

THE NOVA SCOTIA MEDICAL BULLETIN

EDITORIAL BOARD

Acting Editor-In-Chief

DR. J. F. O'CONNOR

Associate Editor

DR. A. C. IRWIN

Dr. A. J. Buhr
Dr. P. C. Gordon
Dr. S. M. A. Naqvi
Dr. J. A. R. Tibbles
Dr. J. P. Welch
Dr. W. Putnam
Dr. T. J. Murray

Managing Editor

MR. D. D. PEACOCKE

Editorial Assistant

MRS. T. CLAHANE

The Physician's Self-Image

"He had the callousness common to doctors, for whom the suffering of others count as so much new experience, or profit, or professional advantage, men to whose fortunes death and pain are frequent ministers."

Do you recognize yourself? It would be the rare physician that would allow himself to be described in such a manner. Yet the writer of the above, Roger Martin DuGard received a Nobel Prize in 1937, some critics believing the prize deserved because of the honesty and integrity of his social viewpoint. Our vision of ourselves, as physicians, has never been the same as our society, who use our talents with, more or less, reluctance.

The picture that all too many physicians have of themselves as dedicated, overworked, underpaid professionals is not borne out in the press. The proceedings of the recent council of The Medical Society of Nova Scotia published in this journal, show physicians relating to many of the broader aspects of our profession. Unfortunately discussions about fee negotiations seem to be what capture the media attention.

Dr. Steven Levinson, a prominent medical commentator on CBC was recently quoted as saying, "If doctors were less paranoid about being misrepresented, and made more of an effort to initiate contact and treat the press positively, they would see a shift in their public image". Perhaps though, before considering our public image it would be useful to take a second look at our own self-image for, if we are not viewing ourselves correctly, we certainly cannot present ourselves adequately to the public. If we do not understand ourselves adequately, it is no wonder our public relations as a group is so poor. With our individual patients telling us how wonderful we are, it is always a surprise when that patient's political representative will not agree to our "reasonable fee" or request for facilities.

HOW WE SEE OURSELVES

Overworked, underpaid, unappreciated, all seem common terms doctors apply to themselves.

Overworked

We began our feelings of being overworked in medical school where the study load was often endless and where we learned that postponement of gratification demonstrated our maturity. Then, all too often, we made this postponement of gratification a way of life as everything in medicine took precedence over family and self-interest. Many of us brought into medical school a "need to be needed" that treating patients fulfilled nicely. But for many of us, that was not enough and we discovered meetings — another place to affirm ourselves as people. In a recent address, Dr. Lewis Bird, speaking on healthy life styles and physicians, suggested "attending numerous meetings is a reflection of low self-esteem", a thought that should cause many of us to look again at our self-image. No matter how often we project ourselves as overworked, whether true or not, it is a poor public relations ploy.

Under Paid

This complaint seems to be more common and hold more truth with every fee negotiation. Government refuses to see us as small businessmen with overhead, a short working life, and a need for pension and vacation. But how do we see ourselves? The economics of medicine and of running a business, not to mention tax planning, investments and budgeting, are hardly mentioned in the medical curriculum. The graduating doctor does not see himself as a negotiator for a fee or even a planner in resource allocation. In fact, many physicians almost consciously refuse to get mixed up in the "financial stuff" of their practice or department. They fail to see that only by handling the economy of medicine can they achieve any quality care in this society.

Until we see ourselves as businessmen and responsible financial people, with a need to understand economic planning, it is no wonder that government does not see us in that light either. Once again, our own self-image has frustrated our goals.

Unappreciated

The media really must take some responsibility in this area. Somehow, the public has come to believe in sexuality without consequences, painless delivery of babies, venereal disease that can be cured, technology that always is beneficial, and preventive medicine as cheap.

Dr. Barbara Law, former Chairman of the National Association of Family Planning in Great Britain, drew the attention of practitioners to the fact of the changing expectations of patients in a recent lecture in Halifax. "Once the patient was grateful for any contraceptive help we might offer", but this is no longer so. "When limitations of present contraceptive methods are explained, a reaction of anger and disappointment is not unusual", she stated.

Did society learn from physicians that we could prevent pregnancy and that sexually-transmitted diseases were "handled easily"? While we may handle individual cases well, on a societal level it is just not true. Was it our own image that allowed successes to be portrayed while our limitations were not stressed? Of course thinking positively about our current treatment helps, but soaring rates of sexually-transmitted disease, large numbers of abortions, and inability to handle teenage mothers must be admitted.

Even in death, we often do not meet our patient's expectations. Dying patients are still dealt with poorly by many of us, and studies show that physicians and health care personnel have a greater than average fear of death. This lack of understanding of ourselves and our own limitations, if faced, may allow us to see ourselves as others see us and give a very essential viewpoint for our own mental health.

Dr. S. C. Beering, in an article in this issue, urges us to look at our medical education again in "Medical Education in Ferment". He points out there are fewer young physicians interested in careers as medical scientists. Somehow, we are failing to create in the new physicians a self-image that has within its bounds a professional who is based in the scientific method. The division between "providers of care" and scientific researchers is an artificial one. Unfortunately, the general practitioner has often not been seen as a person very interested in research, but the facts are that large numbers of primary care physicians in this province have shown interest in participating in research, even though only as part of group

projects. Studies such as Dr. Michael Hebb's Fetal Risk Project demonstrated that involvement in such projects was one of the best means of educating the general physician toward better quality care. With proper organization and funding, research on a very basic level could be shown to be a very real part of most doctors' practices.

If the majority of the profession does not see itself (self-image) at least interested in some "scientific" endeavour, how then can we expect the public and government to see it as worthwhile?

Is it possible to create this perfect individual that sees himself as a scientist, economist and caring physician? It is certainly expected of us by society and hopefully by having a correct self-image of ourselves, we may just come close to their expectations.

J.F.O'C

ENVIRONMENTAL HAZARDS

This issue of the *Bulletin* includes two articles dealing with environmental hazards, which had been scheduled for publication in the October issue but which were not completed in time. Before he left on his sabbatical leave, our Editor-in-Chief commented on each article as follows:

"It is almost a century since Pierre Curie discovered a large burn on his chest on the site where he had been carrying radium in his pocket. Since then, although both radium and radon gas have been used therapeutically, the danger to which workers in uranium mines are exposed has been well documented. In publishing a summary of their Brief to Judge R. J. McCleave, Dr. D. C. Brown and his Committee have reviewed the evidence carefully and have clearly exposed the dangers of uranium mining and the sludge-like tailings which could tarnish wide areas of Nova Scotia.

Although this article is careful to point out that the exploration for uranium is not hazardous, one wonders what is the object of discovering this horde of treasure, if there are no satisfactory methods of containing those menacing tailings and of preventing the widespread poisoning of the land.

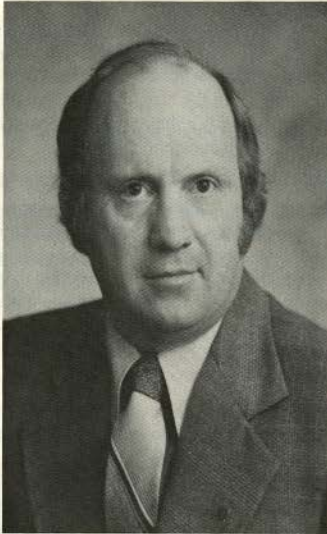
We are pleased to publish an article by Mr. D. W. Freer, Technical Advisor for the Atlantic Vegetation Management Association. His topical update brings a new perspective to the use of powerful herbicides, and he contests the opinions previously expressed by Dr. W. H. Thurlow on this subject. Further discussion is welcomed on this controversy".

