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Egypt: The Cradle of Medical History

Thanks to the dedicated work of scholars, the extraordinary preserving qualities of resins, myrrh, natron, and the remarkable dry climate, a vivid picture of one of man's oldest recorded civilizations has been preserved and decyphered.

There are at least a dozen papyri which concern medicine. These documents written in hieroglyphics on a parchment made from eight foot high reeds, provided a lighter and more convenient form of communication than the heavy royal despatches written on clay used at that time.

The most famous are the Edwin Smith and Ebers papyri. Some confusion surrounds the exact nature of their discovery, but in 1862 an Arab, Mustafa Aga, sold a collection to Dr. Edwin Smith, an American scholar living in Egypt. Two months later Mustafa Aga turned up with another collection of papyri glued together, and sold them to Dr. Smith. Whilst this remarkable American never published any articles, it is clear that he decoded their meaning to a large extent. After his death, the documents were given to the New York Historical Society by his daughter. This society engaged the famous Egyptologist Professor J. H. Breasted to study them. Thanks to a lifetime of diligent study, he was able to publish one of the great masterpieces of medical history *The Edwin Smith Papyrus* on behalf of the Oriental Institute of the University of Chicago, and it is a very detailed analysis of the document.

Whilst this surgical treatise was written sometime around 1500 BC, much of the contents were transcribed from earlier scholars — some dating back to the First Dynasty, 3400 BC. The work is a combination between scholar, commentator and scribe. Whilst the latter's characters were beautifully executed, he had some difficulty in transcribing some of the older hieroglyphics and hieratic characters. Professor Breasted's scholarly publication contains fascinating detailed notes and explanations with reproduction of a glossary. Amongst the explicit clinical descriptions are exact instructions how to reduce a dislocated mandible — almost identical with that used by Hippocrates many years later. The Ebers papyrus unfortunately was not so accurately translated and is a divers collection of medical prescriptions.

Another Egyptologist, Professor Warren Dawson, Fellow of the Anthropological Institute of Great Britain, has also written extensively on many aspects of Egyptian culture. After an exhaustive study of all relevant papyri, he portrays them as either mainly medical, or mainly concerned with magic, and he sees nothing illogical in combining the two. As Sir Allan Gardner (who described the oral and manual rites) remarked: "Medical books are seldom free from incantations and magical papyri are interspersed with medical prescriptions." We have only to look at the advertisements in our own medical journals or to spend a few moments listening to the claims of analgesic manufacturers, to appreciate the power of suggestions.

The Ebers papyrus was probably first the property of Edwin Smith, before it was acquired by Professor Ebers of Leipzig, who has pinned his own name to the manuscript. Warren Dawson gives an extensive account of the history of Egypt from the first Dynasty to the defeat of this great civilization by the Persians in 55 BC — four thousand years of culture that has yet to see its rival in the magnificence of its statues, the opulence of its Royal Family, and the organization of its populace!

The Greeks and Romans certainly based their Empires on the foundations of Egyptian knowledge. The scholars at Alexandria were direct descendants of the scholars of the Nile. Medical knowledge of Hippocrates can be linked with Imhotep, the Aesculapius of Egypt. The Egyptians were a resourceful people essentially practical, but inspired by a magic that transcended bodily death — a magic that inspired the pyramids — a magic that matched medical skills with organization. It allowed physicians to specialize, drew medical practitioners from Greece and won praise from Herodotus.

The skill of their medicine is described by Guido Maynoe in another wonderful treatise *The Healing Hand* in which he traces the origin of knowledge concerning the healing of wounds. He describes the oldest medical document in existence, the Sumerian Clay Tablet, dating 2100 BC. This is inscribed in cuniefom characters and describes the application of prothesis.

Thanks to the genius of experts in deciphering this cuniefom script, and to Champollion in solving the riddle of the Rosetta Stone in 1822, this rich store of history has been pried open. This stone was originally discovered by a French cavalry officer in Napoleon's army. On the capitulation of Egypt to Britain, the stone was sent eventually to the British Museum where it still resides. A mutilated block, it contains a decree in Greek, Egyptian hieroglyphics, and demotic writing. Thus, by a happy combination of political and historical circumstances, a new Science of Egyptology was created.

We are grateful to Charlotte Resch for gathering a wide collection of material together, and for presenting it in an attractive treatise. Many texts, from which she quotes, are readily available in the Kellogg Library and it behooves students and practitioners to realize the origin of many of their prescriptions and surgical procedures used today.

Yes, even the splinting of fractures was performed very adequately 5000 years ago! The Eye of Horus would be excited by the extent of present day medical knowledge. He would appreciate the study of scoliosis in school children before the curve becomes deforming. He would be impressed by the skillful elucidation of cranio-facial pain described by Dr. Delcampo.

He would have been amazed at the article by Fraser and Embil on *Chlamydia trachomatis*. The isolation of the organism responsible for thousands of cases of blindness in the Middle East is a remarkable feat. The recent secotyping of this organism linking it with a wide variety of diseases in adults and infants is an outstanding achievement. Its full implications have yet to be realized.

Above all, the Egyptians would have appreciated the dedication of skilled physicians honored in this issue. Dr. W. Greer had a distinguished career in the Canadian Armed Forces. Dr. Atlee was one of Nova Scotia's greatest physicians. Scholar, physician and pioneer, even the physicians of the Nile would have been unable to surpass his brilliance. □

B.J.S.G.

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Medicine in Ancient Egypt

Charlotte S. Resch,*
Halifax, N.S.

INTRODUCTION

"... the earliest dawn of medical science broke over the Valley of the Nile"¹

The medicine of the Ancient Egyptians was famous throughout the world. Their physicians were praised by Homer as being the best of his time², and Egyptian doctors were sought by the kings of many countries.³ They were not surpassed by the Greeks until the Sixth Century B.C.⁴, and even then Galen suggested that prescriptions containing a few Egyptian words would strengthen the patient's faith in the medicine.⁵ In fact, a relic of Egyptian medicine survives to this day in the form of the Rx symbol associated with prescriptions: this symbol may have been derived from the sign for Jupiter, placed at the tops of the prescriptions of Medieval doctors and alchemists. This sign, in turn, may have developed from the protective Egyptian symbol, the Eye of Horus (one of the gods of healing).⁶

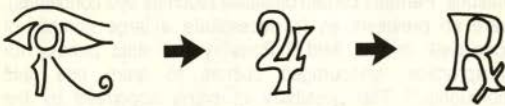


FIGURE 1

Derivation of Rx from the Eye of Horus.⁷

Was this fame deserved? Fortunately, one of the great discoveries of the Egyptians was writing. This made their medical knowledge enduring, so that not only could it spread and be built upon by other peoples, such as the Greeks and the Romans,⁸ but it has come down to us in the writings of numerous medical papyri.

However, the works of the Egyptians also offer some difficulties. They are written in a complex and incompletely understood language, so that the amateur is at the mercy of experts who may differ, not only in interpretation, but sometimes in actual translation as well. For example, an idiom roughly translatable as "give the patient bed-rest", is translated by one author as "... [putting] the patient on his fingers"⁹ and by another as "... [mooring] him at his mooring stakes".¹⁰ Luckily a gloss exists in the manuscript which explains the meaning of the idiom and thus clears the confusion.

The problem is compounded in the medical papyri by the use of many medical and technical terms, particularly the names of specific plants and minerals required in the making of drugs.¹¹

THE KNOWLEDGE OF THE GODS

"... clinging to the divinely set origins. . ."¹²

*Third Year Medical Student, Dalhousie Medical School, Halifax, N.S.

Religion pervaded all aspects of Egyptian life. For most of their history they did not actively seek knowledge of the unknown, for they believed that to be the realm of the gods.¹³ In fact, they actually attributed all their knowledge, even that of writing, to the god Thoth.¹⁴ This knowledge was contained in the thirty-two Hermetic books of Thoth, all of which have been lost.^{15 16} Of the thirty-two, six dealt solely with medicine, divided into books as follows: anatomy of the human body, the study of diseases, surgery, materia medicae, eye diseases, and diseases of women.¹⁷ The medical papyri in existence are probably ultimately derived from these six books.¹⁸

This belief in the divine origin of knowledge had a crippling effect on progress in all fields, including medicine, for it precluded any questioning of or addition to what was written in the Hermetic books. The Egyptians were trapped in a "divinely inspired, unprogressive tradition. . ."¹⁹, which did not change for hundreds of years.

MAGIC AND MEDICINE

"... Egyptian magic . . . is the parent of medicine. . ."²⁰

Magic was equally as pervasive in ancient Egypt as religion, to which it was closely allied²¹, and was commonly used to a greater or lesser extent throughout Egyptian history, to cure the sick. This grew out of the early belief that illness was caused by a possessing spirit in the form of a dead man or woman, or a god or goddess, which, once having entered the body, began "... [breaking] the bones, ... [sucking] out the marrow, ... [drinking] the blood, ... [devouring] the flesh"²², and generally physically damaging the patient.

Obviously, the cure for this was to remove the evil spirit. The magician accomplished this by reciting a spell demanding that the spirit leave, often calling upon the help of one or more of the healing gods and goddesses: "O Isis . . . mayest thou deliver me from everything evil. . ."²³. Usually accompanying the spoken incantation, which may be referred to as the oral rite, was some sort of ritual, or manual rite.²⁴ The latter often consisted of reciting the spell over various objects (e.g. an amulet, a string of beads, or a knotted cord).²⁵ Alternatively, the patient could be given something to ingest, usually foul and unpalatable, in order to drive away the spirit.²⁶ For this reason the Egyptians described diseases treated by magical means, not as being "cured", but as being "banished", "terrified", and "killed".²⁷

Some of the mixtures accidentally aided the patient, and these tended to be used more frequently than the others. Gradually, more and more emphasis was placed on the manual rite, and less and less on the oral rite²⁸ and, with this development, medicine was born.

Medicine, however, never entirely replaced magic. The removal of the evil spirit, and thus the actual cure, continued to be attributed to magic; medical care with drugs was believed only to relieve the pain and repair the damage

caused by the spirit.²⁹ Magic continued to be the treatment of choice for most "hidden" (i.e. internal) diseases.³⁰ The suggestion that Egyptian medicine was not closely tied to magic, because there are 1200 prescriptions and only 80 incantations,³¹ is hardly valid because most of these incantations had a very wide range of use. Consider in how many different situations an incantation titled "...[A] Recital for Applying a Remedy on Any Part of the Body of a Man"³² or "... [A] Recital for Loosening Any Bandage"³³ might be applied.

The use of incantations may also have survived for the practical purpose of reassuring the patient³⁴, at the same time placing him in awe of the physician.

THE HEALERS

Egyptian documents refer to three types of healers — the physician, the priest, and the magician.³⁵ The magician enjoyed a higher status than the physician³⁶, presumably because he treated the more mysterious internal diseases and was believed to remove the actual cause of the illness, the possessing spirit. Similarly, priests were called in for the gravest illnesses³⁷, possibly to seek divine intervention.³⁸ In any case, these distinctions blur into near-uselessness when one considers the close association between magic and medicine, coupled with the fact that physicians *were* priests.

Since the Hermetic books were of divine origin, only priests were allowed to read them.³⁹ Thus priests made up the educated class.⁴⁰ The highest caste of priests studied all thirty-two Hermetic books; each lower caste studied fewer, and the lowest caste of all studied only the six Medical books.⁴¹ This might be expected to have two effects: 1) more priests had studied medicine than any other subject; and 2) those who wished to learn medicine need not study any other subjects if they so chose. The close association with priests conferred status on the medical profession⁴² and continued for most of Egyptian history. It is probably this physician-priest who is referred to by the following hieroglyph.

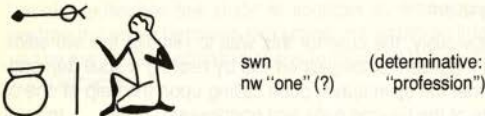


FIGURE 2

The Swnw — The Physician⁴³

This association of the priesthood with medicine extended to the Pir-ankh, or Houses of Life.⁴⁴ These were temples which functioned, not only as places of worship, but as libraries and teaching centers for medicine and probably for other sciences as well. They were also a sort of hospital, for many sick people would gather there to seek cure, either from a doctor or a god.⁴⁵

As far as ethics were concerned, the Hermetic books were the final authority. So highly were they respected that the physician was expected to follow the prescribed treatment to the letter and, no matter what the outcome, he was not held responsible. However, any deviation from accepted practice, resulting in the patient's death, was a capital offence.⁴⁶ Aristotle states that if no improvement in the patient's

condition was evident after four days, the treatment could be changed,⁴⁷ thus the standard injunction on Egyptian prescriptions to "treat with _____ for four days."

In addition to diagnosing and treating the patient, the doctor's duties included the preparation of his own drugs, and cosmetics as well.⁴⁸ And although gynecology was included under medicine, obstetrics was handled by midwives.⁴⁹

The fee for a doctor's services was at times determined as follows: since Egyptians shaved their hair for hygienic reasons, and a patient, while ill, was unable to have his shaved, the fee was calculated from the weight of hair shaved off upon his recovery.⁵⁰ Less picturesque, but probably more common, was the salaried physician appointed by a king, noble, or group of workers. Since he was on salary, he was required to treat all travellers passing through, and soldiers on campaign, free of charge.⁵¹ All patients, however, had to pay for their own medicines⁵², which is perhaps why magical treatments were less expensive.⁵³

Herodotus said: "The country is full of physicians; one treats only diseases of the eye; another those of the head, the teeth, the abdomen, or the internal organs."⁵⁴ One of the Pharaohs even had, as a personal physician, a specialist with the title "shepherd of the anus."⁵⁵ This marked abundance of specialists could be due to a number of reasons. Perhaps certain diseases (such as eye conditions), were so prevalent as to necessitate a large number of specialists in that field.⁵⁶ Possibly the strict penalty for "malpractice" encouraged doctors to learn one field thoroughly.⁵⁷ The possibility of being appointed by the Pharaoh, who often had a number of specialists for different parts of his body⁵⁸, may also have given physicians the incentive to specialize.

Two particular physicians deserve individual mention. One is Imhotep, who lived at about 3000 B.C., and is the first recorded physician of antiquity.⁵⁹ He was later deified by the Egyptians, and became the Asklepios of the Greeks.⁶⁰ He has been suggested as the author of the Smith Papyrus.⁶¹ The other is Peseshet, the only recorded female Chief Physician of ancient times.⁶²

ANATOMY AND PHYSIOLOGY

"... the body . . . to the Egyptians was a mass of flesh and bones traversed throughout by canals, with a heart in the center"⁶³

The Egyptians' knowledge of anatomy was both aided and hindered by their religious ritual of mummification. No knowledge of anatomy could be gained directly from the ritual, which was carried out by priests, not doctors.⁶⁴ It was considered the sacred preparation of the body for the afterlife; the idea of dissection was as abhorrent to the ancient Egyptian as to the medieval Christian. Indeed the unfortunate "paraschite", whose task it was to make the initial incision in the body, was forced to flee for his life under a hail of stones from the relatives of the deceased.⁶⁵

Yet a great deal of knowledge was derived from this process accidentally. It is unlikely the anatomy was observed "only in animals in the kitchen or in sacrifices at the temples."⁶⁶ Nor is it giving the Egyptians their due to dismiss their knowledge of anatomy and physiology as "of the most rudimentary character."⁶⁷ Considering the time and the

circumstances, their degree of sophistication was quite remarkable: there are well over 100 different anatomical terms in the Egyptian language. Further, many of these words are written in the same way when referring to animals as when referring to man,⁶⁸ the earliest indication of an understanding of comparative anatomy.

For all this, odd incongruities do arise such as the use of the same term for both the ear and the nose.⁶⁹ More significant, however, is the use of the all-encompassing word *mt* to describe arteries, veins, ureters, spermatic cords, tendons, ligaments, nerves, and muscles,⁷⁰ as though they were all similar or related organs. This can obviously give rise to a great deal of confusion in translating the ancient texts.

Apparently the Egyptians understood best the larger organs, especially those they considered most important. Therefore, the larger thoracic and abdominal organs, handled of necessity during mummification, all received separate names⁷¹, including the brain, the heart, the lungs, the stomach, the liver, the gall bladder, the intestines, and the urinary bladder.⁷² There is no word for kidney,⁷³ although the organs of the alimentary canal were all carefully named,⁷⁴ possibly because the Egyptians considered them a source of disease (see "The Theory of Disease").

The Egyptian concept of the circulatory system is particularly interesting, for it was surprisingly advanced and very primitive at one and the same time. It was known to them that the heart was the center of the vascular system.⁷⁵ They believed, as did many ancient peoples, that the heart was the seat of intelligence and emotions.⁷⁶ All vessels (*mt*) lead to the heart, and these vessels were thought to carry, not only blood, but air, water, mucous, semen, urine, tears, and feces.⁷⁷ A diagram of this peculiar system may be seen in Figure 3.

Remarkably enough, despite this rather confused idea of anatomy, the Egyptians apparently recognized the existence of the pulse, some 2,500 years before the Greeks.⁷⁸ The pulse was described as the heart "speaking through" the vessels⁷⁹, and was known to be synchronous with the heartbeat and palpable in different locations on the body.⁸⁰ Even more amazing, the pulse was routinely checked during examination of a patient, "in order to know the action of the heart."⁸¹

THE THEORY OF DISEASE

"...the wandering of the *ukhedu*"⁸⁴

The Egyptians described diseases rather simplistically as either symptoms or, less commonly, groups of symptoms.⁸⁵ Indeed, the symptoms and the disease were thought to be one and the same.⁸⁶ This causes difficulties in interpreting exactly what the diseases described in Egyptian texts are.⁸⁷

One entity the Egyptians believed to cause disease, the evil spirit, has already been discussed in some detail.

But disease was also attributed to a peculiar rotten substance thought to be found in the feces. This substance, called *ukhedu*, theoretically arose from the "decay" of the food in the small intestine.⁸⁸ Thus overeating was believed to be a factor in causing disease.⁸⁹ Moreover, the vessels were thought to concentrate around the anus, and even open directly on it (see Fig. 3.), so that the *ukhedu* could spread from there throughout the body.⁹⁰ Thus the cryptic suggestion in the Ebers Papyrus that certain symptoms are the result of "the vessels of the heart . . . [containing] feces"⁹¹ Pity the poor Egyptian, "condemned to walk around all day with an internal load of deadly material . . ."⁹² It is hardly any wonder that the Egyptians discovered the enema⁹³, nor is it surprising that, of 900 prescriptions, 81 refer exclusively to the anus.⁹⁴

In view of this, it is unlikely that the "shepherd of the anus" mentioned earlier was a mere "specialist in hemorrhoids".⁹⁵ More probably he was responsible for the general health of the Pharaoh, a very important position indeed.

DISEASE IN ANCIENT EGYPT

Much of the information on diseases afflicting the ancient Egyptians has been derived from the study of well-preserved mummies, and even those not so well preserved yield information of a skeletal nature. Statues, drawings, and the work records of overseers on building sites⁹⁶ give additional information.

Bone diseases such as osteoarthritis, rheumatoid arthritis, and tuberculous osteomyelitis were very common.⁹⁷ In fact, the determinative indicating old age is a man suffering from arthritis deformans.⁹⁸ It has been suggested that the prevalence of osteoarthritis was the result of the large

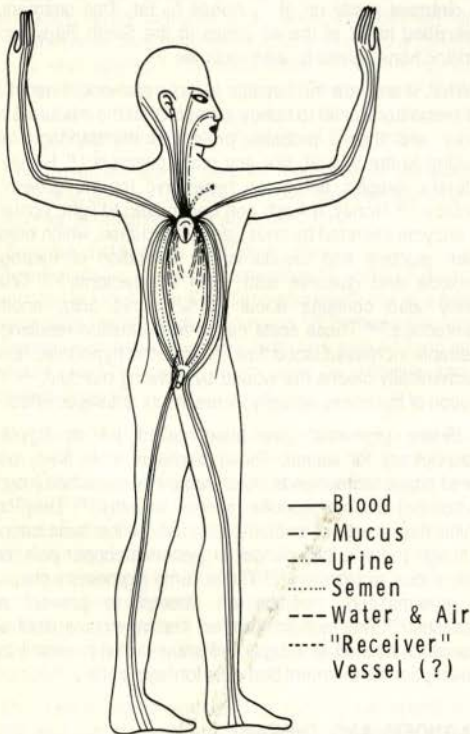


FIGURE 3

The Circulatory System as the Egyptians Saw It.⁸²

- vessels carry blood⁸³; four open directly on the anus.
- - - - vessel carries mucus to the nose.
- vessels carry urine and go to the bladder.
- vessels carry semen and go to the testes.
- - - - - vessels carry air, four to the lungs and spleen, and four to the liver.
- "Receiver" vessel (?)

numbers of people involved in the building of the massive Egyptian monuments.⁹⁹

In addition, evidence of bladder, kidney, and gall stones has been found, as well as tuberculous disease of the spine (Pott's disease), pleural adhesions, appendicitis, atherosclerosis, arteriosclerosis, and Bilharzia eggs in the kidney.¹⁰⁰ Also a few internal diseases, such as diabetes and schistosomiasis, are recognizable from their descriptions in the medical papyri.¹⁰¹ Syphilis and rickets have not been identified.¹⁰²

As today, dental caries existed primarily among the wealthy, who could afford a rich diet, although the coarser diet of the poor could result in wearing away of the enamel, and subsequent development of alveolar abscesses.¹⁰³

Congenital defects such as hydrocephalus, spina bifida, clubfoot, and achondroplastic dwarfism have also been noted.¹⁰⁴

THE PHARMACOPOEIA

"the fertile soil of Egypt is most rich in drugs. . ."¹⁰⁵

It is easy to believe that drug therapeutics was at the center of Egyptian medicine.¹⁰⁶ One third of all raw drugs known today were in use,¹⁰⁷ to say nothing of countless rare and useless substances. The ingredients given for prescriptions run the gamut from prosaic kitchen vegetables such as the onion, to exotica like the uterus of a cat.¹⁰⁸ To the Egyptian, everything was a potential drug.

