during recent months in coming issues.

THE SECOND ANNUAL MEETING

ATLANTIC SOCIETY OF OBSTETRICS & GYNECOLOGISTS

Saint John, N. B., Sat. May 25, 1963

9.00 – 9.30 a.m. – Registration, Laboratory Building Saint John General Hospital.

9.30 – 11.00 a.m. – Business Meeting.

11.00 – 11.15 a.m. – Coffee break.

11.15 – 11.45 a.m. – Case Presentation – Dr. Tanzman.

11.45 – 12.15 a.m. – Cytology Program in Nova Scotia – Dr. Robinson

12.30 – 2.00 p.m. – Luncheon (courtesy Saint John General Hospital).

2.00 – 3.00 p.m. – **Panel** – "Uniform Atlantic Provinces fee Schedule". Drs. Foster, Corston, Irwin & O'Dea.

3.00 – 3.30 p.m. – Case Presentation – Dr. Wanamaker.

3.30 – 3.45 p.m. – Coffee break.

3.45 – 4.15 p.m. – Medical Inductions – Grace Maternity Hospital – Dr. Kingston.

4.15 – 5.00 p.m. – Completion of business.

7.00p.m. – Cocktails and Dinner for members and wives – Admiral Beatty Hotel – Speaker to be announced later.

N.B. – Luncheon for wives 12.45 p.m. at the home of Mrs. F. D. Wanamaker, 891 Manawagonish Road, Lancaster. Directions and transportation can be arranged by calling 694-1516.

Members are encouraged to invite and bring to the Meeting all Obs and Gyn Specialists in their area who may be non-members of the Society.