INTERNATIONAL HEALTH DAY CONFERENCE

An article by Dr. John Hamilton entitled *Learning About Nutrition in Nigeria* appears on page 142 in this issue of the *Bulletin*. Dr. Hamilton is the keynote speaker for the International Health Day Conference being held on Saturday, January 15, 1983 at the Sir Charles Tupper Medical Building, Dalhousie University. For more information please turn to the outside back cover. □

Dr. E. V. Rafuse
PRESIDENT

The Medical Society of Nova Scotia
1982-1983



Dr. E. (Ed) V. Rafuse may only have been an officer of The Medical Society of Nova Scotia for one year, but his wealth of CMA and Halifax Medical Society experience eminently suits him for the 1982-83 presidency.

A native son of Berwick and an Annapolis Valley boy right through to his 1956 B.Sc. graduation from Acadia, Ed Rafuse acquired his M.D. in 1961 from the Dalhousie School of Medicine and then practised family medicine in Neil's Harbour until 1964.

From there it was four years of ophthalmology at the University of Toronto. He then established his specialty practice in Halifax in 1968.

Dr. Rafuse says his family has no medical history and, apart from 21-year-old Beth who is studying physiotherapy at Dalhousie, he does not appear to have started one. His two boys — Paul, 23, and Vic, 19 — are at the University of Alberta and Acadia University, respectively. His wife Barbara runs the family.

Ed spent three years on the CMA's board of directors and a subsequent three years as board chairman. He is also a past president of the Halifax Medical Society and a former council member of the Canadian Ophthalmology Society.

His hobbies take him out of the field of medicine entirely and quite literally involve *not* having both feet firmly planted on the ground. He is both a sailing enthusiast and a flying buff, with a recent leaning toward experimental aircraft of the ultra-light variety. In his rare more tranquil moments, he still likes to pursue a long-standing interest in antique cars.

Tranquility, of course, is not one of the fringe benefits associated with the presidency but Dr. Rafuse's "hands-on" experience promises to lend itself to steadiness of purpose. □

ANNOUNCEMENT

Current Topics
In Community Health

A new series entitled, "Current Topics in Community Health" will commence with the next issue of *The Nova Scotia Medical Bulletin* as a service of the Department of Preventive Medicine, Dalhousie University.

The purpose of the series will be to bring to the attention of practising physicians in Nova Scotia, trends and issues in the broad area of Community Health as these affect the Maritimes and elsewhere. The format will consist primarily of brief summary reports.

Many of the items will be extracted from disease surveillance bulletins that may not normally come to the attention of practising physicians, and from time to time there will be short review articles on special topics and notes on epidemiology methods. An effort will be made to solicit items of interest from the readership, especially from the public health community. All such contributions will be fully acknowledged.

Editor of the series will be Dr. Frank White, Head, Department of Preventive Medicine, Dalhousie University (5849 University Avenue, Clinical Research Centre, Halifax, B3H 4H7). Contributions and suggestions are welcome at any time.

Join the majority-
Be a non-smoker



National Non-Smoking Week
Jan. 23-29, 1983

Medical Education In Ferment*

Steven C. Beering, ** M.D.,

Indianapolis, Indiana

It is useful every so often to question what we are doing in medical school. Are we still relevant?

Let me set the scene by considering medical scholarship in a somewhat broader context. I shall begin by talking about research, then about the delivery of health care and finally the Medical School curriculum. I think you will agree that we really cannot isolate the curriculum from the concerns of creative scholarship and the patient.

Last year the University of Maryland published a comprehensive report on the issues facing the modern state university in the 1980s. This report was the result of a two-year study under the chairmanship of the late Dr. Malcolm Moos, one of the most able and experienced educators of our time. Dr. Moos, in his report, began by reminding us that Thomas Jefferson, who wrote the Charter of the University of Virginia in 1818, defined his new state university as, "An institution in which every branch of knowledge useful at this day is to be taught in its highest degree."

It was not until 1862 that the United States came around to the Jeffersonian philosophy that was expressed so pithily in that Charter of the University of Virginia. In 1862, the Morrill Act was authorized nationally and it provided for the establishment of land grant universities in every State of the Union. This piece of legislation truly revolutionized American higher education. At that time nearly all universities were private, and were built on the European model teaching Hebrew, Latin and theology, and admitting only the sons of the aristocracy. Like their European counterparts, they were gentlemen's schools. It was revolutionary to suggest that higher education be useful, open not just to men but also to women and to the offspring of the common man!

Subjects like science, engineering, agriculture and economics were not taught until the Morrill Act began to be implemented. First, this made possible the liberal and practical education of students in the "several pursuits and professions of life." Secondly, it advocated changing the instruction in higher education from lectures to demonstrations, discussions, experiments, and even laboratory and practical experiences. Research by the students and the faculty would become a natural extension of this development. The third, and perhaps most important contribution, is that it became a statutory fact that in the U.S.A. we would seek to have higher education for the daughters and the sons of everybody.

What then are the university activities, to use Jefferson's term, "useful at this day"? I would submit to you that the most distinguished institutions of the over 3,000 U.S. universities are in fact research universities.

*Phi Rho Lecture delivered to Dalhousie Faculty and students on September 23, 1982.

**Dean of the Faculty of Medicine, Indiana University, Indiana, U.S.A. and President of the American Association of Medical Colleges.

There is one other very important distinguishing characteristic of major American universities; almost all of them have a medical center. That means then that the most significant universities of the U.S.A. not only admit men and women from all classes but they perform research, conduct medical teaching and deliver medical services.

One hundred years ago the medical schools of our country used public hospitals — asylums for the insane and alms houses — for the purpose of instructing future physicians. A good many students received their clinical experience from proprietary preceptors. Anyone who wished to be a truly proficient doctor, however, would have to leave America. He would go to Europe to centers in Edinburgh, London, Berlin, Vienna and Paris in order to be exposed to hospital-based, university-related medical education.

In 1889 the Johns Hopkins Medical Institutions were founded. That was the first time in the U.S.A. that a college degree was required for admission to the study of medicine. Soon Harvard and Western Reserve University followed suit. In 1903, when Indiana University School of Medicine was founded, it became the fourth institution to require a college degree for admission to medical school.

Today, every medical school in the United States and Canada — 144 in all — requires college preparation for admission. In due course we added postgraduate hospital-based residency education which included not only highly intense patient-care requirements but basic and applied research experience under the supervision of the faculty.

Medical education like general education implies discipline. It is not just vocational training any more. It means an orderly approach to the great concepts of western civilization and the body of medical knowledge we have accumulated. Every student of medicine must have an appreciation of the history of medicine, learning what has gone before, what is known now and what may yet be uncovered. Good education, whether it is in the classics or in medicine, allows us to master our thoughts so as to materialize our ideas and to make forward progress. The best way to get new ideas is to ask questions and the systematic inquiry to find answers, we call research.

There are many problems facing us today and they have a direct impact on what we do with the four years of the medical curriculum. Let me cite seven challenges:

1. There are less and less young physicians interested in careers as biomedical scientists.
2. The U.S. as a whole has de-emphasized the priority for scientific investigation and has reduced available funding for research.
3. The environment for scholarly and creative work is deteriorating; the laboratories and equipment are aging rapidly.