The very multiplicity of Egyptian drugs suggests the arbitrary nature of their use.¹⁰⁹ One could choose from numerous remedies for a single disease¹¹⁰, and sometimes the same remedy was given for wholly different diseases.¹¹¹ The prescriptions are also usually followed by the suspicious claim that they have been "proven a million times".¹¹²

The actual effectiveness of many Egyptian drugs remains a mystery. The names for specific ingredients, such as plants and minerals, are sometimes completely untranslatable. The possibility of misinterpretation also exists: the word "mouse tail" refers to a plant.¹¹³ In addition, experimental studies on their effectiveness are few.¹¹⁴

Medicines, as previously noted, were compounded on the spot by the physician himself. They could take the form of draughts, electuaries, masticatories, gargles, snuffs, inhalations, salves, plasters, poultices, injections, suppositories, enemas, or fumigations.¹¹⁵ The prescriptions for these drugs were carefully and precisely given. A list of ingredients indicating the specific amounts of each required was followed by instructions on how to compound them (i.e. whether to mix, boil together, etc.).¹¹⁶ Instructions were also given the patient as to how, when, how often, and for how many days to take the medicine.¹¹⁷ Drugs were of two types: to be given for one day or for four days, depending on whether they were intended for the acute stage of the illness on the first day or were meant to be follow-up treatment.¹¹⁸

Plants, animals, and minerals all served as raw ingredients. A great variety of plants were used, including those with actual medicinal properties, such as juniper, mustard, and turpentine.¹¹⁹ The opium poppy was also known, and traces of opium were discovered in an ointment jar from an archeological site.¹²⁰ All possible products (saliva, urine, feces, bile, and various organs¹²¹) were collected from

elephants, lions, bats, mice, crocodiles, vultures, hyenas, and numerous other animal species.¹²² These were the sorts of substances probably used for the purpose of driving out demons. Minerals were primarily used in ointments, which often contained zinc oxide, sulphur, or copper compounds.¹²³

Rare and exotic materials added mystery and resulted in a "better" drug.¹²⁴ This is vividly illustrated in the oft-quoted remedy for baldness, a mixture of fat from the lion, hippopotamus, crocodile, goose, snake, and ibex.¹²⁵ Also, spells were often said over the remedy which suggested that its ingredients were of divine origin.¹²⁶ This use of rare ingredients and incantations may have increased the effect of the drug in a superstitious patient.

Although many of the prescriptions seem nonsensical today, others were particularly apt. For example, for constipation castor oil mixed with beer was prescribed¹²⁷; liver, rich in Vitamin A, was suggested for night blindness¹²⁸; and in one instance an infected wound was bound with "spoiled barley-bread"¹²⁹ (a reference to penicillin?). Two other drugs, honey ointment and the copper compounds, though unremarkable at first glance, were also highly beneficial.

The standard treatment for wounds of all kinds consisted of binding on fresh meat the first day, followed by treatment with an ointment made up of $\frac{1}{3}$ honey $\frac{2}{3}$ fat. This ointment is prescribed in 22 of the 48 cases in the Smith Papyrus; in addition honey alone is used six times.¹³⁰

What, if any, are the benefits of this treatment? First of all, the proportions of fat to honey are such that the mixture is not sticky, and thus it probably prevented the bandage from sticking to the wound, like any other ointment.¹³¹ Honey is naturally aseptic, being too hypertonic for the growth of bacteria.¹³² Honey, if fresh and unexposed to light, contains an enzyme secreted by bees, glucose oxidase, which breaks down glucose and results in the formation of hydrogen peroxide and gluconic acid, both disinfectants.¹³³ Crude honey also contains about 0.1% formic acid, another disinfectant.¹³⁴ These acids cause mild irritation resulting in desirable increased blood flow¹³⁵, while the hypertonic honey mechanically cleans the wound by drawing out fluid.¹³⁶ The dilution of the honey actually increases its antiseptic effect.¹³⁷

"Green pigments" are often called for in Egyptian prescriptions for salves. These pigments were finely powdered copper compounds, most frequently malachite (copper carbonate) and chrysocola (copper silicate).¹³⁸ They both inhibit the growth of bacteria because of the toxic copper, although there is little danger of systemic copper poisoning from a local application.¹³⁹ These same pigments were used as eye-makeup, perhaps an attempt to prevent eye diseases.¹⁴⁰ This explains the fact that physicians dealt with cosmetics as well as drugs, and shows what is meant by a prescription for ointment that calls for "eye-paint".¹⁴¹

DIAGNOSIS AND THERAPY

Knowledge of diagnosis and therapy in ancient Egypt has been derived primarily from the numerous magico-medical papyri that have been discovered. They vary considerably as to state of preservation and degree of legibility.¹⁴² Many deal with only one particular branch of medicine, such as pediatrics or proctology, and they contain greater or lesser numbers of spells.¹⁴³ By far the most famous of these papyri are the Smith Papyrus and the Ebers Papyrus. They date

from about 1850 B.C., but were recopied (apparently) from originals as old as 3000 B.C.¹⁴⁴ These two papyri offer a startling contrast in both form and content, as will be seen below.

The Ebers Papyrus lists remedies for everything "from crocodile bite to pain in the toenail."¹⁴⁵ The main emphasis is on diseases of the eyes, small intestines, and stomach, and on fevers.¹⁴⁶ However, the Ebers Papyrus, like most of the others, is not a medical text as we know it today. Rather, it is a confusing, utterly disorganized collection of prescriptions for various ailments.¹⁴⁷ Of 875 recipes given, only 47 are accompanied by a diagnosis of the disease it is presumed to treat.¹⁴⁸ In addition, the entire papyrus is heavily laced with magical charms and spells.¹⁴⁹

The Smith Papyrus deals with the treatment of traumatic wounds and fractures (surgery). Surgery had not reached a very high level of development in ancient Egypt, and "relied to a large extent on the natural healing process."¹⁵⁰

Trephination, common in many ancient cultures, was not practised¹⁵¹, nor was amputation or bloodletting.¹⁵² Cauterization was used in order to minimize bleeding, and was performed with a heated knife (which cut at the same time)¹⁵³ or a special cautery instrument.

Casts for the setting of fractures existed in a form remarkably similar to that of today. Mixtures of different types of flours (or in one instance "builder's lime") and cream or honey were applied to the set fracture, often in conjunction with bandages, and allowed to dry.¹⁵⁴ The presence of many well-healed, non-deforming fractures in mummified remains¹⁵⁵ attests to the effectiveness of these casts.

The Egyptians also apparently made use of the surgical suture although the translation of the Egyptian word *yr* as "stitching" is not universally accepted.¹⁵⁶

Surgical instruments included knives, hooks, forceps, cupping glassess, probes, and needles¹⁵⁷, some of which are illustrated in Fig. 4. The Egyptians also made use of a type of "disposable blade" made from reeds.¹⁵⁸ Perhaps even more amazing were awy-strips, gum and resin soaked linen strips used in wound closure, which were a primitive sort of adhesive tape.¹⁵⁹

The Smith Papyrus is typical of Egyptian surgery in that it relies primarily on conservative treatment.¹⁶⁰ However, it is remarkable in several other respects. In the first place, unlike the Ebers Papyrus, it is very well organized, listing the 48 cases discussed in order of the location of the injury, from the head down, and each sub-group of injuries affecting one area in order of severity.¹⁶¹ Furthermore, each case is broken down into five different sections: title (the injury to be described), examination (a listing of the symptoms), diagnosis, opinion (whether easily treatable, possibly treatable, or incurable), and treatment.¹⁶²

The cases are described with meticulous attention to detail, and indicate careful observation. Consider Case 5:¹⁶³

If thou examinest a man having a smash of his skull, under the skin of his head, while there is nothing at all upon it, thou shouldst palpate his wound. Shouldst thou find that there is a swelling protruding on the outside of that smash which is in his skull, while his eye is askew because of it, on the side of him having that injury which is in his skull; (and) he walks shuffling with his sole, on the side of him having that injury which is in his skull . . . while he discharges blood from both

his nostrils (and) from both his ears, (and) he suffers with stiffness in his neck. An ailment not to be treated.

Note that although the case is considered untreatable, it is included and carefully described, an example of interest in medicine for its own sake, unique among the medical papyri.¹⁶⁴ There is also very little reference to magic. The argument that the author's offer to "contend with" some of the ailments of questionable outcome is a reference to fighting a spirit¹⁶⁶ is tenuous at best, since physicians still speak of "combatting" disease. Magic is not even suggested for the hopeless cases.¹⁶⁷ However the possibility exists that the author of the Smith Papyrus merely assumed that the terminally ill patient would seek the aid of magician or priest.

Finally, it appears that the difference between sterile and infected wounds was recognized, and treatment altered accordingly:

If thou examinest a man having a gaping wound in his shoulder, its flesh being laid back and its sides separated . . . thou shouldst draw together for him his gash with stitching. If thou findest [the next day] that wound open and its stitching loose, thou shouldst draw together for him its gash with two strips of linen [adhesive tape] over that gash . . .¹⁶⁸

Unfortunately, the Smith Papyrus ends approximately halfway through.

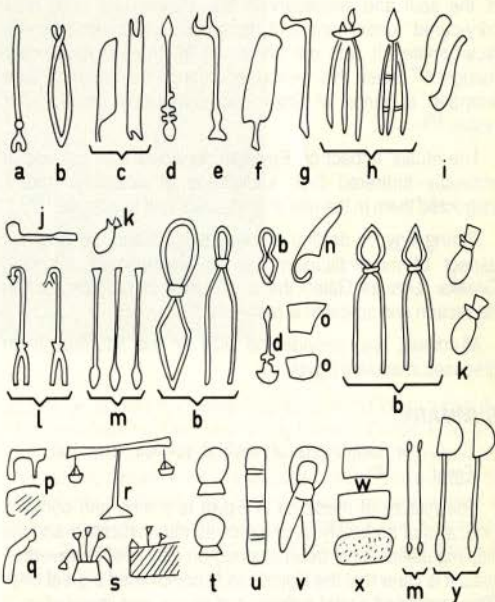


FIGURE 4

Egyptian Surgical Instruments.¹⁶⁵

- | | | |
|---------------------|----------------------|--------------------|
| a. probe-director | i. bandages | r. balance |
| b. forceps | j. scalpel (?) | s. plants |
| c. saw | k. flask | t. cupping glasses |
| d. probe | l. cauteries | u. instrument case |
| e. double retractor | m. probes | v. shears |
| f. saw (?) | n. saw (?) | w. (?) |
| g. cautery | o. medicine cups (?) | x. sponge |
| h. braziers (?) | p. "magic eyes" | y. scalpels |
| | q. strigil | |

PREVENTIVE MEDICINE AND HYGIENE

"... the health of the people was the king's most sacred care"¹⁶⁹

Personal and public hygiene in ancient Egypt was regulated by law.¹⁷⁰ Priests presumably set an example, regularly bathing four times in a twenty-four hour period.¹⁷¹ A form of meat inspection existed whereby sacrificial animals were carefully examined, which was useful for public health because most of the animal was not used in the sacrifice, but was consumed as food.¹⁷² Also, for three consecutive days each month the Egyptians purged themselves by means of emetics and enemas¹⁷³, in order to rid themselves of the *ukhedu*.

Before one waxes overly enthusiastically about these hygienic measures, one must remember that they had no soap, and had to make do with fuller's earth, natural soda, and pounded lupins as cleansers.¹⁷⁴ It also appears from excavations that only the houses of the wealthy were equipped with bathrooms.¹⁷⁵

MUMMIFICATION

Mummification, one of the most discussed aspects of Egyptian culture, was only peripherally related to medicine. It was a highly complex religious ritual in which the "Opening of the Mouth" alone comprised 75 different steps.¹⁷⁶ After removal of all organs except the heart, which was the home of the soul and necessary in the afterlife, the body was "dry-cured" under lumps of natron (sodium carbonate and bicarbonate); it was not immersed in brine as previously thought.¹⁷⁷ After this period of curing, the mummy was wrapped in strips of linen and completely coated with resins.¹⁷⁸

The rituals' impact on Egyptian medicine was two-fold: it indirectly furthered their knowledge of anatomy, and it instructed them in the use of antiseptics and bandages.¹⁷⁹

During Egypt's decline in Alexandrian times the religious aspect of mummification was de-emphasized, affording Greeks such as Galen the opportunity to perform human dissection and anatomical research.¹⁸⁰

Mummies also provide the bulk of the information on diseases in ancient Egypt.

SUMMARY

"... the foundations of medical science were laid in Egypt..."¹⁸¹

The history of medicine in Egypt is a long and complex one, and of necessity such topics as mummification and the healing deities have been touched on only briefly. Nevertheless, it is clear that the Egyptians accomplished a great deal. They compiled a vast collection of drugs, and invented such things as suturing, plaster casts for fractures, and adhesive bandages. They recognized infection in wounds and the importance of hemostasis, as well as developing a crude idea of the circulatory system. They formed a solid foundation upon which others might build. □

ACKNOWLEDGEMENT

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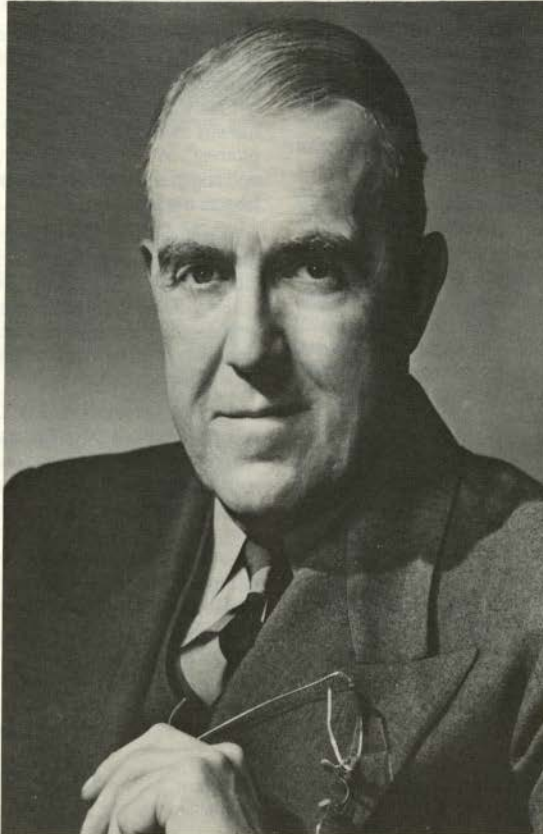
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A Physician and Pioneer Passes

Dr. Harold Benge Atlee



Harold Benge Atlee passed away at his home on 5770 Spring Garden Road on Sunday November 5, 1978, at the age of 87. His passing brings almost to an end an era in Dalhousie Medical School, when a small group of medical practitioners, working entirely on their own time and money, provided Dalhousie Medical students with a first class medical education. Dr. Atlee stood high among this group of distinguished physicians.

'Hal,' as he was known to his friends, was born in Pictou, Nova Scotia in 1890, moving at an early age to Annapolis Royal, where his father was a druggist. Here he grew up and early in his career, distinguished himself as a student, leaving home for Dalhousie Medical School at the age of 16 and graduating from Dalhousie Medical School at the age of 21. He himself said he had the dubious honor of being the youngest student ever to graduate from this medical school.

Following graduation, Dr. Atlee practiced for a short time at Joggins Mine, Nova Scotia. Very quickly he realized his need for further education and journeyed to London, England,

where he worked in various hospitals. World War I broke out and he enlisted in the Royal Army Medical Corps, emerging for years later still unscratched as a major and the recipient of the Military Cross. After further post-graduate education, he returned to Halifax in 1921 where he was appointed head of the newly-formed department of Obstetrics and Gynaecology, Dalhousie University — a position he held with distinction from 1922 to 1958.

His appointment met with considerable opposition. The general surgeons in the Victoria General Hospital had been doing their own Gynaecology for many years and were loath to give it up. By sheer tenacity, strength of purpose and statesmanship, Dr. Atlee gradually won his point. The story is told that if a surgeon did a hysterectomy, Dr. Atlee immediately found someone who needed a gall bladder procedure. Gradually, he convinced the medical hierarchy in Halifax that the speciality of Gynaecology was here to stay. This was not without sacrifice for the struggle meant that for years, his practice was small and because of this, he had to turn to other means of support.

While in the army, he had begun a literary career that was to be of great use to him in the future. This began with war stories of Gallipoli, later a novel, and then as he called them, the 'Pot Boilers'. These were short stories, written under the pseudonym of Ian Hope and published in *Maclean's* magazine. He himself said that the only reason he wrote the short stories was to support himself and his wife, while waiting for his private practice to support them. As soon as he was financially able, he stopped this source of income and put his talent to scientific articles and books. We will all remember him for his notes in obstetrics and gynaecology, finally resulting in the book *Gist of Obstetrics* written 1957, and still a source of enlightenment and delight to his many students. He had a way with words, even though some of those were four letter.

In the life of the Faculty of Medicine, there are many periods when Dr. Atlee played a major role. I remember one of these in particular. The Medical School was unable to progress because of the lack of autonomy from the University. Enthusiasm was at a low ebb, and progress was slow. It was at this point that Dr. Atlee led a concentrated effort to correct this deficiency. He was successful. I can see him now, this tall, gaunt, square-jawed man with a cane, striding up University Avenue — you knew something was about to happen.

Dr. Atlee was against tradition. He had to be shown that something was true. There are many examples of this. His getting post-delivery patients out of bed early, when the normal tradition was that they stayed in bed for at least seven days. He disbelieved in the need for having mothers 'drugged' while having their babies and introduced delivery by natural childbirth. Vaginal hysterectomy was traditionally reserved for those cases requiring repair after delivery. Dr. Atlee believed this was wrong and he introduced into Canada, the concept that this approach could be used for most cases requiring hysterectomy. He was always questioning, and seeking ways and means to make a better world.

He himself used to say "I am forward looking" and many times since, we have said on discussing some new idea, 'Dr. Atlee said that 20 years ago'. Dr. Atlee preached that the mother should have the baby immediately after delivery, and the baby should be placed on her abdomen to nurse. He did not know anything about mother-baby bonding but he knew somehow or other that that baby should go to the mother and that it would be better for both of them.

Dr. Atlee was a proud man and he gave pride and dignity to his work. He insisted on excellence in everything he did and he expected the same of everyone else. This was the way he ran his wards, his department, and his life. There was no halfway measure and he did not know the word "compromise". We who worked with him could get awfully upset and angry at his constant demands but in the end, we knew he was correct.

Music played a very important part in Dr. Atlee's life, and he loved classical music. A favorite pastime of medical students was to be asked to spend an evening at Dr. Atlee's home to listen to classical music and be entertained by his interpretation of the various operas, etc. I am sure that the beginning of many very profitable hobbies began at the knee of this very wonderful man.

After his retirement in 1958, Dr. Atlee moved to Bedford, to a cottage high on the cliffs overlooking Bedford Basin, from which he himself said "I can see the world". There he spent, with his wife Margaret, many happy years. Mrs. Atlee passed away in 1967. In 1975, Dr. Atlee, because of illness moved into the city, into an apartment which overlooked the University and the Grace Hospital. His interest in the University and in particular, the Department, never waned and he continued this interest to the end.

Dr. Atlee has left us a wonderful heritage — the desire to make a better world. He tried and was continually encouraging us to do the same. Can we possibly fail him? □

W. R. Carl Tupper, M.D., F.R.C.S.(C),
Professor, Obstetrics and Gynecology,
Dalhousie University, Halifax, N.S.

A Tribute to Dr. Harold Bengé Atlee*

We are here tonight to mourn the passing of Harold Bengé Atlee, a man who can only be described as great. Bengé Atlee was a great physician and surgeon, he was a great teacher with a mind always curious and dissatisfied with the state of things, and always believing that there must be a better way and that it was part of his job to find it. Above all he was a great human being who tolerated no sham or pretensions — in himself or his friends. He dealt with his friends' frailties with kindness and compassion, while at the same time laying bare his own with ruthless self-criticism.

The facts of his life are known to all. He was born and spent his early days in Pictou and always fancied he had escaped from the Pictou Presbyterian conscience — fancied, because that conscience was to rule him all his life, determining his drive to perfection in his own performance

*Delivered at a Memorial Service, Sir Charles Tupper Medical Building, November 14, 1978.

and that of his students and friends. He grew up in the Annapolis Valley, graduated early from the Dalhousie Medical School and, after a short period of general practice, his conscience and his curiosity drove him to look for more knowledge and he continued his studies in the United Kingdom. These years were interrupted by World War I and typically he succeeded in manipulating himself into the worst place that one could be — the Hell-hole of Gallipoli. If one could get him started he had many amusing and interesting stories about that experience and, in an incautious moment, it might slip out that his performance there had led to the award of the Military Cross.

The end of the war saw him return to London to complete his studies, and then came the great temptation to stay on and enjoy the cultural and professional opportunities so dear to him and so available in that city, but again, conscience said his duty was to return to Halifax and Dalhousie — at that

time, neither, offering much cultural or professional opportunity. Conscience said specialty practice led to better medical care and he became the Head of the fledgling Department of Obstetrics and Gynaecology which, under his direction, was to become one of the foremost in the country. For the next forty years he remained one of the stalwarts of the Dalhousie Medical School, always to be called upon when its existence was threatened. To the students he was perhaps the most effective and stimulating teacher that the Dalhousie Medical School has ever had. Certainly, as one who has had the opportunity to go across this country on several occasions and meet our graduates, the first person they asked about was Benge Atlee — to many he was synonymous with Dalhousie.

But Atlee was a true Renaissance man. He dabbled in politics. The CCF was the party that expressed his disgust with the establishment and his desire to see a better lot for less fortunate Canadians, and particularly, a better lot for Canadian women. Supporting himself largely through short story writing for Maclean's, he gave up hour after hour of unpaid time to patients on the wards and to the students at the Victoria General Hospital and the Grace Maternity Hospital. Equally, he spent hours on the committees of the medical school and hospitals but the Presbyterian conscience was difficult to satisfy. Always, there was the feeling that things could be done better and his curious mind devised one research project after another to find the better way. From this grew his research on natural childbirth, on spontaneous abortion (carried out by Drs. Carl Tupper and R. J. Weil), on the better management and better architecture for maternity hospitals and so on. His notes, finally brought together in the *Gist of Obstetrics*, became the delight of medical students — firmly establishing the principle that good teaching need not be dull. He supported many movements to improve the health and well-being of the citizens of this country. He added a dash to our life as we turned to the correspondence column of the paper each morning to see if H. B. had a letter there and when, as frequently he did, the day was made.