4. New knowledge has led to new technology which is quite expensive.
5. The new technology has led to communication capabilities which make current libraries and research support systems obsolete.
6. West Germany and Japan are rapidly assuming leadership in science and technology.
7. The world economy has led to widespread reduction in funding of education, research and service.

Given such challenges, there are a number of possible prospects for the future.

1. I believe that the academic community — it is not just the medical school — must reassert the Jeffersonian principle of pursuing knowledge “useful at this day.”
2. We must persuade the public officials at all levels — state, regional and national — our students, alumni and our patients, that creative scholarship is, in the final analysis, the only way to safeguard the future of our civilization. If we remain content to rest on what we know now and the skills we have today, we are surely doomed to returning to vocational training in place of professional education.
3. We must recruit financial support from the private sector. The days of federal support are numbered.
4. We must foster relationships with business and industry.
5. We must seek interdisciplinary collaboration within the school, the university, among universities, among states and between nations. We must explore joint ventures with hospitals and other schools.

A very important partner in the support of medical education and creative scholarship is the community hospital. They are eager to work with us, not just in the education of the second- and fourth-year students but also in residency education, product development and research. They are willing to provide space, capitalize some very expensive equipment and provide funding for joint projects.

Research then is the difference between university education and vocational training; it is the very cornerstone of creative scholarship.

Now let me turn from the bench to the bedside. In America the modern teaching hospital is also a creature of the 19th century. It began for the purpose of creating a charity institution for the sick poor in Boston with the founding of the Massachusetts General Hospital in 1810. In the early 1800s, anyone who could afford to become ill was cared for at home. The Massachusetts General was so successful, however, and its early alliance with the Harvard Medical School was such a signal event, that the overseers of Harvard and the trustees of the hospital early on provided for a few private rooms. The few private rooms grew and grew so that today, it is one of the three largest medical institutions in North America. The history of hospitals is a fascinating one because all hospitals started like the Massachusetts General. They were charity institutions, alms houses, orphanages, reformatories and places where sick people could be segregated. The first hospital in Indiana was built in Indianapolis in 1854 on the site of the city dump. It was the opinion of the city fathers that the sick poor of this city should be kept safely apart from where healthy people lived and worked.

The next phase of hospital development came in the early 1900s when we established chronic disease hospitals: hospitals for mental illnesses, tuberculosis, polio, and so on. Then in the 1930s and 1940s it became fashionable to have a hospital in each county. As a result, we now have over 7,000 hospitals in America of which all but about 400 are tiny hospitals ranging in size from 15 to 75 beds.

In the 1940s and 1950s we developed larger community hospitals and a while later we began to build university hospitals. Naturally we felt that the student should have his clinical education on the premises of the university hospital under the watchful eye of the full-time faculty. Fortunately, the Senior Elective Program provides opportunities for continued learning at the community hospitals.

Then in the 1960s we had another new development, namely the appearance of HMOs, clinics, ambulatory centers and investor-owned proprietary hospitals. Perhaps we ought to look at our curriculum and reevaluate whether or not the student should have an exposure to those new kinds of practice patterns.

The university hospitals are in the distinct minority of those 7,000 hospitals. In fact, there are only 63 like them. Less than half of the medical schools of the U.S. have their own university hospital. When medical faculty think about hospitals, we think about our kind of hospital — large and sophisticated. Yet only two percent of America's hospitals are 500 beds in size or larger. Again, one wonders if we are doing the right thing by exposing our students predominantly to the two percent.

Our primary mission in an academic medical center, regardless of how involved we are in creative scholarship, is still to care for the sick and injured, and particularly to provide complex tertiary care.

There are currently some 400 hospitals in the Council of Teaching Hospitals of the AAMC. While these hospitals represent only a small fraction of all hospitals in the United States, this is where a good bit of the action is. For example, the Council of Teaching Hospital members:

- Admit 20% of all patients hospitalized in the United States;
- See 30% of all ambulatory patients;
- Provide 50% of all burn care;
- Perform 44% of all transplant services;
- Provide 40% of open heart surgeries; and
- Operate 35% of newborn intensive care units.

There are multiple other services and products which are of benefit to society but not separately costed:

- Education of 215,000 students in medicine, dentistry, nursing, pharmacy and allied health;
- Clinical training of 66,000 resident physicians and some 15,000 clinical fellows;
- Development of new technology;
- Provision of charity care; and
- Participation in applied and basic research.

The question then is how can we remain at the “cutting edge” of progress and at the same time share what we are doing with the students during their four years. It means that we have to assess where we are; that we have to plan for the

1990s and beyond; that we have to get our priorities in order; that we have to think about what it is we want to teach differently and what it is that we want to teach that is new.

We are constantly teaching about the scientific frontiers; what are we doing about the social frontiers? Are we teaching geriatrics in sufficient intensity? Are we aware of the fact that the students who start this year will probably treat mostly patients who are over 65 when they are ready for practice. Are we aware of the fact that we are not going to lick cancer in our time. There will be more patients, they will live longer, they will have more chronic and complex illness and among these a major one will be cancer. Even though during the past decade the incidence of heart and cerebrovascular disease has dropped by a remarkable figure, there is still going to be a significant number of patients with heart attacks and strokes. At the other end of the age spectrum, are we alerting our students to the problems of teenage alcoholism and pregnancy? Are we including these considerations as we review the curriculum in the clinical and basic science courses? Those are issues that tomorrow's doctors had better be keenly aware of if not as a physician in practice, then as citizens in their communities.

This makes us question then not only the curriculum but the programs of the Medical Center as a whole. What faculties, what staff, what facilities, what equipment do we need to be ready for the 1990s and the year 2000?

There is another important consideration. You and I are used to teaching our students with the sickest patients — those who are horizontal. I wonder if we are paying enough attention to the continuum of care, particular as patients grow older, and to the vertical patient who does not need to be hospitalized, who could have outpatient surgery, who can be followed in an office, a clinic, an affiliated small hospital or even at his home. Maybe we ought to reexamine the practice of making house calls.

There is currently much national discussion about the four years of undergraduate medical education. The AAMC and the AMA have agreed that we had better look at the curriculum again. There was remarkable consensus. Let me read you the preamble of the AMA report. It said: "The medical profession and those responsible for medical education should strengthen the general broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty." It was agreed that, "Medical schools are chartered for the unique purpose of educating students to become physicians and they (the schools) should not assume obligations that would significantly compromise this purpose." It was echoed by everyone that the first order of business for the medical school is to educate a physician — a broad general physician not a subspecialist — who is ready upon receipt of his M.D. to enter residency education.

We who are privileged to belong to the medical faculty should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize not only the diverse nature of disease but also to provide preventive medical care. Medical schools should provide a broad general education in both the basic and clinical sciences. The curriculum of a school should be designed to provide students with experience in clinical

medicine ranging from primary through tertiary care in a variety of both inpatient and outpatient settings.

The "Future Directions" document also states: "Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience to a more formal structure and improve faculty counseling."

Have we truly decided that it is all right to spend the whole last year just doing anything that comes to mind? Are there not some things that you cannot fit into the junior year, which is now 11 months, that ought to be required rotations for the benefit of the student.

As you contemplate the senior medical school year, please consider that the AMA House of Delegates resolved to recommend to return to the undifferentiated first post-graduate year or the so-called rotating internship. I do not know how popular that will be with the Residency Review Committees, the teaching hospitals or the faculties but this was probably the single strongest sentiment expressed at that AMA meeting about the "Future Directions" report.

Simultaneously, the AAMC is studying medical education on a much more ambitious and broad basis. "The General Professional Education of the Physician" project concerns the total education of the future physician — from college preparation through graduate medical education.

The Project Steering Committee has worked out some key assumptions addressing the medical school curriculum. It is felt that students should have the essential knowledge to understand normal and abnormal conditions in disease processes. The question is, how can the assimilation of biomedical science knowledge be reinforced, not just in the first 18 months but throughout the full four years, and set up a pattern of continued learning and reinforcement through a physician's life time.

Why is this important? It is important because the average life span, or the half-life of biomedical knowledge, is just about seven years. By the time today's freshmen finish an average residency, half of what they learned, if they remember it, is totally out of date. What can we do to strengthen retention of knowledge? What changes in the approach to graduate medical education would make it possible for greater involvement of the basic science faculty in the education of residents?

Another assumption which is important is this: "Study of the basic biomedical sciences provides the students with the essential concepts needed to incorporate new knowledge into their care of patients in the future."

The question is what methods can you and I as faculty employ to identify these essential concepts that will equip the students to assimilate new knowledge in the years after they graduate from medical school. How can we encourage students to conceptualize the application of science and its principles to medicine and discourage the excessive memorization of rote information?

Another assumption is that students acquire *essential* knowledge in the clinical disciplines. They learn these essentials in the clinical clerkships which are required now only during the junior year in 90+ percent of our medical schools, and they learn this haphazardly during that smorgasbord of the senior year electives.

The tough questions here are which disciplinary clerkships provide the greatest opportunities to learn essential knowledge and skills. Which disciplinary clerkships might be reduced or eliminated? Who of you would be willing to step forward and say, "My clerkship is not all that important. I'll give up a week or two so that something new can be brought into the curriculum." Another question is which discipline usually offered only as an elective should now be a required clerkship?

Another assumption in the AAMC study is that clinical clerkships are predominantly based in hospitals and furthermore, in the hospital's inpatient services. The questions are what deficits in essential knowledge may result from concentrating all of those clinical experiences in tertiary care complex patients who are horizontal. Why are clerkships in ambulatory settings so uncommon? What approaches might faculties use to increase student's opportunities to follow patients with chronic problems? Have we thought about this in a continuum?

Another question might be what disciplines or special areas receive insufficient emphasis in medical school? What methods might we use as a faculty to establish a criteria for their incorporation into college and medical school curriculum?

Last year our Education Committee was asked why we were not teaching more sex education, emergency medicine, nutrition and rehabilitation. This year we are asking what to do about world population, world hunger, hazardous wastes and the issue of nuclear warfare and its consequences. What about humanism in medicine, geriatrics, alcoholism and

substance abuse? What about the economics of medicine? Why is it that medical care costs so much and we as a nation have decided that 10 percent of the GNP is all we can afford?

Here is another important one from the GPEP study assumptions. All faculties believe that physicians should be skillful in assessing medical literature and that this fundamental skill must be developed by students. What do we do to help our students sort out the morass of medical literature? In the future physicians increasingly will have available sophisticated electronic devices — computers, telecommunication tools and so on. What are we doing as a faculty to become skilled and literate in these devices and secondarily teach our students?

Let me suggest to you "that there is nothing more difficult to take in hand, more perilous to conduct or more uncertain in its success than to take the lead in the introduction of a new order of things." That was written in 1513, not by a physician but by a statesman named Nicolo Machiavelli. Nothing is more difficult than to change the old order and start anew, to revise that with which we are comfortable and to update the way we are doing things.

There is one overarching priority to all these concerns, assumptions and challenges and that is that you and I must set an example for the young physician to continue a lifelong study for the purpose of taking care of his neighbor. The patient must be central in our concern. All the other things are merely ancillary support systems to allow us to educate the next generation who will take our place in the long white line to minister to our fellow man with our special knowledge and skills. □

MEDICAL SOCIETY INSURANCE PROGRAM

Level Term Life Coverage

(Maximum Available — \$300,000.00)

Age	Annual Premium Per \$25,000	Special Student Rate For one \$25,000 unit
Under 31	\$ 45.00	
31-35	\$ 55.20	
36-40	\$ 62.40	
41-45	\$ 98.04	Under 31 — \$30.00
46-50	\$126.96	31 & Over — \$35.40
51-55	\$199.68	
56-60	\$272.04	
61-75	\$421.92	

(Additional units available
at regular rates)

LONG TERM DISABILITY, PHYSICIANS OFFICE EXPENSE AND ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE AVAILABLE THROUGH THE ONTARIO MEDICAL ASSOCIATION.

SHOULD YOU WISH INSURANCE COUNSELLING PLEASE CALL MR. SCHELLINCK AT THE MEDICAL SOCIETY OF NOVA SCOTIA OFFICE 453-0205.

Learning About Nutrition in Nigeria

John D. Hamilton, *M.D.,

Washington, D.C.

*"The student is to collect and evaluate facts.
The facts are locked up in the patient.
To the patient he must go".*

Abraham Flexner¹

INTRODUCTION

In his study of the state of medical education in North America, Abraham Flexner identified the fundamental importance of rooting medical education in the disciplines and methods of science. Students should go through the process of scientific research and discovery. For the study of clinical medicine the patient becomes, in a sense, a laboratory. The same principle applies to learning of medicine relevant to the community. To the community must the student go. The community becomes a laboratory.

In the new medical school at Ilorin in western Nigeria, this principle of going to the community is an important part of the educational philosophy. This article describes how it works in practice, using the study of nutrition as an example.

COMMUNITY DIAGNOSIS

My own interest in nutrition started 20 years ago in Zambia, looking after children admitted to St. Francis Hospital, Katete, suffering from marasmus or kwashiorkor, the manifestations of severe protein-calorie malnutrition. The children were all treated in hospital. It was only on one day at the end of my stay, when I arranged to examine every child in one remote village, that I came face to face with the volume of milder and unrecognised malnutrition and ill health of which hospital patients represented only a part. Pursued further, this study would have identified the mechanisms and beliefs and constraints that contributed to the problems. I would have been making a "community diagnosis".

MEDICAL EDUCATION

In 1978 I joined the new medical school in Ilorin. We were determined to train doctors to respond to the needs of the community and to do so at an academic standard on a par with schools elsewhere. We based some of the learning in a community, and integrated this with the learning of clinical sciences and basic sciences. We used clinical problems as a stimulus to learning basic mechanisms. Those familiar with the devotional literature of medical education will recognize that we were planning a "community-oriented, community-based, problem-based integrated curriculum." We felt a lot better once we knew that! I will describe how students learnt about protein-calorie malnutrition as an example of how this was done. First, I shall describe briefly the organization of the community experience.

*Formerly Professor of Medicine and Chairman, Curriculum Committee Faculty of Health Sciences University of Ilorin, Nigeria.

Present Address: Population, Health and Nutrition Department, World Bank, 1818 H Street, N.W., Washington, D.C. 20433, U.S.A.