All this is enough to justify my use of the word "great" but there are other things that we who knew him more intimately

would put ahead, or perhaps regard as fundamental to all these surface achievements. The greatest of these was his deep concern for his fellow humans — particularly humans in distress: a woman suffering in labour; a student in difficulty; an employee with financial worries. Often he railed at himself and others because he felt we were not solving problems fast enough. Only occasionally and by chance did one learn of the trouble he had taken to help the distressed student: the \$50.00 he had slipped in an unmarked envelope to an employee in financial trouble and of the hours he had spent by the bedside to relieve suffering. The second trait which I think derived from the feeling that he must do better, was his courage to always be ahead of the pack. For example, his early espousal of natural childbirth, of early ambulation after surgery and even of psychiatry and the CCF, when both were slightly 'pinkish' and dirty words.

Finally, and most evident in the last months of his life was hope — not for personal salvation or survival but hope for the human race. On a Sunday afternoon some three weeks before his death, I visited him with my classmate Dr. B. H. Rosenberg of New York. We comparative youngsters were depressed — the dollar was down, prices were up, cars were falling apart, and even Sadat and Begin had stopped speaking to each other. Rosenberg and I bemoaned and bemoaned — until H. B. stopped us with the assurance that the future of the human race had looked uncertain on many occasions and, somehow, it had always survived. He didn't quite see how it was to be accomplished but he was sure that human ingenuity would pull us through again. I think this is the way he would like us to feel tonight as we mourn his passing. A gap has been left in the lives of all of us. We extend our great sympathy to his loved ones but in the celtic version he was "a long way up the road" and he was ready to go. He has made great contributions in many spheres. Now he would say we shouldn't waste energy in mourning but act as best we can to see that his belief in a better world comes to pass. □

R. O. Jones, M.D., F.R.C.P.(C),
Professor, Department of Psychiatry,
Dalhousie University, Halifax, N.S.

A Portrait of a Physician*

He strode into the classroom to give an introductory lecture on obstetrics. As we stood, out of courtesy, he bellowed "Stand up, stand up for Jesus but don't stand up for Benj." Thus we were introduced as a class to Dr. H. B. Atlee. He is an incredible man and was a most credible Chief of Obstetrics and Gynecology for Dalhousie Medical School.

I had been introduced to him many years before through stories and anecdotes told to me by my parents. He had introduced them to each other when they had been members of his staff. Armed with these stories I was prepared for his colourful, vibrant personality.

He ran the most efficient service I have ever seen. The development of this was honed through the years by his tenacity, strength of purpose and sheer bull dogging in the

face of opposition. It was not an easy beginning. He arrived with shiny pants and walking stick to set up a separate gynecology service. The general surgeons had been doing their own gyn. surgery and were loathe to turn it over to anyone, even a brother surgeon better prepared to deal with it. Surgeons are a breed apart. If their hands were not busy exploring the bodies of their patients they might be used in more pugilistic form on each other. The story is he would announce that he was going out of town the next day and then sneak back to the O.R. to see who was removing a uterus that should have been his to remove. If he found anyone doing so it was not beneath him to threaten to excise a gallbladder that belonged to another surgeons territory. "Big men acting as small bad boys" was my mothers remark, whereupon my father would add "I don't blame him — I would do the same thing."

*This was written one week before Dr. Atlee died.

As specialization became more the norm his problems lessened but even thirty years later when I arrived on the scene the undercurrent of battle still existed.

Dr. Atlee is a tall, lantern jawed, direct eyed man. He carried himself with pride and direction. There was never any doubt as to why he was chief. He carried on his "grand rounds" with great style. I'm sure he knew that he aroused terror in the breast of many a young intern. I'm sure also he had many a chuckle about it, not out of meanness, but out of the sure knowledge that if they were scared they'd come with their homework done. He understood human frailty but was unforgiving about incompetency and stupidity. Rightly so.

Dr. Atlee had supplemented his income as a student, by writing fiction. He certainly had a way with words, though a great many of them had only four letters. The effect he wished to make worked well for very few of his students will forget the answers to their questions. The mimeographed notes we were given had many spicy passages. He was encouraged to tone it down and finally he published *The Gist of Obstetrics*. It is, as the title suggests, a study of obstetrics for general practitioners. He felt it was very important for doctors not to presume on their knowledge and when to call in a specialist. One of his famous quotes, and I do not remember whether it is from his book or his previous notes, is as follows "and you say to me — what shall I do about pelvic abscesses? and I say to you — "Leave her lay where Jesus flang her and call me!" As usual — brief and memorable. He of course taught in detail about such things as pelvic abscesses but he also taught how to make valid judgement and how to know when something you are treating is beyond your specific knowledge.

Dr. Atlee was a proud man who gave pride and dignity to his work. This was also part of his teachings, regardless of whether you were involved in a highly technical skill or a lesser task. Again I quote "you may be overworked, it may not be your business to do so, but you will get higher marks with God and be not only a better nurse but a better person if you do what you can to keep a ward running on all cylinders. Don't be too proud to swing a mop at a dirty floor." But perhaps his greatest lesson, aside from direct medical and nursing knowledge was this. "It is the doctors duty to prolong life but not to prolong death." He eased his dying patients from this world with excellent care when all that could be done was done. Added to this was kindness, efficient staff, morphine and a multitude of brandy eggnogs.

A strong dimension of this man's personality was his fine sense of humour. Though considered by some to be outrightly sacrilgious, many of us saw the sparkle in his eyes. We knew much of his teasing was only to see who he could shock. A favorite story is as follows. My mother was scrubbed with him during an operation. As the surgical procedure progressed she began to talk about the miracle of reproduction and how a human would grow and develop inside this small muscular tissue. Dr. Atlee began to poke fun at her whereupon she questioned him indignantly "Don't you believe in miracles?"

"No such thing" says he.

"Well! How do you explain Jesus walking on the water"

"Oh Christ, I don't know unless he had a canoe on each foot!"

My mother expected him to be struck dead right over the O.R. table. But of course this did not happen. I talked to him on the phone last Friday. Though he is now eighty-seven and failing he still retains his humour. He told me I was free to write about him as long as I told the truth. I told him I would write about him as I saw him. He then gave a knowing laugh and hung up. □

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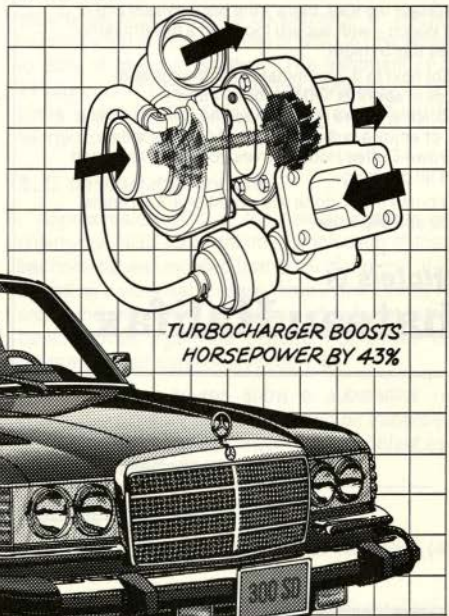
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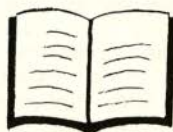
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***Chlamydia trachomatis*:** **The Versatile Microbe**

Lynn Fraser*, B.Sc., and J. A. Embil**, M.D., Ph.D., F.R.C.P.(C),

Halifax, N.S.

In most standard medical tests, *Chlamydia trachomatis* is described in connection with trachoma and lymphogranuloma venereum, diseases not usually seen by physicians in Nova Scotia.

Although *C. trachomatis* is an obligatory intracellular parasite, the chlamydiae differ from viruses in having both RNA and DNA and in having a discreet cell wall. Energy and metabolites necessary for reproduction are obtained from the host cell, and for this reason the organism cannot be grown on non-living media.

In the past, identification of the organism has been made by staining conjunctival scrapings with Iodine or Giemsa to show the intracytoplasmic inclusion bodies that are typical of chlamydiae. New culture methods, using cells sensitized by treatment with radiation or an antimetabolite which act as hosts for *C. trachomatis*, have facilitated a reassessment of the prevalence of chlamydial infections.¹ In a laboratory utilizing these new techniques, chlamydial infections can be rapidly diagnosed.

Despite the fact that trachoma is considered to be one of the world's leading causes of preventable blindness, in Canada and the United States, the disease is limited to North American Indians, Samoans, Filipinos and immigrants from the Far East and Mexico.² Blinding trachoma is a result of infection and reinfection with *C. trachomatis* serotypes A, B, Ba, and C, by direct eye-to-eye transmission.³ Multiple reinfections with superimposed bacterial infections lead to blinding sequelae of entropion, trichiasis and corneal ulceration with subsequent opacification.

C. trachomatis serotypes D to K have been implicated in sexually transmitted oculo-genital diseases,³ which may be one of the leading public health problems in the United States, Britain and perhaps in Canada as well.⁴ Even more disturbing are reports of diverse chlamydial infections in the neonatal population.

DISEASES OF ADULTS

1. Adult Inclusion Conjunctivitis (Paratrachoma)

Adult inclusion conjunctivitis is not trachoma. This acute follicular conjunctivitis is not spread directly from eye-to-eye but occurs as a result of exposure to infective genital tract discharges. It is normally a benign and self-limiting infection, although in some chronic cases conjunctival scarring and pannus formation may result.⁵

*Second Year Medicine, Dalhousie University, Halifax

**Associate Professor Microbiology and Assistant Professor Pediatrics, Dalhousie University, Halifax, N.S.

Mailing Address: Dr. J. A. Embil, Infectious Diseases Research Unit, The Izaak Walton Killam Hospital for Children, Halifax, N.S. Canada, B3J 3G6.

2. Non-gonococcal Urethritis (NGU)

The diagnosis of chlamydial NGU (also known as non-specific urethritis or post-gonococcal urethritis) is largely a diagnosis of exclusion. The patient has urethral discharge, and may complain of dysuria or frequency. Polymorphonuclear leukocytes can be demonstrated in a smear of the discharge. If *Neisseria gonorrhoeae*, *Mycoplasma hominis*, *Trichomonas vaginalis*, *Ureaplasma urealyticum* or *Candida albicans* cannot be isolated from the patient, the possibility of chlamydial NGU must be considered.⁶ *C. trachomatis* has been isolated in 37% of cases of NGU in one study⁷ and in up to 68% of cases in another.⁸ The treatment of choice is a 21-day course of tetracycline but erythromycin (250 mg four times a day for 21 days) may be substituted for patients allergic to tetracyclines.⁶

3. *C. trachomatis* cervicitis

Approximately 70% of the sexual partners of men with chlamydial NGU have chlamydial infection of the cervix.⁹ *C. trachomatis* was isolated from 31% of a group of 279 women attending a venereal disease clinic in the United Kingdom as compared with 3% of 63 women attending a family planning clinic.¹⁰ Once again the treatment of choice is a 21-day course of tetracycline or erythromycin.

The above figures show a substantial reservoir of chlamydial genital infections that can be transmitted not only among the adult population but also to an infant as he passes through the infected birth canal.

DISEASES OF NEONATES

1. Inclusion Conjunctivitis of the Newborn (ophthalmia neonatorum).

Inclusion conjunctivitis of the newborn (inclusion blennorrhoea) becomes evident within three to thirteen days after passage through the infected cervix. The first sign of infection is a discharge from the eye; if untreated this may lead to edema of the eyelid, congestion of the conjunctiva and mucopurulent discharge. Although the disease usually lasts only one to two weeks, there have been cases of longer duration with subsequent micropannus and scarring.¹¹ Permanent eye damage may occur, particularly if there is a superimposed bacterial infection.

This type of conjunctivitis, due to *C. trachomatis*, is now the most common form of ophthalmia neonatorum seen in the United States.¹² It is unfortunate that Credé prophylaxis, developed for the now less common gonococcal eye infections, has proven ineffective against chlamydial inclusion conjunctivitis.¹³ Treatment consists of topical 10% sulfacetamide or 1% tetracycline four times daily for three weeks.¹⁴

In a study of 142 pregnant women attending an obstetric clinic in the United States, 18 (12.7%) had positive cultures

for *C. trachomatis*. The infants of these women were followed and 8 (44%) developed clinically evident inclusion conjunctivitis.¹⁴ In another study, the prevalence of chlamydial infections in the prenatal population was only 5% but a similar proportion of infants at risk (10 of 25) showed signs of conjunctivitis.¹⁵

Assuming the prevalence of *C. trachomatis* cervical infections to be between 5 and 13%, then 2 to 6% of all neonates risk chlamydial infection. If the result of these neonatal chlamydial infections were only the self-limiting and relatively benign inclusion conjunctivitis, perhaps these figures would not be cause for alarm. However, *C. trachomatis* has been linked to a distinctive neonatal pneumonia syndrome.^{16 17}

2. *C. trachomatis* Pneumonitis

In studies of the distinctive pneumonia syndrome by Beem and Saxon¹⁶ and by Harrison *et al*¹⁷ over half the infants had preceding inclusion conjunctivitis. Of the two confirmed cases of chlamydial pneumonia at the Izaak Walton Killam Hospital for Children, Halifax, one had conjunctivitis.¹⁸

The disease is characterized by its afebrile course, episodic tachypnea, a distinctive staccato cough and early age of onset. Symptoms begin in the second week of life and maximal illness presents at four weeks of age. The infants demonstrate slight eosinophilia and elevated serum immunoglobulin levels (IgG \geq 500 and IgM \geq 110 mg/dL). Radiographic features include hyperinflation of the lungs accompanied by interstitial and alveolar infiltration.

In many infants the disease is resolved without intervention. Since the drug of choice, tetracycline, is contraindicated in pediatric populations, the current treatment has been erythromycin and sulphonamides.¹⁹

3. Other Associated Diseases

Although at present there are no studies to indicate the prevalence or extent of the problem, the possible involvement of *C. trachomatis* in otitis media has been recognized. In a group of 84 adult volunteers infected with chlamydia by the ocular route, otitis media was a complication in 14% of cases.²⁰ In another study of conjunctivitis one individual with follicular keratoconjunctivitis also had otitis media and *C. trachomatis* was isolated from the middle ear.²¹

There is much speculation about the increasingly broad spectrum of diseases attributed to *C. trachomatis* infections. One report showed a greater prevalence of chlamydial infections in premature infants than in full-term infants,¹⁵ but obviously much more evidence is needed before citing *C. trachomatis* infections as a cause of prematurity.

In a recent study of 17 infants with *C. trachomatis* nasopharyngitis and pneumonitis, 3 infants presented with apnea and a fourth subsequently died of Sudden Infant Death Syndrome (SIDS).²² This is another area that requires study since the populations at risk for both SIDS and *C. trachomatis* infections are similar.

The recent flurry of interest in *C. trachomatis* has done much to illustrate the expanding spectrum of chlamydial disease, beyond the classic diseases of trachoma and lymphogranuloma venereum mentioned in textbooks. It appears that as a human parasite, *C. trachomatis* is a much more versatile microbe than previously suspected. □

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THE MEDICAL SOCIETY OF NOVA SCOTIA
PROCEEDINGS OF
14th MEETING OF COUNCIL
AND
125th ANNUAL MEETING

November 16 - 17, 1978

INTRODUCTION: The 14th Meeting of Council began as the Medical Society Officers accompanied by Dr. K. O. Wylie, President of The Canadian Medical Association, paraded through Council Chambers to the head table. Following call to order by Dr. M. A. Smith, Chairman of the Executive Committee and General Council, the Officers were introduced and Dr. Wylie brought greetings from The Canadian Medical Association. Dr. Wylie wished Council well in its deliberations and indicated that he would be available to participate in the Meeting as required.

Dr. Smith welcomed the Exhibitors and recognized their contribution to the Annual Meeting. He encouraged Council members to visit the displays and discuss the products and services with the representatives. Dr. Smith extended the Medical Society's invitation to the representatives to attend the Banquet and Ball on Friday evening.

Council began as Mr. D. D. Peacocke, Executive Secretary, read the names of Society members deceased since November 17, 1977 as follows: Dr. Harold B. Atlee of Halifax; Dr. Howard A. Creighton of Lunenburg; Dr. Joseph H. Digout of St. Peters; Dr. Thomas W. Gorman of Antigonish; Dr. Francis J. Hanco of Dartmouth; Dr. Edward G. Kelley of Amherst; Dr. G. Murray MacDonald of Yarmouth; Dr. Carlton L. MacMillan of Baddeck; Dr. Kailash C. Mathur of New Glasgow; Dr. Eily C. McDonagh of Sydney; Dr. V. R. Rao of Halifax; Dr. Hugh R. Ross of Sydney; and Dr. Henry J. Townsend of New Glasgow.

The Transactions of the 13th Meeting of Council and the 124th Annual Meeting (1977) as printed in the December 1977 issue of The Nova Scotia Medical Bulletin were approved.

ARCHIVES COMMITTEE REPORT: Dr. Edwin F. Ross reported that the Archives Committee had been active during the year in reorganizing as well as collecting and cataloguing material. He expressed the Society's appreciation to Messrs. Alan H. MacDonald and Tom Fleming from the Health Sciences Library for their assistance. Mr. MacDonald pointed to the importance of summer employment of medical students in the organization of archival material, and indicated that the Joint Committee (an amalgamation of the Archives Committees of the Alumni Association, Provincial Medical Board, Faculty of Medicine, and the Health Sciences Library) would be seeking additional funding in order to support the increased activity by the Committee. Dr. Ross urged members and their conferees to send in any pertinent information that would help preserve the history of the medical profession.

CANCER COMMITTEE REPORT: This report was referred to the Executive Committee in the absence of the chairman and committee members.

CHILD HEALTH COMMITTEE REPORT: Dr. N. P. Kenny reported to Council that the major objectives of her Committee for the year were: 1) to improve the status of immunization in Nova Scotia; 2) to actively pursue the concept of physician participation in the Child Abuse Registrar; and 3) to promote a more general participation from physicians in establishing priorities for child health in the Province.

She informed the meeting that the subject of immunization would be dealt with later, but that her Committee was pleased indeed with progress in this area. She added that involvement by physicians in dealing with the Child Abuse problem had improved markedly during the year, but there were still some areas of the Province not appropriately cared for. She urged once again that all those interested and prepared to co-operate should contact her directly. Dr. Kenny indicated that a priority for the future year would be pursuit of objective 3) above, and indicated that the representation on the Child Health Committee would be broadened to include both general practitioners and paediatricians in an attempt to clarify priority items for child health within the Province in a more representative manner.

COMMUNICATIONS ADVISORY COMMITTEE REPORT: Dr. A. J. MacLeod informed Council that this Committee had been formed in April 1978 with the objective of advising the Officers of the Society on matters pertaining to communications and public relations over the immediate and long term future. The Committee, broadly represented throughout the Province and by specialties, had met twice and was in the process of discussing a variety of problems in order to provide recommendations to the Society. He noted that the Committee saw as a problem the matter of communications within the Society. The President's Letter was seen to be an effective means of communicating important information, however, this Committee urged members to participate to a greater extent in Branch Society meetings and activities. He added that this would become increasingly important in the next few months, particularly in relation to the economics of medicine.

COMMUNITY HEALTH COMMITTEE REPORT: Dr. R. D. Stuart reported to Council that his Committee had carried out further investigations into family physicians' office health screening procedures. Dr. Stuart's report included an infant screening sheet giving prenatal complications, delivery and birth history, first physical examination tick-off, and preschool assessment tick-off sheets, as well as information on length, weight, head measurement, graphs and a development chart to test gross motor, fine motor, social and language development to four years. His recommendation that the Medical Society circulate the attached records as well as the periodic health assessment flow sheet to the Branch Societies for study was referred to the Executive Committee for further consideration. The

referral arose as a result of discussions regarding the variety of screening forms and reporting forms being developed by different organizations. Concern was expressed that confusion, duplication and overlap could well result. It was the expressed belief of many that efforts in this regard should be more closely co-ordinated.

DISCIPLINE COMMITTEE REPORT: Dr. J. F. Hamm, reporting that there were no complaints reviewed the year necessitating action by the Discipline Committee, assured Council that the reason for this was not delinquency on the part of the Medical Society but that problems in this area are the responsibility of the Provincial Medical Board. Dr. Hamm quoted from the Medical Act the appropriate Section which dealt with this subject to clarify for Council the differences in responsibilities.

DRUG & ALCOHOL ABUSE COMMITTEE REPORT: Dr. H. A. Locke informed Council that Committee members continue to be active as Chairmen of Treatment Standards Committees of the Nova Scotia Commission on Drug Dependency in the five provincial regions. He also reported that he had met on several occasions with representatives of the Commission and Department of Education to lay plans for the school educational program on alcoholism prevention. Council approved four recommendations: 1) THAT Society members continue to encourage and support the various treatment efforts of the Commission on Drug Dependency in its Outpatient Detox Twenty-Eight Day and other programs; 2) THAT individual members of the Society help whenever possible in education programs in public schools and medical school to aid in the prevention of drug and alcohol abuse; 3) THAT the Medical Society approve the purchase of the manual on "Diagnosis and Treatment of Alcoholism for Primary Care Physicians", and its distribution to physicians, internes, medical students, this being a co-operative effort with the Commission with a projected cost of \$1,365. to the Medical Society; 4) THAT the Drug and Alcohol Abuse Committee co-operate fully with the Joint Medical Society/Provincial Medical Board Committee on Physician Rehabilitation to help physicians with drug or alcohol problems.

EDITORIAL BOARD COMMITTEE REPORT: Dr. B. J. S. Grogono reviewed for Council the topics which had been highlighted in recent issues of The Nova Scotia Medical Bulletin and indicated those which would be featured in future issues. He reported that lack of advertising remains a problem and suggested that the reason for this might be the relatively small circulation. In spite of this he urged continued support of the Bulletin noting that only four divisions continue to publish a medical journal. Dr. Grogono said a deficit for 1979 is predicted in the sum of \$2,500. Council approved his recommendation that financial support be continued for the following year.

EMERGENCY MEDICAL SERVICES COMMITTEE REPORT: In Dr. Petrie's absence the Emergency Medical Services Committee Report was presented by Dr. G. H. Ross. Failure of Government to proclaim the seat belt legislation passed in 1974 was spoken to by a number of Council members. Council approved a recommendation that The Medical Society of Nova Scotia approach and recommend to the new Government of Nova Scotia, proclamation of the already enacted seat belt legislation.

Dr. Lynk suggested that when the Medical Society and Faculty of Medicine are selecting topics for the next television series, that the topic of traffic crashes be considered. She expressed the opinion that the objective of the series, public education, would be well served by a well prepared program on this topic.