COBES

COBES stands for "Community-based experience and service". Each year students live for one month in a community; ten students together with their supervisors. Their task is to learn about the community, make specific studies of health problems, provide health education and, supported by the staff, serve the community as far as they are able. In the classroom they learn basic skills and concepts in epidemiology, statistics, demography, cartography, parasitology, social sciences and health education. These they apply in the field. Each group prepares a report and presents it to the class as a whole for discussion. Evaluation is based on individual assessment of contributions to teamwork in the field, the group report and a written test based on class and field learning. Problems studied in the field are used as models for classroom learning of basic sciences.

The experience starts in the early months of medical school, before students have any formal training in clinical skills and before they have learnt that inquisitorial technique that we call "taking of a history". Students relish the contact with the community, where they build warm relationships with the community, with their supervisors, and with each other. They learn to work in a team. They appreciate the relevance to their future role of studies in the classroom.

NUTRITION AS A PROBLEM TO STUDY

Although nutrition was a topic identified ahead of time for the second posting, the students in my own group came to their own decision on the matter as a result of experience in their first posting. We were working in Okelele, a district at the edge of Ilorin town. As in most parts of the town, the community has a strong social structure with local leaders, but the physical development has been haphazard. Buildings, mud walled, are crowded. There are no latrines or drains. Water supply has been poor ever since the mains were dug up during road widening. In the rainy season puddles and pits dug out for building clay provide a ready water supply and a fine site for mosquitoes to breed in. There are many children, and most attend a few years of primary school or a Koranic school, for this is a Moslem area. Many do not get to go to school age for infant mortality is high.

Despite these problems, the general atmosphere as you walk about is buoyant and cheerful. But if you go indoors you will find children too weak to join the play. It was during a map making exercise for a demographic survey in their first posting that the students discovered one such child — and then another. Their mothers were anxious and concerned and not sure what to do. Although we took the children to the clinic, we knew that a proper nutrition rehabilitation program was only available in the center of town, and this was too far for regular attendance.

These children triggered the students' concern to explore the problem in detail. Two issues arose. The first was the

degree to which other children might also be malnourished. If this turned out to be a common problem (so belying the impression gained by a casual glance around the play areas), then the second issue was how best to solve the problem. The group decided to address both issues in their next posting and it was agreed that a study of nutrition should be a task for all student groups. They were to study the incidence and severity of protein-calorie malnutrition, and also biochemical principles involved and antecedent causes, with a view to designing a plan to deal with the problem.

The main event in preparation for the study was a half-day seminar on malnutrition. This was preceded by lectures on carbohydrate, fats and protein and intermediary metabolism relevant to nutrition — part of an introductory course in biochemistry. Readings were distributed on growth curves and their use in monitoring nutrition.²

A CLASSROOM SEMINAR ON MALNUTRITION

Four children with marasmus were brought from the nutrition clinic, together with their mother or grandmother. Students were grouped and asked to note down abnormalities using their experience of children at home and in their study community. They were to obtain from the mothers the story of the child's life and feeding. They did not know, and we did not say that they were doing a "history and physical" but this is what they were doing. A member of the staff guided the students and we did our best not to "teach on the case". The class then turned to a general discussions organized to explore the following themes:

a) Clinical Signs — in simple descriptive term the students identified virtually all the signs — thin muscles, reduced skin fat, brittle hair, weak muscles, weak cough, apathy. These were written on the left hand side of the blackboard.

b) Biochemical Basis of Clinical Signs — a biochemist revised the basic principles of intermediary metabolism relevant to protein-calorie malnutrition. From this students derived biochemical and physiological explanations for each of the clinical signs on the blackboard and these were written on the right hand side. Discussion was drawn out to establish linkages. Such a linkage is that between protein deprivation, weak muscles, weak cough, and risk from respiratory infection.

c) Antecedent Causes of Malnutrition — from these four cases, most of the recognized causes could be identified, such as insufficient breast milk, late and insufficient weaning food, twinning, close birth interval, recurrent diarrhea, measles, rejection of an illegitimate child, death of a mother. The only cause missing was overt shortage of food in the family. To link these causes to basic mechanisms brief explanations were given of the effect of infection on protein and calorie balance and changing calorie requirements with age. Students had studied water sources in the first postings and were able to add additional examples of social and environmental factors involved.

d) Definition of Normal — general principles were revised in preparation for the use of percentiles in growth curves.

e) Growth Curves — background reading was discussed and examples of different growth patterns were presented in

preparation for the interpretation of growth charts in the field, both for single and for sequential measurements.

f) Interventions — the nurse in charge of the nutrition clinic outlined their practice in nutrition supplementation and education, and she showed photographs of children demonstrating recovery. Anecdotes about them and her own experiences as a mother complemented the observations of the students.

g) Evaluation and Reinforcement — each student submitted an account of selected topics from the seminar and these were annotated for feedback. The end of session test included one problem based upon the interpretation of a growth curve.

FIELD STUDIES

In the second COBES posting, each student group was required to undertake a study relating to nutrition. They worked out details with their supervisors:

a) In Okelele, every child under five (140 in all) was weighed and mid-arm circumference was measured. Students discovered the difficulties of identifying age, even using a local events calendar. They also recognized the need for strict accuracy in map making for a survey. They were startled to find over 40% of children to be below third percentile for weight on a scale constructed for a population of similar ethnic background at Imesi, Nigeria. The finding was supported by low values for mid-arm circumference. The problem of malnutrition was serious and extensive, and it warranted an intervention that covered the entire population.

b) In the remote area of Northern Borgu, in the bend of the Niger River, a preliminary study during the first posting enabled students to study seasonal change. The first posting had been after the harvests and the second posting was before the harvest at the end of the hungry season. Communities with access to markets showed little change. But those remote from markets showed deterioration and this was most marked among semi-nomadic Fulani families whose cattle had migrated in search of pasture, so depriving them of milk.

c) In Mopa, a fairly prosperous market town, a different study was done. Food prices were assessed in the market and weekly food use assessed by discussion with housewives. Seasonal change in prices and food choices in poverty were noted.

Formal presentation and discussion of these three studies shared experiences among the whole class.

FOLLOW-UP

With respect to completeness of curriculum, of course these studies of protein-calorie malnutrition leave many topics of nutrition untouched. These other topics, including vitamins and minerals, are explored in later parts of the curriculum, linked with an appropriate body system.

As far as the objectives of COBES are concerned, the studies do not of themselves, allow students to achieve their objective of serving the community other than by referral or provision of care for intercurrent illness. A more substantial response to the problem has been possible in Okelele which is within reach of the medical school. The Department of Child Health has set up a nutrition clinic in cooperation with

the local government. It concentrates on case finding, home visits, early intervention combined with routine child care, and above all on education. For both faculty and students it has become a community laboratory. For students it will provide a continuing experience during their clinical years, as they learn to organize health programs for the whole community. For the faculty it provides the opportunity to study the factors that influence health and disease. It is encouraging that education is proving to be as effective as providing food. We began with Flexner, so why not end with him?

"... the physician's function is fast becoming social and preventive, rather than individual and curative. Upon him society relies to ascertain, and through measures essentially educational to enforce, the conditions that prevent disease and make for physical and moral wellbeing."

ACKNOWLEDGEMENTS

Faculty members of all disciplines contributed to the community based experience. The founding Dean, Prof. Eldryd Parry, and his successor, Prof. Adeoye Adeniyi initiated and sustained the program. The main players were the students and the people in the community.

References

1. Flexner A. Medical education in the United States and Canada. New York, The Carnegie Foundation, 1910.
2. Morley D. Paediatric Priorities in the Developing World, London, Butterworth.

C REALTY LTD.

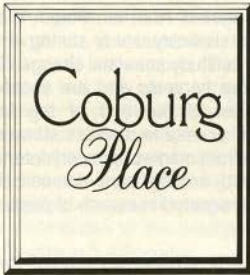
MEMBER: Nova Scotia Real Estate Assoc.

V. F. Clahane

PRESIDENT

BUS: 423-3002

HALIFAX, N.S. RES: 477-5706



Professional Centre

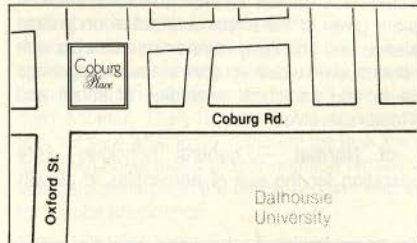
Prestige professional office space available.

- Ideal South end location
- Close to hospitals and universities
- On site parking for clients
- Adjacent to 120 condominium units
- Convenient banking facilities
- Easy access by city transit

For information and viewing call:

J.R. Adams, Administration Officer
 ATC PROPERTIES LIMITED
 1741 Barrington St.
 P.O. Box 2224
 Halifax, N.S.
 B3J 3C4

(902) 422-1701



Brief on the Health Effects of Uranium Exploration and Mining in Nova Scotia

Presented to Judge R. J. McCleave, Commissioner,

Uranium Inquiry — Nova Scotia, on July 16, 1982,

by The Community Health Committee of The Medical Society of Nova Scotia.*

The Medical Society of Nova Scotia's brief to the uranium inquiry is presented, together with its five recommendations. In order to add clarity and understanding for the reader, more background information has been added in the form of excerpts from the Valley Medical Society's brief to the inquiry.

The beginning of exploration for uranium in Nova Scotia aroused concern in many persons about the health consequences to Nova Scotians not only from the exploration itself but also from any mining and milling operations that might be expected to follow from the discovery of economically viable deposits. The Community Health Committee of the Medical Society of Nova Scotia spent more than a year studying this issue. On July 16, 1982, we presented a brief to Judge R. J. McCleave, Commissioner, Uranium Inquiry — Nova Scotia. In it we recommended, in accordance with a resolution passed at the Council Meeting of the Society on November 1, 1981, that "no mining or exploratory drilling proceed until technology has been developed to adequately and acceptably contain [any resultant] contamination".¹ What follows is a brief summary of the information that led to that recommendation.

As found in nature, uranium is normally at, or near, equilibrium with its decay products which include the inert gas radon. Because radon diffuses from the rock into open areas in mines, most underground miners are exposed to concentrations in excess of those found above ground. The range of atmospheric radon concentrations in mines varies widely from 10^{-3} picocuries per millilitre (pCi/ml) in potash mines to 30 pCi/ml in some poorly ventilated mines.

When pure radon is breathed, it diffuses throughout the body and gives what is essentially whole-body radiation. Its retention, however, is limited since inhaled radon is also exhaled within its half-life of 3.8 days. For the immediate daughters of radon, however, the story is different. These radionuclides (^{218}Po , ^{214}Bi , ^{214}Pb , and ^{214}Po) collectively have an average half-life of about 50 minutes. When formed in the air of a mine, they quickly become attached to solid surfaces, most notably dust particles. When the latter with their attached radionuclides are inhaled, the radiation from them (largely alpha particles) is delivered to those sites in the nose, pharynx and tracheobronchial tree where the dust particles are deposited. The radiation dose of these elements delivered to the lungs of uranium miners is about 20 times greater than that from inhaled radon.

Measurements of radiation exposure and of the biologic effects on miners have been attempted repeatedly since about 1880. In 1962, Wagoner *et al.* reported a ten-fold excess of respiratory cancer among white miners who had worked underground for five or more years.² In 1971, ninety years after miners in the Erz Mountains of central Europe were observed to be dying of lung malignancy³, and thirty years after radioactivity in these mines was generally accepted as the cause of these lung cancer,⁴⁻⁵ thousands of American uranium miners were still working in environments where radon daughter concentrations were of such magnitude as to triple their probability of dying from lung cancer. Indeed, in the same year, MacMahon stated (as cited in Lundin) "The epidemic of lung cancer now in progress among American uranium miners could readily have been and, indeed was, predicted on the basis of past experience in other parts of the world".⁶

Other studies carried out on American uranium miners have shown that their risk of respiratory cancer is related to the magnitude of exposure to radon daughters.⁷⁻⁹ A similar excess risk, however, was not clearly demonstrated among either non-cigarette-smoking white uranium miners or among non-white uranium miners (mostly American Indians).⁷ Some publications report a loss of pulmonary function among uranium miners, but little attention has been paid to mortality from pulmonary insufficiency.¹⁰

An update of the earlier mortality studies carried out by Archer *et al.* now provides data for dealing with these three deficiencies.¹¹ They conducted an intensive follow-up on 3,366 white and 780 non-white workers, between the years 1950 to 1960, who had had one or more months of underground mining employment prior to January 1954. In many cases, detailed occupational and smoking histories were obtained by personal interview at the time of examination. These data were supplemented by an annual census of uranium miners from 1954 through 1969, cross-checked by alternate sources. The follow-up period was ten years for both groups.

Cumulative radon daughter exposure values were calculated for each miner from the date of his first mining job to each sequential month of observation through September 1969. These values were expressed as "working level months" (WLM), that is the cumulative product of length of underground exposure in working months (170 hours) and the concentration of radon daughters in "working levels" (WL) specific for the mine and calendar year. (One WL is equal to 1.3×10^5 MEV of potential alpha energy per litre of air). They followed up all the Indians and 98.2% of the whites and, using life-table methods, found a significant excess of respiratory cancer among both groups. Non-malignant respiratory deaths among whites are approaching cancer in importance as a cause of death, probably as a result of

*Chairman: — Donald C. Brown, B.Sc., M.D., C.C.F.P., F.C.F.P.

Members: — Ian Cappon, B.Sc., M.Sc., Ph.D., Wayne L. Phillips, B.Sc. (Hons.), M.D., Allan Pysemansky, M.D., F.R.C.P.(C), John Savage, M.B., B.Ch., (Q.U.B.), Barry Wheeler, M.B., B.Sc., D.R.C.O.G., C. Noel Williams, M.D., F.R.C.P.(C), F.A.C.P.

diffuse parenchymal radiation damage. The exposure-response curves for non-smokers are linear for both respiratory cancer and other respiratory diseases.

At the Bates Royal Commission into uranium mining in British Columbia, Wagoner in 1980 presented a summary of work carried out in the U.S. which showed that the risk of lung cancer has increased with the passage of time, indicating that the induction-latent period may be longer than other studies to date have accounted for.¹² Thus, the rate of lung cancer amongst uranium miners compared with the normal population can be expected, in time, to be greater than currently reported in the literature.