ETHICS COMMITTEE REPORT: Dr. T. F. Higgins reported on behalf of Dr. R. L. Langdon who was unable to attend Council. He stated the majority of matters that come before his Committee relate to advertising by physicians and these were referred to the Provincial Medical Board. Recent revisions in the Medical Act placed this matter under the jurisdiction of the Board.

EXECUTIVE COMMITTEE REPORT: Dr. M. A. Smith noted that his report was a summation of the activities of the Executive Committee over the past year. Council approved a recommendation that the actions of the Executive Committee during the past year be ratified.

Dr. Smith reported that at the most recent Executive Committee Meeting a proposal was heard regarding voting membership on the Executive Committee for representatives of the Internes and Residents in the Dalhousie Faculty of Medicine program. Following discussion Council approved a resolution that the By-Laws (1976) of The Medical Society of Nova Scotia be amended to provide for representation on the Medical Society Executive Committee from the Internes and Residents representatives to a maximum of two in number, who are members of The Medical Society of Nova Scotia and nominated by the Internes and Residents in the Dalhousie Program.

Council then gave lengthy consideration to a motion introduced by Dr. Parsons that whereas the physicians of Nova Scotia have been asked to sign sick certificates in ever-increasing numbers by the employers of the Province, and whereas some of these certificates are demanded whenever an employee misses even a part day's work due to illness or a doctor's appointment, be it resolved that The Medical Society of Nova Scotia inform management, unions and the public at large that its members will no longer act as truant officer for employers and will not sign medical certificates of illness unless the physician has been directly treating the patient for an illness which results in a loss of work for the employee of at least five days. In presenting the resolution, Dr. Parsons noted that his proposal was not precedent-setting. The Canadian Medical Association passed a similar resolution some years ago. The difficulties of the existing situation from the point of view of physicians, employers and employees were examined in detail. A suggestion that the resolution be referred to the Executive Committee was defeated on the basis that the Executive Committee had already discussed it and referred it to Council. Subsequently, Council defeated the resolution. It appeared that the consensus of the meeting was that each physician would have to deal with the problem in his own particular way and using methods appropriate to his situation. The efforts of the Society in the past in reducing the dimensions of this problem were noted, as was the availability of the Society to assist physicians in resolving a specific problem in this regard.

FINANCE COMMITTEE REPORT: Dr. P. D. Jackson presented the budget for fiscal year 1979 which had been approved by the Executive Committee in September. The budget forecast a modest surplus and therefore a dues increase for fiscal 1980 was not recommended.

Dr. Jackson's recommendations that the financial statements of The Medical Society of Nova Scotia for the fiscal year ending 1978, and that H. R. Doane and Company be retained as The Medical Society of Nova Scotia auditors for the year 1979 were approved. (The financial statements of the Society were circulated to all members of Council at Council and are available to any member of the Society through the Society office.)

HOSPITAL COMMITTEE REPORT: Dr. W. G. Dixon reported that his Committee had dealt almost exclusively with the subject of hospital board/medical staff/hospital administrator relations and the role of the medical staffs in decision making. Dr. Dixon indicated that his Committee felt that difficulties being experienced in this area appeared to be connected with the application of Prototype By-Laws which had been adopted by the Health Services and Insurance Commission several years ago. An examination of the situation in a number of hospitals seemed to indicate that the extent of the problem varied directly with the extent to which hospitals adhered to the Prototype By-Laws. Also considered by the Committee was the subject of physician privileges in hospitals and the criteria upon which they are granted or removed.

Council approved the following three resolutions: 1) Whereas in many instances governing boards of hospitals appear to have

adopted the Prototype By-Laws without adequate consultation with their medical staff, that the Medical Society recommend to hospital boards throughout the Province that they utilize the experience of physicians on their staff so that the greatest community good can be achieved in the development of, or changes in the By-Laws. 2) Whereas the competence of a physician is not determined by his age, but by the quality of his intellect and his standard of performance, the Medical Society recommends to the Board of Management of the various hospitals throughout the Province of Nova Scotia, that they make it mandatory that the Credentials Committee of their medical staff review on an annual basis, the quality of performance of each physician on its staff and that this, not age, be the basis for reappointment to the active staff. 3) Whereas the efficacy of the Canadian Council on Hospital Accreditation would be severely diminished if a statute were to be passed respecting the confidentiality of patients' records in hospital that excluded the Council from access to them, that the Medical Society express its concern at this possibility to the appropriate government body so that the Canadian Council on Hospital Accreditation can continue to have access to these documents.

MATERNAL AND PERINATAL HEALTH COMMITTEE REPORT:

Dr. R. H. Lea presented to Council a detailed statistical analysis of maternal and perinatal mortality statistics for 1977. Dr. Lea's report provided Council with a detailed summary of the activities of the Reproductive Care Program and Committee. Council received and approved his Committee's recommendation that The Medical Society of Nova Scotia continue to support and participate in programs initiated by the Reproductive Care Program.

MEDIATION COMMITTEE REPORT:

Dr. J. F. Hamm expressed concern that the number of complaints requiring mediation continues at an unacceptably high level, with most of the complaints falling within the doctor/patient relationship category. He said that of the duties required to be performed by the President, dealing with complaints against members of the Society has to be the most unpleasant of all. Pointing to the process whereby Branch Presidents are involved in mediation of complaints, Dr. Hamm extended his sincere appreciation for their co-operation and efforts.

Dr. Hamm encouraged all physicians to give this particular matter special attention as the image of the profession generally depended to a great extent on individual instances such as are reported to the Medical Society from time to time. He said the medical profession must strive to provide the most expert care possible and provide it in such a way that it is understood and appreciated by those who receive it.

MEDICAL EDUCATION COMMITTEE REPORT:

Dr. J. D. A. Henshaw reported that during the year his Committee had reviewed the recommendation from C.M.A. that a Regional Advisory Council be formed to rationalize and co-ordinate continuing medical education in the region. The Committee felt that the creation of this body (representatives from divisions, universities, royal colleges, Canadian Council on Family Practice and licensing bodies) would be a duplication of the existing Advisory Committee on Continuing Medical Education, and that the Executive Committee had approved his Committee recommendation that the Regional Advisory Council not be formed. The Committee recommendation "THAT the specialty sections consider setting standards for continuing medical education for their members" was referred to the Executive Committee after extensive debate on the pros and cons of establishment of the Advisory Council. The subject came to the surface again during the presentation of the report from the representative to the C.M.A. Council on Medical Education at which time Council approved a recommendation "THAT the Medical Society of Nova Scotia initiate with New Brunswick and Prince Edward Island Medical Societies the development of a Regional Continuing Medical Education Council whose purpose would be to identify needs, co-ordinate, encourage, and assess programs, and courses, and evolve expertise for continuing medical education. The Council should have representatives from the three Medical Societies, the three Provincial Medical

Boards, the Royal College of Physicians and Surgeons, the College of Family Practice, and Dalhousie Faculty of Medicine."

Dr. Henshaw continued his report providing Council with a comprehensive resume of the extent of physician participation in the short courses and community hospital programs. His Committee expressed disappointment at the low participation level in the community hospital programs when it is considered that not only are those programs tailored on the advice of the co-ordinator in each hospital, but the cost to each physician is, at \$2.00/per 2 hour session per physician, exceedingly low.

Dr. Henshaw concluded his report with an expression of admiration for the Nova Scotia Medical Bulletin for its contribution to Continuing Medical Education in Nova Scotia.

MEMBERSHIP SERVICES COMMITTEE REPORT:

Dr. D. R. MacLean provided Council with a resume of his Committee's activities over the past year. This included design and printing of a brochure setting out briefly the benefits of membership in the Society. Also reported on was the matter of the possibility of amalgamating Nova Scotia's insurance program with the Ontario insurance program. The Committee also noted that it was making considerable effort to encourage non-members to join the Society. He expressed the view that although this percentage is quite low for a volunteer organization, the Committee felt that it was still most unfair that these physicians would take the benefits of Society activity but not contribute in any way to the organization. A resolution "THAT the names of non-members of The Medical Society of Nova Scotia be published by Branch Societies so that peer pressure may be applied to these doctors to have them join the Society", was referred to the Executive Committee. The suggestion was made that a more discrete but equally effective means of doing this would be to provide Branch Executives with a copy of the names of their members whereupon it would be seen who was not on the list.

NUTRITION COMMITTEE REPORT:

In the absence of the Committee Chairman this report was referred to the Executive Committee.

OCCUPATIONAL MEDICINE COMMITTEE REPORT:

Dr. J. M. Williston provided Council with a lively review of his Committee's activities over the past year and referred in particular to the establishment of a Canadian Centre for Occupational Health and Safety. Dr. Williston stressed the point that occupational medicine is everyone's problem, and that all doctors should be concerned with this facet of medicine as it relates to the illnesses or problems of the patients they see. The physician should also follow this up with action to achieve change in situations which are obviously unacceptable. Physicians, he said, should also assume the responsibility of educating their patients relative to taking advantage of all available safety features of their place of work.

PHARMACY COMMITTEE REPORT:

Dr. George C. Jollymore reported to Council on the activities of this Committee. He informed Council that a topic receiving increasing attention is that of "patient package inserts". He indicated that this subject was being looked into by the Committee and that the Society would hear more from the committee in the near future.

PHYSICAL FITNESS COMMITTEE REPORT:

Dr. B. R. Wheeler reported that the support to the Orienteering Association of Nova Scotia had been extremely well received and that it should continue but a lesser level than previously, with the money left over to be utilized to promote other sports such as cross country skiing. A resolution to this effect was approved by Council.

"THAT The Medical Society of Nova Scotia continue with its grant to Orienteering, be reduced from \$1,000. To \$750., and THAT a means be looked at for further encouraging participation in other sports such as Cross Country Skiing where a very large number of members of the public can obtain exercise in an enjoyable way."

Dr. Wheeler raised the question of physical fitness training in

schools and described the deplorable level to which this has sunk. There was wide support for his proposal that the Society present a Brief to Government encouraging increased utilization of school athletic facilities, and a motion was passed "THAT an approach to Government at ministerial level is necessary to promote fitness levels in students of all ages, but particularly those attending high schools where physical education is no longer compulsory. In some schools the level of participation in any sport is probably 20% and not enough attention is given to teaching students the value of lifetime physical activity."

PRESIDENTS' LIAISON COMMITTEE REPORT: Dr. J. F. Hamm reported on a very active year on the part of the Officers and the President. He expressed deep thanks for the support he had received from all quarters during the year. Dr. Hamm's report touched on such topics as public relations, relations with Government, the Trade Union issue, a report on the activities of the Nova Scotia delegation to C.M.A. General Council, the Economics Committee activities, Tariff Review, the problem of business expense, and funding for health services.

Dr. Hamm informed Council that the day before Council the Minister of Health had received the Medical Society's Brief on Health Care Economics. Dr. Hamm reviewed briefly the contents of this Brief observing that the Minister had agreed that arrangements would be made for the Society to present the Brief to Cabinet. In addition to economics which made particular reference to health care costs and physicians' incomes, among other aspects of economics, the Brief included reference to other problem areas such as drug abuse, hospital board/medical staff relations, seat belt legislation, health professional licensing, preventive medicine, the Freedom of Information Act, and smoking by children.

Mr. B. E. Freamo, Executive Secretary of The Canadian Medical Association, spoke on the subject of economics of health care and provided Council with some thoughtful comments on what lies ahead in this regard.

REHABILITATION COMMITTEE REPORT: Dr. J. McG. Archibald presented this report on behalf of Dr. John L. Sapp who was absent from the City. The report referred in the main to an apparent thrust by the Canadian Physiotherapy Association to eliminate the necessity for physician referral of patients to physiotherapists. The report referred to the hazards and dangers of such an arrangement and the long term effect on the quality of medical care should such a situation be allowed to take place. The Medical Society approved the following recommendations: 1) That The Medical Society of Nova Scotia take a firm stand against any change in legislation which would allow direct access to patients by physiotherapists. 2) That The Medical Society of Nova Scotia make appropriate representation to the Minister of Health in the near future to discourage any such change in legislation. and 3) That the medical staff of every hospital in Nova Scotia examine their own situation and be sure that there is a Medical Director of the Department of Physiotherapy in the hospital. As stated in the 1978 Hospital Accreditation Guide this Director must be a duly qualified physician.

During the discussions it was noted by some physicians that in many instances physicians were not assuming and carrying out their responsibilities with respect to physiotherapy, and in fact were losing control of the situation by default. Concern was also expressed by some over the apparent absence of communications between physicians and physiotherapists. A suggestion was made that the Rehabilitation Committee might serve as this link with the physiotherapists. It was agreed that the Medical Society Executive Committee should give some attention to this problem. In response to a question Dr. Archibald suggested that it would be appropriate for each hospital to appoint a liaison person to communicate with the Rehabilitation Committee on this topic.

SALARIED PHYSICIANS' COMMITTEE REPORT: Dr. G. H. Anderson, recently appointed Chariman of this Committee, reported on the activities of the past year noting that the Committee had worked

with four different groups of physicians over the past year; these included emergency room physicians, radiotherapists, and pathologists. As well, the Committee is discussing the possibility of it representing the physicians in the Dalhousie Student Health Service in their negotiations with the University.

MEDICAL SOCIETY/FACULTY OF MEDICINE LIAISON COMMITTEE: Dr. J. F. Hamm reported that this Committee met to discuss matters which might become issues in the future, as well as to exchange information on various events and activities of interest. The Committee has no decision making authority. Dr. Hamm reported that the Society found the meetings highly informative and his recommendation that the Committee continue as an active Committee of the Society was approved.

Dr. J. Donald Hatcher, Dean, Faculty of Medicine, Dalhousie University, was invited to speak at this time and he provided a concise resume of the Research and Development Foundation which had recently been launched. Dr. Hatcher noted that the Faculty of Medicine of Dalhousie was performing exceedingly well in the academic field, being in the top third across Canada; on the other hand, he noted that relative to involvement in research it was in the bottom third. He had high expectations for the Foundation and expressed the hope that with increasing financial support from all possible sources this situation should change.

WORKMEN'S COMPENSATION BOARD LIAISON COMMITTEE REPORT: Dr. G. J. H. Colwell provided the meeting with a comprehensive resume of the activities of his Committee over the past year. His Committee indicated that the W.C.B.'s activities in the rehabilitation field had been less than expected and their recommendation "THAT the Society continue to encourage the W.C.B. to improve chances of getting an injured workman back to some employment by facilitating referral to existing provincial vocational rehabilitation services when it appears a change of vocation will be necessary and by providing partial or full W.C.B. payments during the period of vocational retraining." was approved by Council. He also reported that adjudication of claims where there is some dispute as to their responsibility for payment required upgrading and Council approved a recommendation that the W.C.B. improve its communications with M.S.I. in the matter of claims which are closed or reopened. Dr. Colwell indicated that communications with W.C.B. are satisfactory, but encouraged physicians to report to the Society or the W.C.B. Liaison Committee if they are having recurring problems in their dealings with the W.C.B.

MSNS REP. TO C.M.A. BOARD OF DIRECTORS REPORT: Dr. G. C. Jollymore, recently appointed representative to the C.M.A. Board of Directors as successor to Dr. E. V. Rafuse who was named Chairman of the Board of Directors, in his report summarized the activities of C.M.A. during the past year which would be of particular interest to Nova Scotia physicians. In presenting his report, he called upon Drs. E. V. Rafuse, J. A. Myrden (member — C.M.A. Finance Committee), A. H. Parsons (Chairman — C.M.A. Ethics Committee) to speak briefly of their activities. Each of these physicians provided the meeting with details on financial and ethical problems being dealt with by C.M.A. Each of these physicians received an expression of appreciation from Council for the volunteer work carried out on behalf of the membership.

MSNS REP. TO C.M.A. COUNCIL ON COMMUNITY HEALTH: Dr. M. A. Smith provided Council with an update on his Council's activities. Subjects discussed were therapeutic abortion regarding which his Council was recommending that all reference to Abortion Committees be removed from the Criminal Code, immunization, cancellation of the Canada Health Survey, retirement age, provision of emergency kits on aircrafts, routine blood pressure screening in supermarkets, and emergency medical services, in relation to which a new edition of the "Fitness to Drive" Guide has been approved.

MSNS REP. TO C.M.A. COUNCIL ON MEDICAL ECONOMICS: Dr. P. E. Kinsman provided Council with a comprehensive review of the Economics Council activities during the past year. In particular he

described in detail the activity relating to dissolution of the Economics Council and establishment of a five-member committee of the C.M.A. to concern itself with health economics. He pointed out that Nova Scotia had eloquently supported the retention of the all-provinces Council. A proposal to set up a Committee of Economics was defeated. Dr. Kinsman also provided some interesting details extracted from his Council's Report to C.M.A. General Council in June 1978 concerning the economic situation of physicians.

MSNS REP. TO C.M.A. COUNCIL ON MEDICAL EDUCATION:

Dr. B. L. Reid provided the Society membership with a summation of the activities of his Council over the past year describing the types of problems and issues with which it had been concerned. During this report the subject of establishing a Regional Continuing Medical Education Council was raised and after extensive debate the following resolution was adopted. "THAT The Medical Society of Nova Scotia initiate with New Brunswick and Prince Edward Island Medical Societies the development of a Regional Continuing Medical Education Council whose purpose would be to identify needs, co-ordinate, encourage, and assess programs, and courses, and evolve expertise for continuing medical education. The Council should have representatives from the three Medical Societies, the three Provincial Medical Boards, the Royal College of Physicians and Surgeons, the College of Family Practice, and Dalhousie Faculty of Medicine."

MSNS REP. TO M.D. MANAGEMENT LIMITED:

Dr. L. A. Fried reported to Council on the activities of M.D. Management and indicated that during the past year there has been an improvement in the attitude of M.D. Management, and the Board is becoming more service-oriented. His report described the various plans available to C.M.A. members. He pointed to their advantages and urged all members to give careful consideration to C.M.A. programs as they plan their financial futures.

MSNS REP. TO COMMUNICABLE DISEASE CONTROL — ADVISORY COMMITTEE REPORT:

Dr. M. E. Churchill presented this report to Council. The subject of the Central Immunization Registry was discussed. It was reported that the pilot project was felt to be successful with a number of problems being identified and action taken to rectify them. Criticism was presented by some Council members regarding the complexity of the forms. This was welcomed by the Committee for consideration as the provincial program was being finalized. It was observed that Nova Scotia is the only Province in Canada attempting to establish a Central Registry for Immunization.

Reporting on the matter of provision of live vaccines at no cost to physicians in their offices, Dr. Churchill informed Council that the Joint Committee had prepared a list of criteria which would apply in this situation and they were being presented to Council for ratification prior to their submission to the Department of Health for adoption and implementation. Council approved the following criteria which would be adhered to: 1) That there be a statement in writing from each participating physician to the effect that he/she would like to receive the live vaccine and that he/she understands and agrees to the conditions under which the vaccines will be provided. 2) That each physician participating ensure the existence of adequate refrigerated storage facilities and a mechanism for transporting the vaccines such that they are treated as recommended by the manufacturer. 3) That physicians using the vaccines provided by the Department of Health provide complete and accurate reporting on the individuals immunized with the vaccines. This reporting would be required for all vaccines received (live or killed) by physicians participating in the live vaccine program. 4) That the Department of Health be responsible for checking the dates of expiry of all live vaccines given to physicians, and that vaccines nearing the date of expiry be collected by the Department representatives one month prior to that date. 5) That participating physicians will provide this vaccine to their patients with no additional charge to the patient for the vaccine.

Dr. Ozere who is Chairman of the Joint Committee was present to discuss the storage and use of live vaccines. It was clear that more definitive instructions relative to cold storage of the vaccine was required and Dr. Ozere indicated these would be forthcoming.

MSNS REP. TO JOINT LABORATORY SERVICES COMMITTEE

REPORT: Dr. S. E. York reported to Council on the activities undertaken by this Committee during the past year. He noted that discussions took place on such items as Statistics Canada Schedule of Unit Values for Clinical Lab. procedures, safety programs for hospital labs., rubella testing and the reduction of the fee to \$3.00, T.B. testing in hospital labs, and future development of lab. services in the Province.

MARITIME MEDICAL CARE INC. — PRESIDENT'S REPORT:

Dr. A. N. Lamplugh reported on behalf of the President, Dr. C. Donald Vair, who was absent from the City. He noted that the Corporation had the pleasure of reporting a profit for the recent fiscal year. In addition, his report included additional information relative to the volume of work performed by M.M.C. on behalf of the provincial medical care insurance program.

Dr. Lamplugh expressed the appreciation of M.M.C. for the contributions made by Branch Society Representatives on the Board as well as for the co-operation and courtesy extended to visiting staff persons on the occasion of Branch Society Meetings.

Dr. Lamplugh announced the introduction of a new and improved extended health care insurance program being offered by Maritime Medical Care for members of the Medical Society, noting that each Society member would receive a notice regarding this in the very near future.

MSNS REPS. TO MEDICAL ADVISORY COMMITTEE ON

DRIVER LICENSING REPORT: This report was referred to the Executive Committee in the absence of a member to report.

MSNS REP. TO NOVA SCOTIA SAFETY COUNCIL REPORT:

This report was referred to the Executive Committee in the absence of a member to report.

MSNS REP. TO NOVA SCOTIA LUNG ASSOCIATION

REPORT: Dr. R. T. Michael provided Council with a resume of the activities of this Association in the field of education and continuing medical education, as well as research and other community programs.

MSNS REPS. TO PHARMACY REVIEW COMMITTEE REPORT:

Dr. H. Ian MacGregor informed Council that this Committee was involved with investigation into irregularities and procedures in pharmacies, consideration of benefit additions, continuing review of regulations relating to Authorized Provider status, special hearings relating to applications for Authorized Provided status, consideration of standards for prepackaged unit dosage systems, and abuses in the area of compounded prescriptions.

MSNS REP. TO PHYSICIAN MANPOWER SUBCOMMITTEE

REPORT: Dr. A. J. MacLeod in his report described in detail the activities in which this Committee is involved; these ranging from consideration of residency programs to review of applications for immigration on behalf of Canada Manpower and Immigration. Responding to a question regarding a physician placement service, Dr. MacLeod noted that the Medical Society office is the co-ordinating centre for such a service and that all physicians and students may obtain information on practice opportunities at the Society office, or, alternatively, leave with the office an indication of their availability to join a practice.