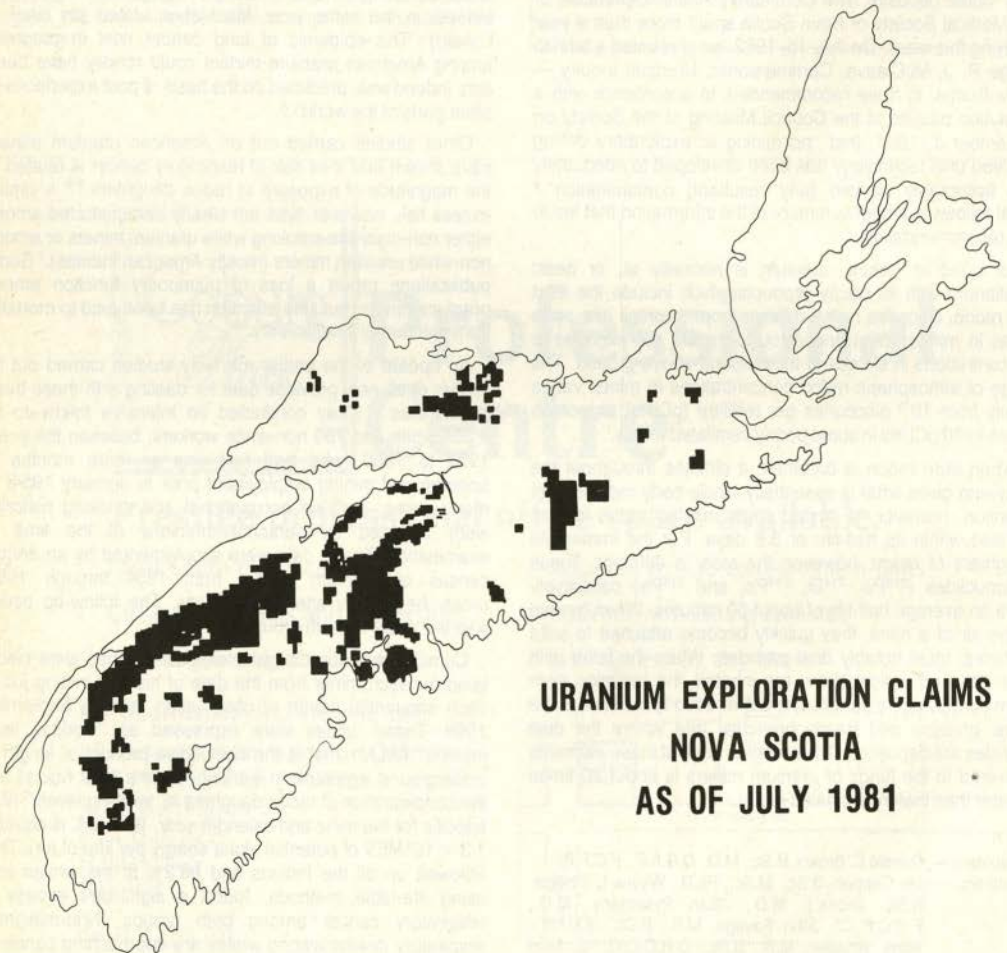
However, miners are not the only people affected by uranium production. Uranium mining, where purified uranium is extracted from ore, exposes the mill workers to much the same occupational hazards as miners encounter and, in addition, poses health problems for the general public. The most important known source of this danger is the "tailings" — a liquid/solid slurry, containing virtually all wastes from the

operation. In general, for each ton of ore removed, only 2 to 4 pounds of uranium are obtained, so that the tailings nearly equal the original ore in mass but, because of the crushing and the addition of water, there is now a larger volume and surface area.

The tailings contain many radioactive elements that are associated with uranium but which are not commercially useful. This radioactivity will remain dangerous for over 100,000 years, and as yet no technology exists to prevent the waste in tailings ponds from contaminating the ground and surface water of the surrounding area.¹³ The most hazardous compound is radium, which is readily absorbed by algae, fish and other aquatic life. Each seven tons of uranium ore contain a gram of ²²⁶Ra; the recommended maximum allowable total-body content for humans is 0.1 micrograms.

As noted above, ²²⁶Ra disintegrates to form ²²²Rn. An air quality study in the mining communities of Elliott Lake and Bancroft, Ontario and in Uranium City, Saskatchewan, found that 15-30% of the houses had higher than permissible levels of ²²²Rn.

Figure 1



According to Torrie, who compiled tailings evidence given before the Bates Royal Commission: "The evidence clearly shows general agreement that the radioactive wastes from uranium mining can . . . [cause] both unacceptable environmental contamination and unacceptable worker and public health hazards".¹⁴

There are fears that the contamination of water and agricultural lands by low-level ionizing radiation from uranium mines and mills will cause, in addition to cancer, genetic damage and premature aging. Concerning the genetic effects of ionizing radiation, Dr. Frank Barnby said: "Over the centuries societies have come into a genetic equilibrium with the mutagenic agents, including natural background radiation, in their environment. To add radiation to the natural levels may be to upset the equilibrium . . . risking, to a quite unpredictable extent, further generations".¹⁵

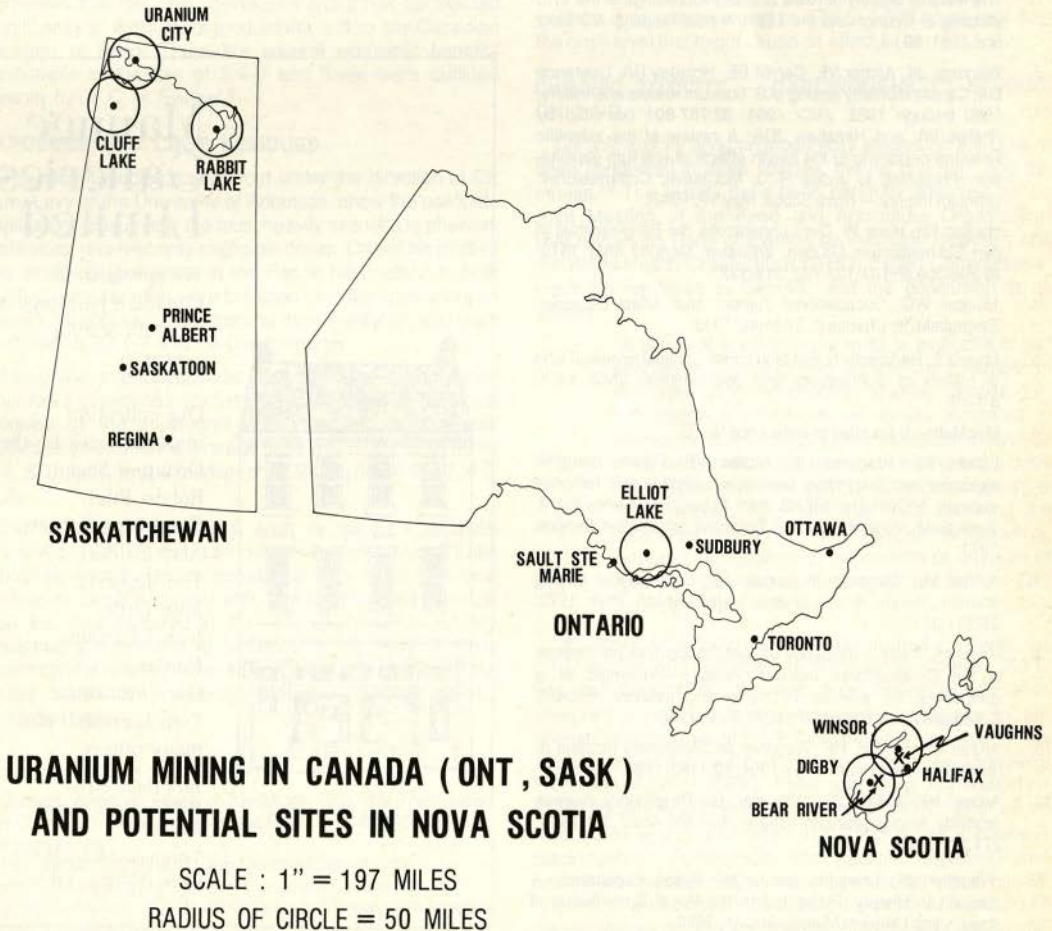
Differences in mortality of American radiologists, relative to other medical specialists "warrant the inference that occupational exposure to ionizing radiation on the part of physicians has in the past produced a non-specific life shortening effect", concluded Seltser and Sartwell.¹⁶