MSNS REPS. TO PHYSICIAN REHABILITATION COMMITTEE

REPORT: Dr. H. K. Hall reported to Council that this had been an active year for the committee, noting that the role of the Committee is difficult indeed and considerable work has gone into ways and means of achieving the objective of assisting physicians requiring

such a service. He described the various ways by which the Committee is attempting to broaden general knowledge of its existence and capabilities. Reference was made to an upcoming short course on the Impaired Physician and encouragement was given to all physicians who may be involved in this particular problem to attend.

MSNS REP. TO PROVINCIAL MEDICAL BOARD REPORT: Dr. H. J. Bland spoke on the subject of Provincial Medical Board financial matters, clarifying the need for the Board to develop a reserve for such things as employment of a permanent registrar, increased staff, increased costs of operation — e.g. the improved Register.

Dr. Bland's report to the Society included reference to the fact that complaints to the P.M.B. continue to increase. This was a matter of some concern to the Board and he urged all physicians to examine their practices and service to ensure that they are in fact really adequate in all respects. Dr. Bland also referred to the Joint Rehabilitation Committee for Physicians noting that it is proving to be effective in seeking out and assisting physicians who have problems, particularly with alcohol or drugs. He also encouraged attendance at the upcoming Impaired Physicians Conference pointing out that this had been extensively supported financially by the Provincial Medical Board, along with the Medical Society and other organizations.

DIRECTOR OF RH. COMMITTEE REPORT: Dr. R. S. Grant provided Council with a brief resume on the RH Committee's three-fold program of service, prevention, and education. Council approved six recommendations of the Committee. 1) That physicians do RH testing at the time of the patient's first possible prenatal visit, 2) That physicians refer their RH negative with -D antibodies cases to the RH Committee for assistance in RH management, 3) That physicians remain aware of the potential high-risk in an RH negative pregnancy case, 4) That physicians endorse the administration of RH Immune Globulin in all of the above criteria for injection, 5) That physicians endorse the administration of RH Immune Globulin routinely at 28 weeks gestation in all RH negative pregnancies where -D antibodies have not yet appeared, and 6) That provincial public health nurses encourage pregnant women to go to their family doctors early in pregnancy, before the third month.

MSNS REP. TO V.O.N. HOME CARE PROGRAM REPORT: Dr. D. A. Weir provided the meeting with a resume of V.O.N. activities and pointed to two major problems existing for the V.O.N.; these being the occasional conflict of services with the public health nurse, and lack of funds for this volunteer agency. In this respect he expressed the hope that the Society would encourage Government to provide increased assistance to the V.O.N.

SECTION FOR ANAESTHESIA REPORT: Dr. David D. Imrie's report was referred to the Executive Committee for consideration.

SECTION FOR GENERAL PRACTICE REPORT: Dr. F. E. Slipp in his report to Council referred to topics which formed the basis of conversation for most of the Section's meetings, these being economic matters, and in particular the subject of billing above tariff. He observed that there is increased feeling amongst general practitioners that physicians should ensure that the value physicians place on their services should be appropriate and adhered to.

SECTION FOR INTERNAL MEDICINE REPORT: Dr. R. N. Anderson's report was referred to the Executive Committee for consideration.

SECTION FOR OBSTETRICS & GYNECOLOGY REPORT: Dr. R. H. Lea provided Council with a brief resume of the activities of his Section during the past year and indicated that during the coming year there would be increased activity in such areas of concern as high risk obstetrics and oncology.

SECTION FOR ORTHOPAEDIC SURGERY REPORT: Dr. R. H. Yabsley's report was referred to the Executive Committee for consideration.

SECTION FOR OTOLARYNGOLOGY REPORT: Dr. K. E. Walling's report was referred to the Executive Committee for consideration.

SECTION FOR PAEDIATRICS REPORT: Dr. N. P. Kenny informed Council that the major objectives of the Section during the past year were the improvement of communications and clarification of issues of concern to members; this included the subject of referral and appropriate use of regional paediatricians as well issues of an economic nature. With respect to the latter, it was again pointed out that paediatricians are the lowest income group in the Province and Canada, but she did give special thanks to the Society and her Section Fee Committee for their efforts in attempting to alleviate this situation.

SECTION FOR PATHOLOGY REPORT: Dr. G. H. Anderson provided Council with a review of the Section's activities during the past year with such topics as the Unit (S.I.) System, technical training, manpower requirements, and accreditation being discussed. His recommendation that the Kleihauer Test is not recommended for general performance in regional hospitals in Nova Scotia but is recommended for use in centres where special circumstances exist and there is sufficient demand for the test to ensure adequate quality of performance was approved by Council.

SECTION FOR RADIOLOGY REPORT: Dr. Gordon M. Jones reported on behalf of Dr. A. J. Johnson noting that the Section had been concerned during the year with a number of matters relating to fees, particularly the subject of radiologists billing above tariff.

SECTION FOR SURGERY REPORT: Dr. S. M. A. Naqvi presented this Section report on behalf of Dr. F. J. Kelley. Dr. Naqvi raised the issue of conflict of meeting dates between Sections and the Medical Society, and suggested that care be taken to avoid interference in the future. He also spoke about the developing shortage of surgeons in the Cape Breton area and urged that the planners take this under serious advisement.

EXECUTIVE SECRETARY'S REPORT: Mr. D. D. Peacocke in his report reported on public relations activities which are managed by the Society office. The series of articles on medical economics by Mr. John Sansom were endorsed, as was the cable television series planned for the coming year. Mr. Peacocke indicated that the Dr. Garnett W. Turner Memorial Trust Fund was continuing to grow but at a very slow rate. He encouraged physicians to utilize this means of expressing sympathy when the occasion arises. Mr. Peacocke's report pointed to the value of Branch Society Meetings in terms of exchange of information and opinions, as well as a method of developing improved relations between Branch members and the Society generally.

ANNUAL MEETING: On two occasions during Council the Society was called to order in Session of the Annual Meeting to ratify the actions of Council and to hear the President's Valedictory Address which appears subsequent to these Transactions. Additionally, the membership heard and approved the report of the Nominating Committee which reads as follows: **Appointment of Branch Representatives to the 1979 Executive Committee** — Antigonish-Guysborough — Dr. R. D. Saxon; Bedford/Sackville — Dr. James Fraser; Cape Breton — Drs. M. A. Mian & M. R. Rajani; Colchester East Hants — Dr. D. G. Dewar; Cumberland — Dr. R. Mcl. Washburn; Dartmouth — Drs. J. P. Savage & J. F. O'Connor; Eastern Shore — Dr. P. D. Muirhead; Halifax — Drs. M. G. Shaw, B. D. Byrne, & J. K. Hayes; Inverness Victoria — Dr. J. O. Belen; Lunenburg-Queens — Dr. M. S. McQuigge; Pictou — Dr. R. A. Nicholson; Shelburne — Dr. J. U. MacWilliam; Valley — Drs. P. Goddard — Judy Kazimirski; and Western — Dr. D. M. Deveau.

The 1979 Nominating Committee members were approved as follows: Antigonish-Guysborough — Dr. J. E. MacDonell; Bedford/Sackville — Dr. S. M. Woolf; Cape Breton — Drs. L. A. Skinner & G. S. Marsh; Colchester-East Hants — Dr. A. C. H. Crowe; Cumberland — Dr. A. Elmik; Dartmouth — Drs. J. P. Savage & J. F. O'Connor; Eastern Shore — Dr. P. B. Jardine; Halifax — Drs. M. G. Shaw, B. D. Byrne, & J. K. Hayes; Inverness-Victoria — Dr. R. B. Wallace; Lunenburg-Queens — Dr. A. H. Patterson; Pictou — Dr. D. G. Kirk; Shelburne — Dr. N. K. Sinha; Valley — Drs. B. Carruthers & Paul D. MacLean; and Western — Dr. D. M. Deveau.

The following nominations were confirmed: President-Elect — Dr. M. E. Churchill; Chairman, Executive Committee — Dr. M. A. Smith; Vice-Chairman Executive Committee — Dr. G. H. Ross; Treasurer — Dr. P. D. Jackson; and Honorary Secretary — Dr. A. J. MacLeod.

The 125th Annual Meeting of The Medical Society of Nova Scotia adjourned at 3:15 p.m., November 17, 1978.

ANNUAL MEETING EXHIBITS

The Medical Society of Nova Scotia wishes to express its sincere appreciation to those firms which exhibited at our Annual Meeting in November 1978 at the Lord Nelson Hotel.

EXHIBITORS

Abbott Laboratories Ltd.
Ames Company
Anca Laboratories Limited
The Bank of Nova Scotia
Boehringer Ingelheim
Bower Hessian & Assoc. Co., Ltd.
W. Carsen Company Limited
Encyclopaedia Britannica
Publications Ltd.
Geigy Pharmaceuticals
Gorman Book Services
MacGregor Contract Sales Ltd.
MacNeil Labs. (Canada) Ltd.

Nova Scotia Commission on
Drug Dependency
Ortho Pharmaceutical (Canada) Ltd.
Parke, Davis & Company, Ltd.
Pennwalt of Canada Limited
Pfizer Company, Ltd.
Pharmacia (Canada) Limited
A. H. Robins Canada Ltd.
Schering Corporation Limited
Syntex Limited
Warner/Chilcott Labs. Company, Ltd.
White Cross Surgical Medical
Maritimes Limited
Winthrop Labs. — Div. Sterling Drugs Ltd.

NOTE: Contributions towards the Society's Annual Meeting were received from Charles E. Frosst & Company, Frank W. Horner Limited, and Merck Sharp & Dohme Canada Limited.

Medical Society members appreciate the extensive financial contributions that exhibitors make toward defraying the costs of conducting an Annual Meeting. As well, the additional expense of preparing exhibits and arranging for the displays are also recognized. Most important, however, is the opportunity the exhibitors have given to members of the profession to meet with representatives of the various firms for discussion of new products and services available to them.

Members of the Society are encouraged to convey their gratitude by giving the exhibitors' representatives an extra expression of appreciation on the occasion of their next encounter.

Presidential Valedictory Address, 1978

John F. Hamm, M.D.,
Stellarton, N.S.

FOR THE 125TH TIME THE PHYSICIANS OF NOVA SCOTIA ARE ASSEMBLED FOR THEIR ANNUAL MEETING AND WE SHOULD ALL TAKE PRIDE IN BEING MEMBERS OF THE OLDEST MEDICAL SOCIETY IN NORTH AMERICA, THIS VOLUNTARY SOCIETY HAS CONTINUED TO ATTRACT ALMOST 90% OF ALL PRACTICING PHYSICIANS IN THIS PROVINCE AND IS ACCEPTED AS THE VOICE OF ORGANIZED MEDICINE, IT, UNLIKE

MANY OTHER MEDICAL SOCIETIES, INCLUDES MEDICAL STUDENTS, INTERNES AND RESIDENTS AND APPRECIATES AND ASSISTS IN THEIR CONCERNS AS WELL. THAT THIS SOCIETY CONTINUES TO FLOURISH AS A VOLUNTARY ASSOCIATION AND ONE THAT IS JOINED AT SOME CONSIDERABLE COST IS A TRIBUTE TO THE SUCCESS IT HAS HAD OVER THESE 125 YEARS.

THE OBJECTS OF THIS SOCIETY AS LAID DOWN IN ITS BY-LAWS ARE:

- (A) THE PROMOTION OF HEALTH AND THE PREVENTION OF DISEASE,
- (B) THE IMPROVEMENT OF MEDICAL SERVICES HOWEVER RENDERED,
- (C) THE MAINTENANCE OF THE INTEGRITY AND HONOUR OF THE MEDICAL PROFESSION.
- (D) THE PERFORMANCE OF SUCH OTHER LAWFUL THINGS AS ARE INCIDENTAL OR CONDUCTIVE TO THE WELFARE OF THE PUBLIC AND OF THE MEDICAL AND ALLIED PROFESSIONS.
- (E) THE PROMOTION OF HARMONY AND UNITY OF PURPOSE BETWEEN THE MEDICAL PROFESSION AND THE VARIOUS BODIES ASSUMING ECONOMIC RESPONSIBILITY FOR THE CARE OF SICK OR INJURED PERSONS.
- (F) COLLECTIVE NEGOTIATIONS,
- (G) THAT NO PHYSICIAN BE DENIED MEMBERSHIP IN THE SOCIETY ON THE BASIS OF RACE, RELIGION OR PLACE OR ORIGIN.

THE PURSUIT OF THESE OBJECTIVES HAS OVER THE PAST CENTURY REQUIRED SPENDING ENERGIES IN VARIOUS DIRECTIONS AND WITH MIXED SUCCESS. WE CAN LOOK WITH PRIDE AT THE PROGRESSION FROM RURAL STYLE MEDICINE TO THE DEVELOPMENT OF A SOPHISTICATED TERTIARY CARE CENTRE IN HALIFAX AUGMENTING THE IMPROVING REGIONAL CENTRES WHICH DEVELOPED CONCURRENTLY THROUGHOUT THE PROVINCE AND FINALLY THE ORDERLY TRANSITION INTO A GOVERNMENT-SPONSORED HEALTH CARE PAYMENT SCHEME. WHETHER OR NOT THE EFFORTS OF THE PAST YEAR WILL BE DEEMED A SUCCESS AWAITS THE JUDGMENT OF THE TRIBUNAL OF TIME. IT IS IMPORTANT THAT WE KEEP BEFORE US THESE OBJECTIVES AS THEY ARE THE COMPASS WHICH DIRECTS OUR COURSE AND THE YARDSTICK BY WHICH TO MEASURE OUR ADVANCE.

THE DELIVERY OF HEALTH CARE TO OUR PEOPLE IS AN EXTREMELY COMPLEX SITUATION. THE GEOGRAPHICAL MAKEUP OF THE PROVINCE IS SUCH THAT A SYSTEM OF DELIVERY WHICH IS APPROPRIATE IN YARMOUTH MAY NOT WORK IN INVERNESS AND IT IS HARD TO DRAW CONCLUSIONS FROM HEALTH CARE DELIVERY IN METRO WHICH ARE HELPFUL IN NEIL'S HARBOUR. THAT THE INDIVIDUALITY OF COMMUNITIES MUST BE CONSIDERED BEFORE SWEEPING CHANGES ARE UNDERTAKEN IS OBVIOUS. DESPITE RUMBLINGS THAT THERE IS AN IMPENDING MANPOWER SURPLUS IN THE PROVINCE LET US NOT FORGET THAT CERTAIN AREAS REMAIN UNDER-DOCTORED AND INCREASED EFFORTS MUST BE MADE TO CORRECT THIS AS EACH AND EVERY PERSON IN THIS PROVINCE HAS THE RIGHT TO ACCESS TO GOOD MEDICAL CARE. WHILE CONSIDERING MANPOWER LET US NOT FORGET THE OBVIOUS SHORTAGES IN CERTAIN SPECIALTIES — ANAESTHESIA, PSYCHIATRY, PAEDIATRICS, OTOLARYNGOLOGY TO NAME A FEW. WE AS A SOCIETY HAVE HAD TOO LITTLE INPUT INTO THE PLANNING OF RESIDENCY OUTPUT OVER THE PAST FEW YEARS AND WERE NOT CONSULTED WHEN THREE YEARS AGO IMPLEMENTATION OF FINANCIAL RESTRAINTS DICTATED A REDUCTION IN THE RESIDENCY TRAINING OPENINGS AT DALHOUSIE. RECENT FIGURES SUGGEST THAT, AS MANY OF OUR GENERAL SURGEONS AT THE COMMUNITY HOSPITAL LEVEL ARE OVER 50 YEARS OF AGE, THEY WILL ALL REACH RETIREMENT AT APPROXIMATELY THE SAME TIME PROVIDING A VERY SERIOUS MANPOWER SHORTAGE IN THAT SPECIALTY. THE MEDICAL SOCIETY INVITES CONSULTATION IN MANPOWER PLANNING AND METHODS TO ENCOURAGE A MORE EQUITABLE DISTRIBUTION OF PHYSICIANS AROUND THE PROVINCE MUST BE FOUND. IN HALIFAX COUNTY THERE IS ROUGHLY ONE PHYSICIAN FOR EVERY 500 PEOPLE AND IN RICHMOND COUNTY THAT SAME PHYSICIAN

WOULD BE LOOKING AFTER 2,500 PEOPLE. MANY MANPOWER STATISTICS ARE BASED ON A STILL UNREASONABLE WORKLOAD AND MANY ON AN UNREALISTIC RETIREMENT AGE FOR PHYSICIANS AND DO NOT TAKE INTO ACCOUNT THAT INDIVIDUAL PATIENTS ARE DEMANDING MORE AND MORE OF THEIR DOCTOR'S TIME. MEDICAL PROBLEMS IN TODAY'S COMPLEX SOCIETY ARE SELDOM SOLVED WITH A QUICK PRESCRIPTION, SOCIO-PSYCHOLOGICAL ILLS OFTEN REQUIRE MUCH PROLONGED DIRECT PHYSICIAN/PATIENT CONTACT AND MANY ADVANCES IN MEDICINE WHETHER IT BE IN OBSTETRICAL CARE, WELL CHILD CARE, ADOLESCENT BEHAVIOUR DISORDERS, HYPERTENSION, GERIATRICS ARE ACHIEVED BY PATIENTS UTILIZING INCREASING AMOUNTS OF A PHYSICIAN'S TIME. THE CHANGING PROFILE OF THE PHYSICIAN'S ACTIVITIES MAKE MANPOWER PLANNING DIFFICULT AT BEST AND HIGHLY INACCURATE AT WORST. THIS SOCIETY MUST PLAY A KEY ROLE WITH OTHERS IN IMPROVING PHYSICIAN DISTRIBUTION, ESTABLISHING NUMBERS OF RESIDENCY POSITIONS, PLANNING MEDICAL SCHOOL OUTPUT.

THE PROVINCIAL MEDICAL ACT OF NOVA SCOTIA RESTRICTS THE PRACTICE OF MEDICINE TO THOSE WHOSE NAMES ARE ON THE MEDICAL REGISTER. ARTICLE 40 (1) NO PERSON WHOSE NAME IS NOT ENTERED IN THE MEDICAL REGISTER OR TEMPORARY MEDICAL REGISTER SHALL

- (A) PRACTICE OR PRETEND TO PRACTICE MEDICINE,
- (B) WILLFULLY PRETEND TO BE A PHYSICIAN, DOCTOR OF MEDICINE, SURGEON, OR GENERAL PRACTITIONER, OR
- (C) TAKE OR USE ANY NAME TITLE, ADDITION OR DESCRIPTION IMPLYING OR CALCULATED TO LEAD PEOPLE TO BELIEVE HE IS A QUALIFIED MEDICAL PRACTITIONER, OR
- (D) ADVERTISE IN ANY MANNER TO GIVE ADVICE IN MEDICINE.

THE MEDICAL ACT FIRST WRITTEN IN 1828 WITH SUBSEQUENT REVISIONS AND AMENDMENTS RECOGNIZES THE FUNDAMENTAL FACT THAT THE TREATMENT OF ILLNESS REQUIRES A BROAD UNDERSTANDING OF ANATOMY, PHYSIOLOGY, PATHOLOGY THAT IS PART OF THE M.D. DEGREE. IT IS DISTURBING THAT IN OTHER JURISDICTIONS PERSONS WITH VERY RESTRICTED TRAINING ARE REQUESTING AND IN SOME CASES RECEIVE THE RIGHT TO PRACTICE MEDICINE IN AN UNSUPERVISED ROLE. THIS IS A STEP BACKWARD.

THE PHYSICIAN DELINEATES PATIENT CARE IN A CAREFULLY STRUCTURED WAY TO PROPERLY TRAINED COLLEAGUES IN THE HEALTH FIELD WHILE RETAINING THE ULTIMATE RESPONSIBILITY FOR THE DIRECTION OF THE CONTINUING TREATMENT OF THE PATIENT AND IT REMAINS DIRECTLY UNDER HIS CONTROL.

THE UNSUPERVISED OR IN SOME CASES THE ISOLATED DELIVERY OF CARE WITHOUT THE BROAD RANGE OF TRAINING REQUIRED FOR THE M.D. DEGREE WILL RESULT IN A FRAGMENTATION AND DETERIORATION OF THE SERVICE AVAILABLE. WE STAND COMMITTED TO THIS CONCEPT AND OVER THE PAST YEAR HAVE COMMUNICATED WITH OTHER JURISDICTIONS CONTEMPLATING CHANGES IN LEGISLATION CONTRARY TO THIS.

THE LOWERING OF STANDARDS IN THE PROVISION OF PRIMARY MEDICAL CARE AS A COST SAVING MEASURE MAY WELL RESULT IN AN OVERALL INCREASE IN EXPENDITURE — NOT TO MENTION DELAYS IN DIAGNOSIS AND THE INITIATION OF INAPPROPRIATE TREATMENT.

MANY OF OUR WELL TRAINED COLLEAGUES IN THIS SOCIETY PRACTICE IN AREAS OF PATIENT CARE WHICH HAVE IN SOME JURISDICTIONS BEEN OPENED TO PERSONS WITH INCOMPLETE MEDICAL TRAINING. THE M.D. DEGREE IS THE BASIC REQUIREMENT TO ANY AND ALL PRIMARY CONTACT MEDICINE AND SHOULD REMAIN SO.

THERE HAS BEEN A PROLIFERATION OF SKILLED PERSONS IN THIS PROVINCE DELIVERING VARIOUS FACETS OF HEALTH CARE TO OUR PEOPLE. AS OUR COMMITTEE REPORTED TO US IN 1976 THERE ARE OVER 50 IDENTIFIABLE GROUPS OF INDIVIDUALS INVOLVED INCLUDING THE 5 PRINCIPAL PROFESSIONS — MEDICINE, DENTISTRY, PHARMACY, NURSING AND HEALTH ADMINISTRATION SERVICES. ONLY 19 OF THE OVER 50 GROUPS ARE COVERED BY LEGISLATION AND MANY ARE LACKING CLEARLY DEFINED STANDARDS OF EDUCATION, LICENSURE, AND PRACTICE. THE LEGISLATION WHICH DOES EXIST HAS DEVELOPED WITHOUT CONSISTENT GUIDING PRINCIPLES AND CO-ORDINATION. AREAS OF OVERLAP EXIST. LAST YEAR WHEN ADDRESSING THE CANADIAN OPHTHALMOLOGICAL SOCIETY THE MINISTER OF HEALTH RAISED THIS MATTER AGAIN — A CONCEPT PUT FORTH IN THE HEALTH COUNCIL REPORT "HEALTH PROFESSIONAL LICENSING" — WE ENDORSED IT IN 1976 AND WE ENDORSE IT NOW. THERE IS A NEED FOR CO-ORDINATION AND WE AS PHYSICIANS MUST ASSUME A LARGE BURDEN OF RESPONSIBILITY TO SEE THAT IT COMES ABOUT. HAPHAZARD PROLIFERATION OF OUR SYSTEM IS IN NO ONES INTEREST.

THE RELATIONSHIP OF DOCTORS WORKING IN INDUSTRY, COMMERCE AND IN THE UNIVERSITY WITH OTHER EMPLOYEES IS AN AREA FOR OUR CONCERN. BY THE VERY NATURE OF THE SERVICES PROVIDED A UNION STYLE APPROACH FOR CLINICIANS PROVIDING TREATMENT TO PATIENTS IS AN UNDESIRABLE ONE, HOWEVER APPROPRIATE FOR THEIR ASSOCIATES, THE SERVICE WE PROVIDE IS SUCH A FUNDAMENTAL RIGHT THAT WE DO NOT HAVE THE OPTION TO WITHDRAW THAT SERVICE. THE PHYSICIAN — PATIENT CONTACT IS NOT AMENABLE TO UNION STYLE NEGOTIATION. THIS MAKES UNTENABLE THE INCLUSION OF THE CLINICIAN IN A UNION SITUATION. WHEN PHYSICIANS HAVE LOST SIGHT OF THIS AXIOM THE SHORT TERM GAIN WAS SOON OVERSHADOWED BY THE LONG TERM DELETERIOUS EFFECTS OF SUCH ACTION.

THE PRACTICE OF MEDICINE IS EVOLVING YEAR BY YEAR UNTIL IT SEEMS WE ARE PRACTICING ON A STAGE. THE INFORMATION PROVIDED US THROUGH PRACTICE PROFILES TEACHES US MUCH ABOUT HOW WE PERFORM BUT ALSO INFORMS OTHERS THE SAME THING. COMMITTEES ASSESS AND ANALYZE WHAT WE DO — OUR FINANCIAL SITUATION IS THE SUBJECT OF CAREFUL SCRUTINY BY THE MEDIA. THE YARDSTICK IS CHANGING AND WE ARE BEING ASKED TO CONFORM OFTEN WITH VERY LITTLE CONSIDERATION BEING GIVEN AS TO THE VALIDITY OF THE NORM. WE ARE BESIEGED WITH INFORMATION SUGGESTING THAT WE SEE OUR PATIENTS TOO OFTEN, TOO LITTLE, OR FOR THE WRONG THINGS. LEGISLATION IS PASSED EVERY YEAR WHICH AFFECTS US AND OUR APPROACH TO OUR PATIENTS. THE RECENTLY PROCLAIMED FREEDOM OF INFORMATION ACT AND ALSO SECTION 63 OF THE PUBLIC HOSPITALS ACT MAY EVENTUALLY PROFOUNDLY AFFECT THE INFORMATION WHICH PHYSICIANS WILL INCLUDE ON PATIENTS' HOSPITAL RECORDS AND THEIR OWN OFFICE RECORDS AND COULD ALSO DETERMINE THE INFORMATION WE COULD LEGALLY RELEASE TO OTHERS EVEN WITH THE PATIENTS CONSENT. THE PHYSICIAN IS FACED WITH A CONFUSING ARRAY OF GUIDELINES, NORMS, STANDARDS WHICH AT TIMES ARE HELPFUL BUT AT TIMES ARE A HINDRANCE TO THE DELIVERY OF THE BEST CARE POSSIBLE. UNDER THESE CIRCUMSTANCES AND DESPITE PROFILES, GUIDELINES, LEGISLATION, NORMS, BASIC CARE IS STILL THE FACE TO FACE CONFRONTATION BETWEEN PHYSICIAN AND PATIENT IN ISOLATION TO BEST RESOLVE THE PROBLEM AT HAND. MEDICINE MUST BE LEFT UNTOUCHED AT THIS LEVEL. GOOD MEDICINE CAN BE FOSTERED, ENCOURAGED SUPPORTED BUT IT CANNOT BE LEGISLATED.

PART OF THE CHANGING PATTERN OF MEDICAL PRACTICE IS DUE TO THE REALIZATION THAT MUCH OF THE TREATMENT

WE DELIVER IS REALLY ONLY A DELAYING TACTIC. ONCE THE DISEASE HAS BEEN RECOGNIZED, THE BEST THAT CAN BE DONE IS SLOW THE PROGRESS OF THE ILLNESS AND MAINTAIN THE QUALITY OF LIFE REMAINING AT ITS OPTIMUM LEVEL. MANY OF THESE CONDITIONS ARE SELF-INFLICTED. SIXTY-TWO PERCENT OF CANADIANS WHO DIE BEFORE THE AGE OF 70 WILL SUCCUMB TO SICKNESS OR ACCIDENTS RELATED TO THEIR LIFESTYLE, ENVIRONMENT, & OCCUPATION. PHYSICIANS MUST BECOME, AS DR. ROBERT GOURDEAU, EXPRESSED TO US LAST YEAR, MANAGERS OF HEALTH. TIME MUST BE SPENT ENCOURAGING PATIENTS AT AN EARLY STAGE TO ALTER THEIR DIET, THEIR EXERCISE HABITS, THEIR SMOKING AND DRINKING HABITS, AND THEIR WORK PATTERNS ENCOURAGING A WAY OF LIFE WHICH WILL PAY LONG TERM HEALTH BENEFITS.

PHYSICIANS MUST USE EVERY OPPORTUNITY TO PREACH THE VALUE OF ALTERED LIFESTYLE IN THE PROLONGATION OF LIFE AND THE IMPROVEMENT IN ITS QUALITY. IT HAS BEEN SAID THAT WE HAVE "ADDED YEARS TO LIFE AND NOW WE MUST ADD LIFE TO YEARS."

WE MUST CONCERN OURSELVES WITH THE PROBLEM OF THE UNDERAGE SMOKER. THE REALITY OF THE SITUATION IS THAT IN THIS PROVINCE CHILDREN OF ANY AGE HAVE READY ACCESS THROUGH REGULAR SOURCES TO TOBACCO PRODUCTS — STAND OUTSIDE ANY THEATRE OR SCHOOL IN THIS PROVINCE AND WATCH THE 10 TO 15 YEAR OLDS LIGHT UP. THE TOBACCO RESTRAINT ACT OF CANADA FORBIDING THE SALE OF TOBACCO TO PERSONS UNDER 16 YEARS OF AGE MUST BE ENFORCED IN THIS PROVINCE. HOW CAN WE JUSTIFY THE SALE OF CIGARETTES TO A CHILD OF 13 YEARS? THE PARENTS OF THESE CHILDREN OBVIOUSLY CANNOT CONTROL THE PURCHASE OF TOBACCO BY THEIR CHILDREN BUT WOULD BE GRATEFUL IF IT STOPPED. MANY TEENAGERS HAVE HAD SUCH EXPOSURE TO TOBACCO THAT BY THE AGE OF 16 THEY HAVE HAD A WELL INGRAINED TOBACCO HABIT. THE DIET OF OUR CHILDREN ESPECIALLY IN OUR SCHOOL SYSTEM WHERE MANY RECEIVE ONE MEAL EVERY DAY IS AN AREA FOR OUR ATTENTION. WE MUST TAKE A VISIBLE STANCE IN PROMOTING GOOD DIETARY HABITS AMONG OUR YOUNG PEOPLE. AS WAS DECIDED BY COUNCIL YESTERDAY, WE ARE TO ASSUME AN INCREASINGLY ACTIVE ROLE IN PROMOTING FITNESS IN SCHOOL CHILDREN.

MANY CHILDREN IN THIS PROVINCE, DESPITE OUR COMPREHENSIVE CHILDREN'S DENTAL CARE PROGRAM, HAVE NEVER BEEN SEEN BY OUR DENTAL COLLEAGUES. WE MUST ENCOURAGE OUR YOUNG PATIENTS TO HAVE PROPER DENTAL CARE AND USE OUR CONTACTS IN OUR PAEDIATRIC PRACTICE TO ENCOURAGE PARENTS TO BEGIN DENTAL CARE FOR THEIR YOUNGSTERS AT AN EARLY AGE.

IF PHYSICIANS ARE TO BE AMBASSADORS OF THE GOOD LIFE, THEN WE MUST TEACH BY EXAMPLE. WE OURSELVES MUST PRACTICE WHAT WE PREACH. THE IMAGE OF A DOCTOR AS A CHAIN SMOKING WORKAHOLIC IS AN OUTDATED ONE AND ONE WHICH IS UNREALISTIC IN TERMS OF TODAY'S SITUATION. THE PHYSICIAN, IN ADDITION TO THE TIME AWAY FROM HIS PRACTICE FOR STUDY, MUST BE ALLOWED TIME FOR HIS OWN RECREATION, HIS OWN FAMILY. PATIENTS CAN NO LONGER EXPECT THEIR DOCTOR TO BE AVAILABLE 24 HOURS A DAY, 7 DAYS A WEEK. THROUGH THE MECHANISM OF GROUP PRACTICE WE ARE REQUIRED TO BE CERTAIN THAT OUR PATIENTS HAVE ADEQUATE COVERAGE AT ALL TIMES BUT ARE NOT TO BE EXPECTED TO ALWAYS PROVIDE THAT COVERAGE OURSELVES. THE BENEFIT IS THAT A PHYSICIAN WHEN WORKING IS RESTED AND ABLE TO DEVOTE HIS FULL ENERGIES TO THE PROBLEMS AT HAND. THIS REQUIRES PATIENT EDUCATION BUT IS A STEP FORWARD IN THE LONG RUN. PHYSICIANS HAVE A RESPONSIBILITY TO ENSURE THAT SIGN-OUT ARRANGEMENTS ARE MADE CLEAR TO THEIR PATIENTS AND AT ALL TIMES A PHYSICIAN IS AVAILABLE TO THEM.

I ENCOURAGE ALL PHYSICIANS TO MAINTAIN A VERY VISIBLE STANCE IN THE MATTER OF LIFESTYLE. I, LIKE YOU, FEEL A SENSE OF FAILURE WHEN TREATING A LIFESTYLE RELATED DISEASE IN A PATIENT I HAVE BEEN SEEING FOR YEARS. MUCH OF THIS TYPE OF ADVICE MAY FALL UPON DEAF EARS BUT AT LEAST THE CHANCE MUST BE GIVEN. THIS PREVENTIVE CONCEPT SHOULD BE AN INTEGRAL PART OF OUR HEALTH CARE DELIVERY AS IS OUR IMMUNIZATION PROGRAM TO WHICH SO MUCH TIME HAS BEEN DEVOTED THIS YEAR AND FINALLY BEEN RESOLVED IN A VERY SATISFACTORY WAY. A CONSTANT VIGIL ON ENVIRONMENTAL AND OCCUPATIONAL HEALTH HAZARDS MUST BE MAINTAINED. WE HAVE ENDORSED THE SEAT BELT LEGISLATION OF THIS PROVINCE IN 1974. WE URGE ITS PROCLAMATION NOW.

ONLY BY A PREVENTIVE APPROACH TO THESE PROBLEMS CAN WE EXPECT TO HAVE A SIGNIFICANT IMPACT ON THE HEALTH OF MANY OF OUR PATIENTS. WE MUST ADD OUR INFLUENCE TO THE PREVENTIVE PROGRAMS BY LOCAL DRUG & ALCOHOL ABUSE PROGRAMS WHICH ARE UNDERWAY AND AS INDIVIDUAL PHYSICIANS VISIBLY ENDORSE, ENCOURAGE, AND PARTICIPATE IN ACTIVITIES IN OUR COMMUNITIES THAT ARE EFFECTIVE IN IMPROVING MEDICAL AND SOCIAL HEALTH.

IT IS UNFORTUNATE, BUT TRUE, THAT SINCE OUR INVOLVEMENT IN A TAX SUPPORTED UNIVERSAL HEALTH PROGRAM NO SYNOPSIS OF OUR ACTIVITIES WOULD BE COMPLETE WITHOUT A CONSIDERATION OF THE ECONOMICS OF OUR PROFESSION. IT IS TRUE THAT PROVINCIAL SPENDING MUST BE CONTROLLED AND AS WAS RECENTLY ANNOUNCED THERE WILL BE A 55 MILLION DOLLAR OVERRUN IN THIS YEAR'S PROVINCIAL BUDGET. DESPITE SUGGESTIONS TO THE CONTRARY, THIS IS NOT THE RESULT OF UNCONTROLLED SPENDING ON HEALTH. FROM 1971 TO 1979, HEALTH DEPARTMENT COSTS HAVE DROPPED FROM 28% TO 26% OF TOTAL PROVINCIAL EXPENDITURES AND THIS DESPITE THREE NEW PROGRAMS AND INCREASING UTILIZATION (3.8% LAST YEAR). DURING THE SAME PERIOD MEDICAL SERVICE COSTS HAVE DROPPED FROM 7% TO 5% OF PROVINCIAL EXPENDITURES. THESE FIGURES HARDLY JUSTIFY TERMS LIKE RUNAWAY HEALTH COSTS, ESPECIALLY WHEN PER CAPITA COSTS OF MEDICAL SERVICE IN THIS PROVINCE REMAIN WELL UNDER THE NATIONAL AVERAGE. WE SUGGEST THAT COSTS, IN FACT, HAVE BEEN CONTAINED. DURING THIS PERIOD, PHYSICIANS' REAL DISPOSABLE INCOMES HAVE BEEN STEADILY DROPPING, AN ESTIMATED MINUS 14% FROM 1971 TO 1977, DESPITE INCREASING GROSS INCOMES, COULD THIS BE AT LEAST PARTIALLY RESPONSIBLE THAT IN 1978, THE EMIGRATION OF NOVA SCOTIA PHYSICIANS TO THE U.S. WILL DOUBLE OVER 1977? PHYSICIANS HAVE FARED LESS WELL DURING THE PAST DECADE THAN OTHER PROFESSIONALS AND WAGE EARNERS IN THE PROVINCE IN TERMS OF INCOME IMPROVEMENT. IS IT REASONABLE TO ATTEMPT TO RATIONALIZE A DECREASE IN HEALTH CARE COSTS WITH THE EXPECTATION THAT THE OVER 65 YEAR GROUP NOW REPRESENTING 9% OF THE POPULATION AND REQUIRING ALMOST 33% OF HEALTH CARE SERVICE WILL INCREASE IN THE NEXT 25 YEARS TO ALMOST 14% OF OUR POPULATION? THE OVER 65 GROUP REQUIRE 5-10 TIMES THE MEDICAL CARE PER CAPITA COMPARED WITH THE YOUNGER GENERATION. THIS FACT ALONE INDICATES A GREATLY INCREASED DEMAND FOR SERVICE. DO DRASTIC CUTS IN HEALTH CARE EXPENDITURES SEEM LIKE A REASONABLE STEP?

HEALTH CARE DELIVERY IS LABOR INTENSIVE AS 5.5% OF THE TOTAL WORKING FORCE OF THE COUNTRY IS INVOLVED, AND A FULL 70% OF HEALTH SPENDING IS PAID OUT IN WAGES. THE AFTER TAX TAKE OF PHYSICIANS IS ONLY 7% OF THE COUNTRY'S TOTAL HEALTH BILL. SURELY THEN PHYSICIANS WHO HAVE FARED LESS WELL IN THE PAST DECADE THAN ALL OTHER HEALTH WORKERS HAVE HAD VERY LITTLE EFFECT ON HEALTH CARE COSTS. THERE IS NO DOUBT THAT SOME COST SAVING EFFICIENCIES CAN BE FOUND IN THE SYSTEM

ESPECIALLY IN HOSPITAL-BASED SERVICES, BUT EVEN THIS IS LIMITED. REDUCTION IN HEALTH CARE PERSONNEL IS UNWARRANTED AS IT WILL ONLY INCREASE COMPLAINTS OF LONG WAITS FOR SERVICE WHETHER IT BE FOR DIAGNOSTIC SERVICES, ELECTIVE SURGERY, OR TREATMENT IN OUTPATIENT DEPARTMENTS. THE RESTRICTION OF VERY EXPENSIVE HOSPITAL-BASED LIFE-SUPPORTING PROGRAMS LIKE CORONARY ARTERY SURGERY, RENAL DIALYSIS, OR ORGAN TRANSPLANTS IS UNTHINKABLE AND WILL NOT BE SUGGESTED BY THIS PROFESSION. FIFTY-FIVE PERCENT OF COSTS ARE GENERATED IN HOSPITAL AND WE, AS PHYSICIANS ON MEDICAL STAFFS MUST WORK WITH HOSPITAL ADMINISTRATORS AND BOARDS IN CO-OPERATION TO ENSURE THAT MAXIMUM PRODUCTIVITY IN TERMS OF QUALITY OF CARE IS ACHIEVED. WE HAVE A COMMITMENT TO DELIVER AS MUCH HEALTH CARE AS POSSIBLE FOR EVERY DOLLAR SPENT, BUT WE HAVE ALSO THE RESPONSIBILITY TO ENSURE THAT THE TAX REVENUE WHICH SHOULD BE DIRECTED TO THE HEALTH CARE OF NOVA SCOTIANS IS SPENT ON HEALTH ESPECIALLY WHEN THE INITIAL JUSTIFICATION FOR THESE TAXES WAS A GOVERNMENT-SUPPORTED UNIVERSALLY AVAILABLE HEALTH CARE SCHEME, AND I HAVE NO DOUBT THE GOVERNMENT OF THIS PROVINCE SHARES WITH US THAT COMMITMENT.

DURING THE PAST FEW DAYS A LOT OF ATTENTION HAS BEEN GIVEN TO THE PROBLEM OF PHYSICIAN EMIGRATION TO THE UNITED STATES, AND THE SUGGESTION HAS BEEN MADE IN THE MEDIA THAT THE SOLUTION MIGHT WELL BE TO REQUIRE PHYSICIANS WHO LEAVE THE PROVINCE TO REPAY THE PROVINCE THE COST OF THEIR EDUCATION.

WE MUST NOT LOSE SIGHT OF THE FACT THAT MUCH OF THE PHYSICIAN MANPOWER IN NOVA SCOTIA HAS BEEN TRAINED IN OTHER COUNTRIES LIKE GREAT BRITAIN AND INDIA WITHOUT COST TO THE PEOPLE OF THIS PROVINCE. WE FOR MANY YEARS DEPENDED ON FOREIGN MEDICAL SCHOOLS FOR MUCH OF OUR MANPOWER. WE MUST NOT LOSE SIGHT OF THE FACT THAT PHYSICIAN EXCHANGE BETWEEN COUNTRIES IS BENEFICIAL TO MEDICINE AS IT FACILITATES EXCHANGE OF INFORMATION. WE MUST NOT FORGET THE FACT THAT PHYSICIANS MAKE VERY SUBSTANTIAL FINANCIAL CONTRIBUTIONS TO THEIR EDUCATION. THERE IS NO MORE RATIONALE TO SUGGESTING PHYSICIANS REPAY EDUCATIONAL COSTS THAN FOR ANY OTHER EMIGRANT REPAYING CANADIAN SOCIETY FOR WHATEVER PUBLIC INVESTMENT HAS BEEN MADE IN HIS EDUCATION.

NO, THE SOLUTION TO PHYSICIAN EMIGRATION IS NOT IN RESTRICTIONS OF PHYSICIANS' FREEDOM TO MOVE, IT MUST BE A FUNDAMENTAL CORRECTIVE APPROACH TO THE PROBLEMS WHICH RESULTED IN DISSATISFACTION WITH THE PRACTICE OF MEDICINE IN NOVA SCOTIA.

DURING THE PAST TWELVE MONTHS I HAVE BEEN AFFORDED THE PRIVILEGE TO SERVE AS YOUR PRESIDENT. I HAVE BEEN ABLY COUNSELLED BY THE OFFICERS, GUIDED BY THE EXECUTIVE, AND SUPPORTED BY STAFF AND FOR THIS ASSISTANCE I AM GRATEFUL. YOU HAVE BEEN SERVED THIS YEAR BY A VERY DEDICATED INFORMED GROUP OF INDIVIDUALS AT ALL LEVELS. WE ARE FORTUNATE THAT DR. BERNIE STEELE WILL BE OUR NEXT PRESIDENT AND HE IS WELL SUITED TO HANDLE OUR PROBLEMS DURING THE COMING YEAR.

THIS SOCIETY WAS AND IS THE BEST VEHICLE TO ADVANCE OUR COLLECTIVE AIMS TO PROMOTE HEALTH, PREVENT DISEASE, AND MAINTAIN THE INTEGRITY AND HONOUR OF THE MEDICAL PROFESSION. I AGAIN ASK THAT ALL PHYSICIANS REGARDLESS OF THEIR PARTICULAR INTEREST IN MEDICINE SUPPORT THIS SOCIETY AS THE MOST EFFECTIVE MEANS TO ADVANCE OUR AIMS AND ASPIRATIONS AS WE ATTEMPT TO PROVIDE THE BEST MEDICAL CARE POSSIBLE IN AN ATMOSPHERE CONDUCIVE TO PROFESSIONAL FULFILLMENT. □

JAMES R. JONES, M.D.

Orthopedic Surgeon

1440 Swampside St.
Gottingen, N.S.

Phone 999-4230

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Craniofacial Pain

Martin DelCampo,* M.D.,

Halifax, N.S.

Craniofacial pain can be one of the most distressing pain syndromes seen in office practice. In many instances, the diagnosis is suggested by the patient's history alone and, in most instances, the pain is due to a "medical" rather than a neurological condition. Nevertheless, the question of intracranial pathology often arises and is a source of concern to both the patient and physician.

A working classification of craniofacial pain is useful to search out the cause. Table I gives an attempt to classify this problem from a physiopathological viewpoint.

TABLE I
CHRONIC FACIAL PAIN

1. VASCULAR

Migraine:

- Classical
- Common
- Cluster
- Hemiplegic/Ophthalmoplegic
- Carotidynia

Non-Migrainous vascular headache:

- | | |
|---------------------------|-------------------------|
| Hypertensive | "Hangover" |
| Related to CVA's or TIA's | Postconcussion headache |
| A-V malformation | Postconvulsion headache |
| Cranial arteritis | Nitroglycerine |
| Caffeine withdrawal | administration |
| Fever | Hypoglycemia |

2. NEURITIC

Paroxysmal:

- Trigeminal neuralgia
- Glossopharyngeal neuralgia
- Nervus intermedius neuralgia
- Occipital neuralgia

Chronic:

- Post-traumatic
- Post-infectious (post-herpetic)
- Secondary to collagen fascular disease

3. RHEUMATIC

- Temporomandibular joint dysfunction
- Cervical spondylosis

4. TRACTION AND INFLAMMATORY

- Mass lesions
- Diseases of eye, ear, nose, throat and teeth

5. PSYCHOGENIC

- Atypical facial pain
- "Lower half pain"
- Burning tongue and mouth

MIGRAINE

Migraine is the commonest type of headache seen by a general physician, and is the commonest single reason for referral to a neurologist. Typically, it is described as a paroxysmal, recurrent headache; throbbing in nature; and associated with nausea, vomiting, photophobia and irritability. In many instances, it is unilateral, but it may be bilateral or shift from side to side.

Most migraine sufferers consulting a physician are women and about half of the patients begin their attacks around puberty. Only occasionally will a person develop migraine in their 50's or 60's. About 70% of the patients relate a family history of the disorder.

Types of Migraine

Classical Migraine

This type comprises about 35% of cases of migraine. Typically, the patient experiences a visual aura which precedes the attack by 10-20 minutes, usually consisting of visual symptoms, but other prodromal symptoms may be present such as paresthesias around the mouth or in the extremities, dysarthria or hemiparesis. Occasionally, the attack will consist only of the aura and the headache will be completely absent (migraine "sans migraine"), posing a difficult diagnostic problem. This occurs particularly when the patient grows older. Associated symptoms include pallor, tenderness over scalp and superficial arteries, abdominal distention, coldness of the extremities, sweating and chills may be present.

Common Migraine

The character of the headache is the same as in the classical form, except that there is no aura and, quite frequently, the pain is bilateral.

Cluster Migraine

This entity is characterized by recurrent attacks of craniofacial pain of high intensity and brief duration. Their name refers to the fact that they are grouped in cycles of about six weeks that occur at regular intervals. Prolonged periods of headache relief are characteristic. Males are mainly affected in a ratio of 10:1.

The pain is usually retro-orbital, almost never bilateral and so severe that they have been called "suicide headaches". Although they are in such agony that suicide is often felt to offer a welcome escape, they rarely entertain this seriously. There is no aura for this type and associated symptoms are flushing of the side of the face, tearing from the eye, stuffiness of the nose and a partial Horner's syndrome — all in the affected side.

The attacks usually occur at night, sometimes at predictable time intervals after the patient has fallen asleep. They last usually between 20-40 minutes but rarely up to four hours.

*Resident in Neurology, Department of Medicine, Dalhousie University, Halifax, N.S.

Reprint requests to: Dr. T. J. Murray, Chief of Medicine, Camp Hill Hospital, Halifax, N.S. B3H 3G2

Provocative factors include ingestion of alcohol or nitroglycerine, and many of the patients are heavy smokers. Only occasionally is there a family history of the disorder and women, who have this problem, observe no change with menses or pregnancy.

Treatment is quite similar to the prophylactic therapy of migraine. Steroids have been found useful as well, with a dose of 16 mg. on alternate days being successful in some cases. Indomethacin (Indocid) and lithium have also been found of use but are not generally recognized forms of therapy. In cases of intractable cluster migraine, however, lithium therapy has been very helpful in most instances. Dietary restrictions have little place in the treatment of this condition other than avoidance of alcohol.

Other Types

Hemiplegic migraine occurs frequently in families, and consists of one sided weakness or sensory loss followed by the headache. Some other patients present with palsies of ocular muscles as an aura. Occasionally, the above symptoms persist for hours or days, after the headache has stopped.

Carotidynia is a non-specific inflammatory change in the carotid artery resulting in pain in the neck and face. The carotid artery is often tender and pressure over the bifurcation and above may produce the facial pain. Although various forms of arteritis may involve the carotid artery, it is felt that carotidynia is usually a variant of migraine and it is treated by the same drugs that treat migraine. A significant percentage of patients with this syndrome have a history of previous migraine.

Other forms of vascular headache are those associated with miscellaneous conditions such as caffeine withdrawal, cerebrovascular insufficiency (Willis headaches, post concussion headaches, post convulsion headaches, nitroglycerin, hypoglycemia and hypertension).

Treatment

Basically, therapy consists of abortive and prophylactic approaches. The former is usually accomplished by using common analgesics at the onset of symptoms but if inadequate, ergot preparations may be used. During pregnancy, these compounds are dangerous to use for obvious reasons but fortunately, most women are free of migraine by the third month of pregnancy. Occasionally, an acute attack may be aborted with an intravenous injection of dexamethasone 10 mg.

Important aspects of treatment include avoidance of tyramine containing foods, a list of which may be found in Table II. If a patient is on oral contraceptives, this should be stopped immediately.

A number of drugs are available for the prophylactic treatment of migraine and should only be used when the attacks are often or severe enough to interfere with patient's activities. Pizotyline (Sandomigran), propranolol (Inderal), methysergide (Sansert), amitriptyline (Elavil) and carbamazepine (Tegretol) are commonly used drugs (in order of importance). Prescribing information may be found elsewhere.³

TABLE II
DIETARY RESTRICTIONS IN MIGRAINE

Alcoholic beverages	Mushrooms
Cheese (except cottage cheese)	Chicken livers
Chocolate	Vinegar (except white vinegar)
Citrus fruits and juices	Meat extracts
Caffeine (excessive amounts)	Eggs
Marinated products	Monosodium glutamate
Yogurt	Chinese food
Sour cream	

TEMPORAL ARTERITIS

This is a febrile, often self-limited disease of elderly people, characterized by painful inflammation of the temporal and other cranial arteries. It may be present in only one artery but more often is part of a more widespread collagen vascular disease.

Systemic symptoms usually include malaise, weakness, weight loss, anorexia, fever and sweating. The pain is described as throbbing, deep and very intense. Often there is a burning component and the temporal artery on the affected side may be tortuous, pulsatile and tender to palpation. There is associated scalp tenderness and the pain may be aggravated by chewing movements ("masticatory claudication").

The main complication of this syndrome is uni- or bilateral visual loss. This may be partial or complete, making the diagnosis and treatment an urgent matter. Severe unilateral temporal headaches in a patient 60 or over associated with a high sedimentation rate, calls for immediate treatment. Confirmation is usually made by temporal artery biopsy but, due to the segmental nature of the pathological process, occasionally the characteristic histological changes may not be found.

In some instances, a picture of proximal muscle stiffness and pain may dominate the picture (polymyalgia rheumatica). The physician should be aware of this association, as the threat of visual loss is equally present.

The treatment of choice is prednisone in high doses (60-100 mg daily) with progressive tapering and maintenance doses of about 10-20 mg. for several months. The sedimentation rate may be a good guide to follow the effectiveness of treatment.

TRIGEMINAL NEURALGIA

In this condition, the pain is experienced mainly in the areas supplied by the second and third division of the trigeminal nerve. It never involves the ramus of the jaw or behind the ear. The pain occurs in paroxysms of unilateral pain, of a very high intensity, lasting about 20-30 seconds. After a period of a few seconds to a minute, the same "jab" will come back. The entire attack of a series of such pains lasts about an hour or more.

There are "trigger" zones associated with this condition. When these areas are stimulated by seemingly trivial factors such as cold air, swallowing, shaving or laughing, the attack will develop. Sometimes, the pain will develop spontaneously. Due to these trigger zones, the patient avoids doing anything to stimulate the trigger areas, and, of course, avoids

rubbing the affected area which is such a common maneuver to relieve pain of any other source.

Usually, there are periods of remission varying from days to years. The age of onset is during the 5th and 6th decades. When it is present for a younger person, the diagnosis of multiple sclerosis should be strongly suspected.

Treatment

The first line of treatment is medical. Dilantin 300-400 mg. in divided doses or Tegretol 600-800 mg. daily are the drugs of choice. Higher dosages are not recommended unless close monitoring of blood levels of the drug is undertaken. Mephenesin (Tolseram) 5-15 mg. five times daily may be added to the above drugs for better control. Clonazepam (Rivotril) may be of help in some cases.

When medical therapy is ineffective, neurolysis may be attempted. Alcohol injections or percutaneous gasserian ganglion electrocoagulation may be tried. The relief with these, or more invasive surgical procedures, is usually only temporary and may lead to more disturbing complications such as corneal anesthesia, and anesthesia dolorosa. The latter condition is characterized by constant, intractable pain in the affected areas.

GLOSSOPHARYNGEAL NEURALGIA

The characteristics of the pain in this condition are similar to those of trigeminal neuralgia, and the pain is usually located in the lower part of the throat, base of the tongue or in the ear. It may be radiated to the external auditory meatus, lobule of the ear and lower jaw. Trigger factors exist, such as swallowing, yawning, coughing, sneezing or protruding the tongue.

Syncopal attacks may occur, presumably because of asystole (vagal stimulus). Occasionally, "secondary" glossopharyngeal neuralgia may be present and secondary to compression of the IX nerve by tumors or abnormal vessels. In these circumstances, the pain is usually continuous and may extend beyond the areas of supply of this nerve.

Treatment

The medical treatment is quite the same as in trigeminal neuralgia. Surgery is sometimes performed with the complications of recurrence of the pain, loss of taste sensation in one side and anesthesia dolorosa.

TEMPOROMANDIBULAR JOINT DYSFUNCTION

This entity is still debated among dentists and physicians, and a large percentage do not believe it even exists as such. The pain attributed to TMJ dysfunction is a moderately intense headache at the vertex, occiput or in the area overlaying the joints. It is believed to be due to muscle tension related to malocclusion of the jaw or arthritic processes of the joints themselves.

In patients with obscure craniofacial pains in which crepitus and pain on palpation of the TM joints are elicited, a 1 ml. infiltration with Xylocaine 2% in the affected joint may help the diagnosis by providing relief of the symptoms. Referral to an oral surgeon for the fitting of a bite plate is the usual management along with maneuvers to relieve the muscle spasm. Because most of these patients have chronic tension states, appropriate management of the psychological factors that result in chronic muscle tension is important.

MUSCLE CONTRACTION ("TENSION") HEADACHES

Muscle contraction headaches are very common and may present alone or in association with other types of headache, particularly vascular headache. Psychologic studies of patients with tension headache have demonstrated that the majority of them suffer from chronic stress or anxiety neurosis. The pain usually begins in the lower posterior neck and radiates forward to a retro-orbital location. It is usually described as a dull, deep, non-throbbing pain which sometimes is accompanied by scalp tenderness. Other descriptions include sensations of "fullness", "tightness" or a "band-like pain around my head". Neck movements and pressure over the greater occipital nerve on the affected side usually aggravate or reproduce the pain. Not infrequently the condition is bilateral.

The onset is gradual and it may occur in paroxysms that are superimposed on a milder chronic headache that can persist for weeks or months. The mechanism is presumed to be a sustained contraction of the muscles of the back of the neck which may or may not be complicated by chronic irritation or compression of the greater occipital nerve by the muscle spasm.

Migraine, cluster headache, and post traumatic headaches are not infrequently associated with this type of headache as well. Cervical spondylosis and degenerative joint disease of the neck are other underlying causes of the same type of muscle contraction headaches. Rarely, paroxysmal pain with typical trigger zones (as in trigeminal neuralgia) may occur in the distribution of this nerve.

Nerve blocks with local anesthetic usually provide relief. Occasionally, neurolysis and radiofrequency may have to be performed to provide longer lasting relief.

ATYPICAL FACIAL NEURALGIAS

After all the craniofacial syndromes that are more or less categorized, there remain a small number of patients for which no etiology can be found. These are usually young women complaining of severe, deep pain in the lower face which is unresponsive to all medications.

A careful search of diseases of the paranasal sinuses, nose, teeth and eyes should be made. Sometimes, when a throbbing component for the headache is found, this may be a manifestation of migraine occurring in the arteries of the face. Disease of the nervus intermedius sometimes is implicated in this type of patient, particularly when the pain occurs in the ears and deep in the face. Occasionally, trigger areas may occur in the ear or in front of the ear; the pain, however, does not come in paroxysms.

A trial with ergot preparations may be tried if there is a suggestion of a vascular component. Drugs as described for the other cranial neuralgias may be tried if there is a suggestion of nervus intermedius disease. Reassurance and supportive therapy are usually what the physician has to resort to in these unfortunate patients who may go from practitioner to practitioner seeking for a miracle cure. Although many forms of treatment are eventually used in such cases, the problem tends to be resistant to treatment and continues despite drugs, psychotherapy, antidepressants, tranquilizers and acupuncture.

POSTHERPETIC NEURALGIA

In postherpetic neuralgia the pain is quite intense, accompanying or following the herpetic injection. It is long lasting, associated with severe aberrations of facial sensations, and patients are commonly depressed with suicidal ideations. It may involve the ophthalmic division of the V nerve or the external auditory meatus, pinna and sometimes the palate and occipital region.

Treatment is extremely difficult, and tricyclic antidepressants and phenothiazines may be of help. Electrical neurostimulation has been successful in some cases, but ablative procedures are not recommended.

Conclusions

As seen above, craniofacial pain can be of multiple etiologies. The management of the various conditions is sometimes difficult and disappointing. Only with a thorough understanding of the patient's problems will the physician be able to deal with these often disabling conditions. □

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Scoliosis and Early Diagnosis by School Screening

A. M. Sinclair,* M.D., F.R.C.S.(C),

Halifax, N.S.

Scoliosis or lateral curvature of the spine can cause great concern for parents and affected children.

It is known to occur in association with neuromuscular and muscular diseases but by far the largest number of cases seen fall within the category of idiopathic or hereditary scoliosis.

The cause of hereditary scoliosis is unknown. However, three basic facts are known about the clinical course of this condition.

- 1) It can be hereditary and familial.
- 2) The curve increases with growth of the spine.
- 3) There is a predominance of cases in girls.

There is a clinical paradox associated with scoliosis for the majority of cases have no specific symptoms referable to their back with the onset of the deformity. Occasionally, the patient may complain of discomfort in their back when sitting in school. This is usually associated with an advanced curve and is due to prominence of the scapula secondary to rotational deformity of the spine.

Many cases occur in adolescents and many cases are noted initially by someone other than the child's parents.

*Associate Professor, Department of Surgery (Orthopaedics), Izaak Walton Killam Hospital for Children, Halifax, N.S.

There are usually no symptoms and because adolescence is accompanied by an increased sense of modesty in most girls, parents are often shocked by the severity of the deformity when it is first brought to their attention.

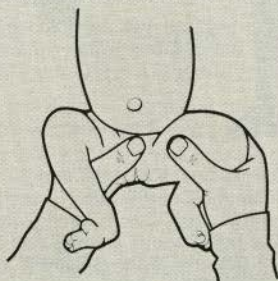
The first suspicion of an abnormal spinal curve is often brought to the attention of the patient or the parents by a friend, gym teacher, swimming teacher, or even a sales clerk who may notice that a skirt or dress does not fit properly because of prominence of one hip, or when it seems that one shoulder is higher than the other.

The clinical diagnosis of scoliosis is simple. Obvious prominence of the scapula or iliac crest usually indicates a moderately severe curve in the thoracic and/or lumbar region. Early curves can be detected by having the patient bend forward and touch their knees. Since the lateral curvature of the spine in structural scoliosis is accompanied by vertebral rotation, there will be prominence of the ribs or other paraspinal structures if there is a structural scoliosis with a potential for progression.

If the scoliosis is postural or is associated with a discrepancy in leg lengths, there will be no rotation of the vertebral bodies and therefore no prominence of the paraspinal structures on forward flexion. With leg length discrepancy, appropriate correction of the discrepancy with a lift under the short side will eliminate the curve.

EXAMINE EVERY NEWBORN'S HIP FOR DISLOCATION

1. FLEX HIP TO 90°, ABDUCT TO 45°.
2. HOLD THIGH WITH THUMB IN GROIN MIDDLE FINGER ON GREATER TROCHANTER.
3. PRESS FORWARD WITH MIDDLE FINGER AND BACK WITH THUMB.
4. IF THE FEMORAL HEAD DISPLACES, THERE IS DISLOCATION!



• THE EXAMINATION SHOULD BE CARRIED OUT ON A FIRM SURFACE • RELAXATION IS ESSENTIAL • A BOTTLE MAY BE GIVEN IF NECESSARY • THE EXAMINER SHOULD BE GENTLE AND USE WARM HANDS

EARLY TREATMENT IS SIMPLE • DELAY MEANS OPERATION

SCHOOL SCREENING FOR SCOLIOSIS

The common denominator in the search for early cases of scoliosis is the fact that practically all children at risk attend school.

School screening programmes have been conducted in many communities in Canada and the United States for a number of years. In some areas, such as the State of Delaware in the United States, these screening procedures have been so effective that a very small number of cases of scoliosis from that state require surgical correction. Early cases that are provided with effective bracing and supervision during the period of spinal growth can usually be managed without operation.


A pilot programme for screening school children in Nova Scotia has been sanctioned by the Department of Public Health in this province, and the initial screening will be carried out in the two Public Health Units in Cape Breton. It is hoped that this screening will be carried out before the end of 1978 and the programme will then be extended to include all Public Health Units in the province.

A very necessary part of any school screening programme will be the cooperation of family physicians. The format for screening and case finding will be:

- 1) Clinical screening of Junior High School students (the largest group at risk) by Public Health Nurses in the area.
- 2) Referral of cases, suspected of having scoliosis, to the family physician via a note to the parents indicating suspicion of spinal deformity.
- 3) A note to the family physician indicating the advisability of a spine x-ray.
- 4) Referral of suspicious cases to an orthopaedic surgeon. This will be done by the family physician who can refer the patient for consultation in the usual manner.
- 5) Follow-up examination of suspicious cases will be arranged for intervals of three to six months, and specific bracing or other treatment instituted as recommended by consultation.


This school screening programme will be repeated yearly and, when completely established, could be extended to elementary school classes. □

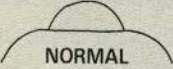
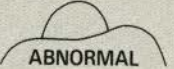
DO THIS



1. STAND CHILD IN BATHING SUIT.
2. CHILD SHOULD BEND FORWARD TO TOUCH KNEE.
3. LOOK FROM BEHIND.
4. PROMINENCE ON ONE SIDE OF SPINE INDICATES SCOLIOSIS.
5. AN X-RAY AND ORTHOPAEDIC CONSULTATION ARE REQUIRED.

PREVENT THIS




NORMAL

ABNORMAL

SCOLIOSIS BEGINS AT 8-10 YEARS. EARLY TREATMENT IS EASY.
LATE DIAGNOSIS OFTEN MEANS OPERATION.

DIAGNOSE SCOLIOSIS EARLY

This poster is a reproduction of the material of the
 Ontario Crippled Children's Society and the
 Hospital for Sick Children Toronto, Ontario.
 It is distributed under the auspices of the
 Atlantic Provinces Orthopaedic Society,
 The Canadian Rehabilitation Council for the Disabled and
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 Walton Killam Hospital for Children Halifax, Nova Scotia.

These posters were designed for the Ontario Crippled Children's Society and the Hospital for Sick Children Toronto, Ontario.

They are distributed under the auspices of the Atlantic Provinces Orthopaedic Society, The Canadian Rehabilitation Council for the Disabled and the Department of Orthopaedic Surgery of the Izaak Walton Killam Hospital for Children Halifax, Nova Scotia.



Do you huff and puff when you run for the bus? You may share the malaise of poor physical fitness with many other Canadians. Get active - your health is at stake.



Continuing Medical Education in Europe and Russia: A Personal Perspective

Marvin R. Clark,* M.D.,
Charlottetown, P.E.I.

In 1977, I was privileged to have the experience of an eight month sabbatical in Europe and Russia. The objective of my visit to the countries of England, Scotland, Norway, Sweden, Denmark, Switzerland, Spain, Netherlands, and Russia was simple — I hoped to gain valuable insight into the whole gamut of continuing medical education in these nations. My goals were to study the design and implementation of the various programs, to record the methods used to evaluate the programs, and to learn how they viewed the relationship between physician performance and the quality of patient care. Needless to say, I was very busy in pursuit of these goals, but found it to be an immensely enjoyable and rewarding task.

I would like to share some of my experiences and impressions with you by inviting you to peruse this "mini-travelogue".



Dr. Clark in front of St. Basil's Cathedral, Moscow.

*Deputy Minister of Health, Department of Health, Province of Prince Edward Island, Charlottetown, P.E.I.

England and Scotland

My family and I arrived in England in January, 1977, and we established our home base in Golders Green, N.E. London. From this location I commuted to all parts of England and Scotland, and made many visits to individuals, hospitals and organizations. Most of my time was spent in interviewing, but I was able to take advantage of several opportunities to work in university clinics and in the offices of GP's.

Continuing medical education in England and Scotland centres around geographical regions, which are usually based on the location of medical schools, and each region consists of several districts. London is an exception with twelve medical schools grouped under the British Post Graduate Medical Federation.

Each region has a post-graduate dean, who is responsible for the administration and financing of CME for GP's in the area. Some educational programs are centrally located, but in most cases are designed and implemented within each district in facilities owned by hospitals, professional and specialty organizations. Specialists in district hospitals act as "clinical tutors" on a regular basis, perhaps one-half hour per week.

The dean's approval entitles a CME centre to a financial grant, and the general practitioner may claim expenses and obtain credit toward his yearly requirement of fifteen hours of post-graduate education. The only limitation to any physician's participation is the amount of funds available in the regional budget.

Both England and Scotland have innovative vocational training programs for GP's. The whole concept of specialist CME is surrounded by a feeling of relative indifference.

I spent many interesting days in London, visiting its medical schools and meeting many professionals concerned with CME, and I had an equally enjoyable experience visiting the smaller centres throughout England, many of them involved in research and innovation in medical education. Sheffield, Manchester, and Nottingham are working with P.O.M.R. and are doing studies of the quality of care in an ambulatory setting. Southampton is doing significant work in the area of hospital and practice audits and Aldeburgh, Suffolk has provided leadership in many areas such as P.O.M.R., teaching methods, and practice audit techniques.

Norway

We left England to proceed to Norway in May and we made our headquarters in Trondheim. Norway has draft legislation relating to adult education and included in this is the continuing education of doctors. This country also has a financial incentive for physicians. Those who fulfill the CME requirements — 200 hours every five years plus three months hospital based education — are called "approved general practitioners", and receive a higher level of

remuneration. Revenue for CME is raised by the government which deducts approximately 5% of a physicians' income and allots it to the Norwegian Medical Association. This amounts to more than \$700,000 per year. The postgraduate program for GP's consists of two years of unsupervised training and one year hospital training plus 300 hours of formal course work over the three year period.

Sweden

From Norway we travelled to Sweden, where I found little difference from Norway in the way of continuing medical education. Health care in Sweden is more socialized and family physicians do not have hospital privileges.

Sweden and Norway both have patient participation fees and use this as a positive and accepted mechanism for controlling demand.

Switzerland

After a two-week stay in Sweden, our family moved on to Bern, Switzerland. This is the home of the prestigious (and only such center in Europe) Institute in Medical Education and Evaluation. The staff at this school were amongst the most educationally sophisticated individuals I encountered during my sabbatical. They are involved in curriculum design, educational research and provide the center for a large national evaluation service.

CME in Switzerland seems to be growing rapidly, based on hospitals and specialty organizations. However, lines of responsibility and authority are not yet clearly defined and there is no obligation on any physician to participate. Funding is haphazard and drug companies are major contributors. Two-thirds of the medical school graduates continue with specialty training and there is some concern about the annual decrease in the number of general practitioners.

The highlight of my visit to Switzerland was my introduction to many individuals who work with the World Health Organization in the City of Geneva, the headquarters of this famous organization. I was very pleased to learn a considerable amount about the types of programs offered by WHO and shared with my contacts there the "Canadian approach" to CME and patient care appraisal.

Spain

Leaving Switzerland, we travelled through northern Italy and France and stopped for several days in Spain, our arrival being on the day after the end of dictatorship. I attended a meeting of the Association of Medical Educators in Europe and gained some insight into the chaotic system of health care and medical education in Spain. One has to admire the determined and enthusiastic approach that is being taken to incorporate the best of the world's experience into their future plans.

Netherlands

Our next stop was Maastricht, Holland. I learned that the entire field of education was restructured in 1975 and at that time continuing medical education was entrusted to medical facilities. Implementation of CME rests with the Ministries of Health and Education, with Medical Faculties and representatives of the Royal Dutch Medical Association. The education program at Maastricht Medical School is patterned very closely on the MacMaster program in Hamilton.

Russia

The high point of my sabbatical was my ten day visit to Russia, where I stayed in Moscow and Leningrad. In Russia, as in all Eastern European countries, CME is obligatory. The Ministry of Health assumes the responsibility and delegates it to educational bodies or organizations for implementation in local regions. These training institutes have the authority to draw on the resources of medical faculties, academic medical societies, health workers' trade unions, national institutes for medical specialties, and medical research institutes.

In Russia, a physician's performance is reviewed at least every five years by an "attestation committee", whose perception of the physician is reflected in each doctor's category of pay. His performance in medicine and society is also recorded in an official "black book", which serves as a significant motivator in that socialist country.

The Russians have a very interesting home study (correspondence) program lasting four to six months, followed by a four to six week session at a designated institute. This program was introduced in 1958 and more than 20,000 practitioners have participated. Approximately 60% of future training will take this form.



Moscow street scene

In August, my family and I returned to Halifax, exhausted from our busy schedule over the preceding eight months, but bursting with the knowledge and experience that we had gained. My conclusions on continuing medical education in Europe and Russia were wide and varied. However, after assimilating my materials and studying my notes, I reached the following conclusions. There is an international recognition that continuing medical education should be directly related to the actual needs of the practitioners in the delivery of patient care. The responsibility for this is distributed in many ways, among governments, medical schools and professional associations.

There is much current discussion on innovations in instructional methods. In 1977 all the countries I visited favoured the lecture method, but some are beginning to experiment with a wide variety of teaching methods. Evaluation of the relationship between CME and the outcome of health care is embryonic but exciting. The funding of CME, although commonly discussed, seemed more of a philosophical and psychological problem than an actual problem. □

For further discussion of C.M.E. Programmes see "Innovations in Medical Education", *Medical Education*. 1978, 12, Supplement, Sept. 78.

NEW MEMBERS

The Physicians listed below have joined The Medical Society of Nova Scotia between August 1, 1978 and November 30, 1978. A most cordial welcome is extended by the Society.

Dr. J. A. Barlow*	Ottawa, Ont.
Dr. A. J. Bishop*	New Westminster, B.C.
Dr. P. C. Boyd	North Sydney, N.S.
Dr. A. B. Buckley*	Victoria, B.C.
Dr. A. G. Cameron	Halifax, N.S.
Dr. E. E. A. Cameron	Sydney, N.S.
Dr. C. M. Campbell*	Charlottetown, P.E.I.
Dr. R. A. Cheong*	Sarnia, Ont.
Dr. C. A. Critchley	Sydney, N.S.
Dr. W. A. Crooks*	New Westminster, B.C.
Dr. R. L. Denton	Digby, N.S.
Dr. D. C. Dobson	North Sydney, N.S.
Dr. R. L. Dobson*	Edmonton, Alta.
Dr. W. M. Henderson	Halifax, N.S.
Dr. C. P. Joulos	Halifax, N.S.
Dr. R. A. Killeen	Lower Sackville, N.S.
Dr. W. P. Killorn*	Victoria, B.C.
Dr. David Marsters	Waterville, N.S.
Dr. G. G. J. Melanson	Cheticamp, N.S.
Dr. R. M. Miller	Halifax, N.S.
Dr. M. F. Moriarty	Dartmouth, N.S.
Dr. G. C. MacCallum	Halifax, N.S.
Dr. J. R. MacLachlan	Hantsport, N.S.
Dr. R. A. MacRae	Halifax, N.S.
Dr. B. J. M. O'Brien	Glace Bay, N.S.
Dr. L. J. Peddle	Halifax, N.S.
Dr. J. D. Prentice	Springhill, N.S.
Dr. A. R. Robertson	Antigonish, N.S.
Dr. Ahmet Slomic	Amherst, N.S.
Dr. S. M. Still	Halifax, N.S.
Dr. D. A. Taylor	Kentville, N.S.
Dr. R. A. Taylor	Lower Sackville, N.S.
Dr. C. G. W. Turner	Mahone Bay, N.S.
Dr. E. L. Tweedie*	Baytown, Texas
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Appreciations

DR. WILLIAM M. GREER

Dr. William M. Greer, formerly Senior Medical Officer of the Eastern Fleet, died at his home in Shelburne County, Nova Scotia, Canada on August 15, 1978.

William Mills Greer was born in Montreal, of Scots-Irish ancestry, on January 21, 1903. Following graduation from Dalhousie University in 1928, he completed his internship at Manhattan State Hospital in New York. He then crossed the Atlantic to pursue a distinguished career in the Royal Navy. He served throughout World War II, being stationed initially in Malta and Gibraltar and later with the Royal Marines in the Middle East. In the latter years, he was the Senior Medical Officer of the Eastern Fleet, then under the command of Admiral Sir Algernon Willis. He was mentioned in despatches and won a gallantry award. During his Naval career he much preferred active service at sea, and was invariably accompanied by his two bull-dogs, which were usually accommodated on the deck of each ship on which he served. He also participated in the early uses of penicillin, then in its experimental stages.

In 1930, he married Elsa Byles, a Queen Alexandra Royal Naval Nursing Service Nurse, who had trained at St. Mary's Hospital, Paddington, and who came from a family with strong Naval traditions. In Elsa he found a kindred spirit who shared completely his varied interests and pursuits. Bill Greer was an outstanding yachtsman and both Elsa and he were formidable competitors in any racing event. In their yacht "Kalkara" they won the "Round the Island" of Malta Yacht race in 1939. "Kalkara" had been built by Bill Greer, with assistance from John Illingworth in Malta and was a copy of "The Brilliant", which had been built earlier by Uffa Fox. In 1951 they sailed "Kalkara" across the Atlantic to the Windward Islands, where Bill took up a post as Medical Officer and where used his boat as his form of transportation between the Islands.

He returned to Canada in 1953 and joined the Canadian Government Health Service for the Indian People, initially at Moose Factory on Hudson's Bay and later at Nanaimo, British Columbia. Following this period he retired to the South Shore of Nova Scotia, where he built a beautiful home, virtually by his own hands and which overlooked Jordan Bay. Later he made all his own furniture and ships' models of the famous Sailing-Ships which he admired.

Bill Greer was a remarkable Canadian who appreciated all that was best in the British way of life. He was enthusiastic about the feats of British engineering in many fields and was particularly proud of his Jaguar XK-120, which he purchased in 1955 and which has since motored 269,000 miles still with its original engine.

Throughout his life he retained an energetic and youthful demeanor, accompanied by an acute sense of humour and a great capacity as a raconteur, who could captivate and entertain with stories of his many varied experiences in different parts of the world. His latter years of retirement were marred by ill-health, which he bore patiently and uncomplainingly, facing his final illness with great courage. Throughout all this he was nursed at home by his devoted wife, Elsa. □

R. C. Montgomey, M.D.

DR. HOWARD A. CREIGHTON

Dr. Howard Alexander Creighton of Lunenburg died on October 27, 1978. Born in Halifax, he was the son of the late Graham and Catherine Creighton. He attended the Morris Street School and completed his high school education at the Halifax Academy. He was a veteran of the First World War, receiving the Military Cross in 1919.

After graduating from Dalhousie Medical School in 1924, he spent four years of post-graduate study in Great Britain — General Medicine and Surgery at London Hospital, Obstetrics and Gynecology in Dublin, and Surgery in Edinburgh. He began his medical practice in Lunenburg in 1928, where he was port physician for 28 years. He was one of those whose efforts led to the building of the Fishermen's Memorial Hospital, where for many years he was a member of the staff. Before retirement in 1972, he was made an Honorary Member of The Medical Society of Nova Scotia. Doctor Creighton was Past President of the Lunenburg Queens Medical Society and served on the Provincial Medical Board for a number of years.

He served on the Lunenburg Town Council and was Commanding Officer of the Lunenburg Air Cadets during the Second World War. He was a member of the Royal Canadian Legion, Lunenburg Branch 23, the Lunenburg Board of Trade, and an officer-brother of the Saint John's Ambulance Association. He was a founding member of the Brittlebones Skating Club, the first Commodore of the Lunenburg Yacht Club, a member of the Unity Lodge Number Four AF and AM, and the Nova Scotia Scottish Rite.

Surviving are his wife, the former Catherine Oxner; two daughters, Ruth (Mrs. R. C. Taylor), Windsor; Ann (Mrs. W. A. Buik), Toronto; two sisters, Edith, Halifax; and Dr. Anna Laing, Amityville, N.Y.; a brother, Dr. Wilfred Creighton, Halifax; and five grandchildren. He was predeceased by his son Graham and two sisters, Lois and Freda (Mrs. Prescott Creelman). The funeral service was held at St. John's Anglican Church, Lunenburg, on October 30, 1978, followed by burial at Hillcrest Cemetery, Lunenburg.

His many years of service and dedication will long be remembered by all those who knew him. Our deepest sympathy goes out to his wife and other members of his family. □

W. I. Bent, M.D.

*... Physicians of the utmost fame
Were called at once; but when they came
They answered, as they took their fees,
'There is no cure for this disease ...'*

Hilaire Belloc, 1870-1953

Some Historical Highlights of the 125th Annual Meeting



Dr. Murdock A. Smith declares the 14th Meeting of Council and the 125th Annual Meeting of The Medical Society of Nova Scotia open. Society Officers and President of C.M.A. are shown with him.



Dr. Gerald Sheehy, Minister of Health shown addressing the Society at the Annual Meeting.



Dr. J. F. Hamm, President of the Society shown with his wife Genesta greeting the Lieutenant-Governor, Dr. C. L. Gosse and his wife Betty.



Dr. Ken O. Wylie, President of C.M.A. installs Dr. B. J. Steele as President of The Medical Society of Nova Scotia.



Genesta Hamm accepts a token of appreciation from The Medical Society for the support of her husband John during his term of office as President of the Society. Dr. Bill Mason does the honors with Dr. Bernie Steele, newly installed President looks on.



Shown is Dr. Margaret E. Churchill of Yarmouth. She was named President-Elect of the Society at the 125th Annual Meeting in Halifax, November 1978.



Dr. Bernie Steele is shown presenting Dr. John Hamm with a symbol of service, the Past-Presidents Pin.



Mrs. J. F. Hamm acknowledges Mrs. K. O. Wylie's contribution to her husbands success as President of C.M.A. by presenting her with a gift from the Society.

Personal Interest Notes



Tove Clahane expresses her surprise and pleasure when the Society recognizes her long service and dedication. No, she has not retired. Dr. Peter D. Jackson, Sydney River makes the presentation while Dr. Steele looks on.

SENIOR MEMBERSHIP CITATIONS THE MEDICAL SOCIETY OF NOVA SCOTIA

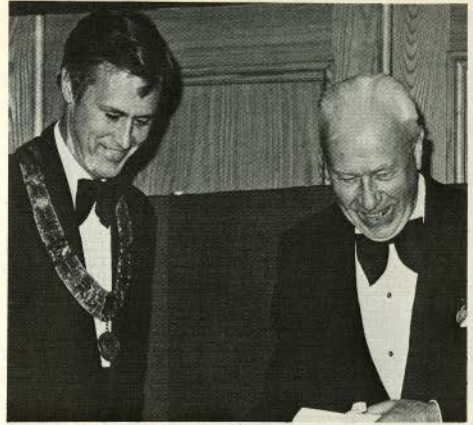
Dr. Kenneth M. Grant

Dr. Kenneth M. Grant was born in Glace Bay in 1904. He spent his early life there and attended public schools to grade 12. He then went to Dalhousie University obtaining a B.Sc., and then the degree of M.D.C.M. in 1929. Between 1929 and 1935 he did postgraduate studies, spending two years at Camp Hill Hospital and four years at the Chicago Lying-In Hospital.

He returned to Halifax with an appointment to Dalhousie University, Faculty of Medicine, Department of Obstetrics and Gynecology working under the notable physicians, Drs. Harold B. Atlee and Kirk MacLellan. Dr. Grant also engaged in private practice at this time. His military service was spent with the Reserve Army at Camp Aldershot. He is a fellow of the Royal College of Surgeons and the American College of Obstetrics and Gynecology.

He has been an active staff member at the Victoria General Hospital, Grace Maternity Hospital, and the Halifax Infirmary, and more recently a consultant to all of these hospitals. He held the position of Head of the Department of Obstetrics at the Halifax Infirmary for over twenty years.

Dr. Grant has always been very active in the affairs of the Halifax Medical Society and The Medical Society of Nova



The Medical Society recognizes Dr. Kenneth M. Grant's long service by presenting him with Senior Membership in The Medical Society of Nova Scotia. Dr. John Hamm of Stellarton officiates.

Scotia. He was the Secretary of the Halifax Medical Society for a number of years in the late 30's and 40's. He held the office of President in 1961. He has served on the Executive Committee of The Medical Society of Nova Scotia for many years. Other Societies as well have had the benefit of Dr. Grant's active participation: these being the Canadian Society of Obstetrics and Gynecology of which he was Secretary in 1949 and 1950 and President in 1971, and the Atlantic Society of Obstetrics and Gynecology of which he was President.

On the academic side, he has contributed to a text book in Obstetrics and Gynecology, and has been author and co-author of many publications. His hobbies include weekend golf, curling and photography.

Through all his endeavors he has had the unfailing support of his wife, Marj. They have one son.

The Halifax Medical Society and The Medical Society of Nova Scotia are better for Dr. Grant's ongoing loyalty and enthusiasm over the years. It is with great pleasure that I propose, on behalf of the Halifax Medical Society, that Dr. Kenneth M. Grant, physician, friend, and gentlemen be made Senior Member in The Medical Society of Nova Scotia.

Dr. B. D. Byrne
President
The Halifax Medical Society

Dr. William J. Lamond

With all my admiration to this durable man, Mr. Chairman, Ladies and Gentlemen, may I present to you William James Lamond.

Born on July 18, 1907 in the town of Sydney Mines, in Cape Breton, where he grew up and attended his early schooling. He graduated from Dalhousie School of Medicine in 1937 in class of 28, with a degree of M.D., C.M. He briefly practised in Dingwall and quickly settled in Sydney Mines to practice Medicine for the last 41 years. In one of those years he managed to marry Isabel.



Dr. J. F. Hamm, President of the Society installs Dr. William J. Lamond of Sydney Mines as a Senior Member of The Medical Society of Nova Scotia.

I am sure it can not do justice to speak for a few minutes for what this man has accomplished in 41 years and I have promised him that I will not make this presentation sound like his obituary!

Bill Lamond has served all the strata of Canadian society. He served his country during the Second World War. He was President of the Cape Breton Medical Society and has remained active in his participation in the business of the society. He has for many years been the Medical Health Officer of the Northside Unit. He served his Church quite ably as a gentleman, scholar, and a good Presbyterian. Last but not least, — his family, — being blessed with two beautiful daughters and three sons. His sailing acumen is unsurmountable and his sailing days are just starting. He is greatly appreciated by his colleagues as a ready-made reference in history and chronicle of events.

Once, a great Japanese artist said: "I am barely learning at 50, just learning at 65, good at 75, very good at 95. I will be a Master at 110" He died at age 89 and at his deathbed he left a note, "If only I had 6 more years I could have been very good". Bill Lamond at his young age of 72 is a Master twice over.

Mr. Chairman, Ladies and Gentlemen, it is my distinct honor to propose to you William James Lamond, for Senior Membership in the Medical Society of N.S. □

Dr. B. S. Ignacio
President
Cape Breton Medical Society

**SENIOR MEMBERSHIP CITATIONS
THE CANADIAN MEDICAL ASSOCIATION**

Dr. Maxwell Daniel Brennan

Doctor Maxwell Daniel Brennan was born in Dartmouth, Nova Scotia on October 8, 1908. After attending Dartmouth High School he became a student at Dalhousie University

from which he obtained the B.Sc. degree in 1930. He then went abroad for his medical education and took his M.B., Ch.B. degrees at the University of Edinburgh in 1936. He was admitted to the fellowship of the Royal College of Physicians and Surgeons of Canada in 1945.

Dr. Brennan was the first native-born Dartmouthian to establish medical practice in his home town. In 1937 he began the first group practice in Nova Scotia, the second in Eastern Canada. This gradually expanded to become an ultra-modern facility, complete with radiological, laboratory and supporting services that made it a decade ahead of its time for many years. It served the enlarging community as an ambulatory medical centre for all types of care. During this period Max Brennan gave leadership in a continuing effort towards the establishment of a Dartmouth Community Hospital. It is only in the year of his retirement that this hospital has now indeed become a reality.



Dr. Maxwell D. Brennan of Dartmouth is installed as a Senior Member in The Canadian Medical Association. Dr. K. O. Wylie, President of C.M.A. performs the ceremony.

Dr. Brennan excelled in many areas of practice, not the least of which was patient counselling. He served many long hours in helping to establish an alcoholic treatment program in his community that was attended by patients from throughout the province. He has had a particular talent for organization and planning and has had a good influence on succeeding generations of young practitioners in the methods and rewards of group practice.

He is a member of the Dartmouth School Board and his interest in music has led to his chairmanship of the Dartmouth Community Concert Association. He is a member of Saint Peter's Church.

Dr. Frederick Murray Fraser

Doctor Frederick Murray Fraser is a native of Halifax and received his medical education at Dalhousie University. During his under-graduate days he was prominent in many university activities; he was president of the Arts and Science Society and a member of the Phi Rho Sigma Fraternity and was manager of the rugby football team. After his graduation

in 1932 he proceeded abroad for post-graduate studies in London, Vienna and Dublin. He took the licentiate in midwifery from the Rotunda Hospital and had a special interest in obstetrics.

Dr. Fraser began general practice in England in 1934 but enlisted on the outbreak of World War II. He spent the next five years in Ethiopia and Africa. When the war was over he re-entered general practice in England before returning to his native province in 1948.



Shown is Halifax physician Dr. F. Murray Fraser receiving Senior Membership in The Canadian Medical Association. Dr. Ken Wylie of Winnipeg performs the ceremony.

Over the past 28 years Murray Fraser has contributed much to his community, to his university and to his profession. He has served innumerable citizen groups and professional bodies. He is a past president of the Halifax Y.M.C.A. He was a member of the Board of Governors of Dalhousie from 1956 to 1962. He is past president of the Dalhousie Medical Alumni Association and in 1973 that association named him "Alumnus of the Year". He has been national president of the College of Family Physicians and for his contribution and widespread reputation in the practice of family medicine that college conferred upon him an honorary fellowship in 1969 and in 1973 named him "Physician of the Year" for Canada.

In acknowledgement of his services to Dalhousie University, to Halifax and to the medical profession, the university conferred on him the degree of Doctor of Laws (honoris causa) in 1974.

Dr. Fraser well deserves the honour of Senior Membership of the Canadian Medical Association.

Slippery conditions will be with us off and on for the next few months, and the smart driver is prepared for them. Please remember that bridges, shady areas and large culverts can be slippery even when the rest of the road is bare.

OBITUARIES

Dr. H. Benge Atlee, (87) of Halifax died on November 5, 1978 at home. Born in Pictou County, he graduated from Dalhousie Medical School in 1911, at the age of 21, the youngest in the history of the school. After further study in London and service in the First World War, he returned to Halifax where, shortly afterwards, he was appointed Head of the newly formed Department of Obstetrics and Gynecology at Dalhousie Medical School. He held this position until he retired in 1958. He is survived by two sisters to whom we extend our sympathy.

Dr. H. A. Creighton (83) of Lunenburg died on October 27, 1978. Born in Halifax, he served in the First World War. He graduated from Dalhousie University in 1924 and then spent four years of postgraduate study in Great Britain. He practised in Lunenburg until his retirement in 1972. To his wife and family the Society offers sincere sympathy.

Dr. R. V. Rao (47) of Halifax died on October 25, 1978, following a car accident. Born in Eluru, India, he graduated in medicine in 1957 and after practising in India and the United Kingdom, he came to Canada in 1969. He has practised in Nova Scotia since that time. Our sympathy is extended to his wife and family.

Dr. K. C. Mathur (45) died in New Glasgow on October 25, 1978. Born in India, he received his medical training in India, England and Canada. He came to New Glasgow in 1965 and was head of the Department of Anaesthesia at Aberdeen Hospital. He is survived by his wife and family. The Society extends our sincere sympathy. □

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NOVA SCOTIA DIVISION OF THE CANADIAN MEDICAL ASSOCIATION

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