Matanoski *et al.* found that over a 50-year period, radiologists had an excess in all-cause mortality rates (even when cancer deaths were removed) compared with other specialists. They concluded that "the data are consistent with the concept of accelerated aging due to radiation".¹⁷ Bartell suggested that biological aging, whether natural or as a result of radiation, occurs as a result of a gradual accumulation of mild mutations.¹⁸

The potential risk to the Nova Scotia public is different from that in Saskatchewan and Ontario. Here, the areas of uranium exploration claims (and, consequently, possible mines and mills) are very close to major populations and major agricultural areas (Fig. 1). It is obvious from Figure 2 that most of the Nova Scotia population would be within 50 miles or uranium mining and milling operations, in contrast with the populations in the other two Provinces.

Since we presented our original recommendation at the 1981 Council Meeting, the Committee has received new information. For the purposes of discussion, we believe now that we should separate uranium exploration from mining and milling processes. It is our opinion that environmental

Figure 2



assessment studies about the effects of uranium exploration should be carried out and documented. We have not yet been assured that there are no risks to humans or to the environment as a result of exploration in Nova Scotia. We await accurate measurements (such as the two studies taking place at New Ross) of uranium and its products in wells, before and after exploratory holes are capped with concrete.

Nevertheless, we can recommend that with rigid safeguards, properly monitored and directed at safety, uranium exploration could be allowed to resume without exposing Nova Scotians to unnecessary health hazards. One safeguard would be for all exploratory drill holes to be filled with concrete and properly capped. We feel that the existing guidelines should be improved and established as regulations. New specific legislation should be established to provide the monitoring, inspection and exploration procedures necessary to protect the workers and the environment.

We maintain the belief that uranium mining would be an unacceptable health risk for Nova Scotia. □

References

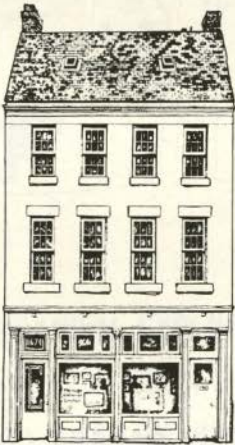
1. The Medical Society of Nova Scotia: Proceedings of the 17th Meeting of Council and the 128th Annual Meeting. *NS Med Bull* 1981; **60**:i-ii.
2. Wagoner JK, Archer VE, Carroll BE, Holaday DA, Lawrence DA; Cancer mortality among U.S. uranium miners and millers, 1950 through 1962. *JNCI* 1964; **32**:787-801 (as cited by Phillips WL and Henshaw JDA: A review of the scientific literature pertaining to the health effects of uranium exploitation. Presented to Judge R. J. McCleave, Commissioner, Uranium Inquiry — Nova Scotia, May 19, 1982).
3. Harting FH, Hess W: Der Lungenkrebs die Bergkrankheit in den Schneebergen Gruben. *Vrthjshsch Gerichtl Med* 1879; **30**:296-309 and **31**:102-132, 313-337.
4. Hueper WC: *Occupational Tumors and Allied Diseases*. Springfield, Ill: Charles C. Thomas, 1942.
5. Lorenz E; Radioactivity and lung cancer: critical review of lung in miners of Schneeberg and Joachimsthal. *JNCI* 1944; **5**:1-15.
6. MacMahon B (as cited in Reference No. 7).
7. Lundin FE, Wagoner JK, Archer VE: Radon daughter exposure and respiratory cancer: quantitative and temporal aspects. NIOSH and NIEHS Joint Monograph Series No. 1. Springfield, Virginia: National Technical Information Service, 1971.
8. Archer VE, Wagoner JK, Lundin FE: Lung cancer among uranium miners in the United States. *Health Phys* 1973; **25**:351-371.
9. Vesely K, Sada J: Incidence of specific occupational disease in the Czechoslovak uranium industry. Presented at a symposium for workers in the mining industry. Pribam, Czechoslovakia. Report NP18271:1-29, 1968.
10. Archer VE, Brinton, HP, Wagoner JK: Pulmonary function of uranium miners. *Health Phys* 1964; **10**:1183-1194.
11. Archer VE, Gillam JD, Wagoner JK: Respiratory disease mortality among uranium miners. *Ann NY Acad Sci* 1976; **271**:377-383.
12. Wagoner JK: Uranium, the United States Experience. A Lesson in History. Presented to the Royal Commission of Inquiry into Uranium Mining, January 1980.

13. Sequin H: Submission of the United Steelworkers of America and British Columbia Federation of Labour to the Royal Commission of Health and Environmental Protection — Uranium Mining, January 1980.
14. Torrie RD: Uranium mine tailings — what the record shows. A review of evidence presented to the B.C. Royal Commission.
15. Barnaby F: The controversy over low-level radiation. *Ambio* 1980; **9**:2.
16. Seltser R, Sartwell PE: The influence of occupational exposure to radiation on the mortality of American radiologists and other medical specialists. *Am J Epidemiol* 1965; **81**:2-22 (as cited in Phillips and Henshaw, *op. cit.*).
17. Mantanoski GM, Seltser R, Sartwell PE, Diamong EL, Elliott EA: The current mortality rates of radiologists and other physician specialists: deaths from all causes and cancer. *Am J Epidemiol* 1975; **101**:3-23 (as cited in Phillips and Henshaw, *op. cit.*).
18. Bertell R: X-ray exposure and premature aging. *J Surg Oncol* 1977; **9**:379-391 (as cited in Phillips and Henshaw, *op. cit.*).

Manuge Galleries Limited

We specialize in
Canadian paintings of
the 19th & 20th
centuries.

Our collection
includes work by the
Group of Seven,
Robert Pilot,
Goodridge Roberts,
Alan Collier,
Tom Roberts,
John Little,
Jean Edmonds
Hancock,
Gary Morton,
Tom Forrester and
many others.



1674 Hollis Street
Halifax, Nova Scotia
B3J 1V7
Telephone (902) 423-6315
Cable Address - Esman

Toxicological Update On 2,4-D

William L. Chen,*Ph.D., John M. Lanham,**M.D.,
Tip Haagsma,†M.Sc.A. and Don Freer.††

After reading Dr. Thurlow's review on the potential health hazards of phenoxy herbicides¹, The Atlantic Vegetation Management Association (AVMA), felt that a response was necessary. Therefore, we asked Dow Chemical Canada Inc. to review the article and, if additional information was available on the phenoxy herbicides, could they please submit a response. As Technical Advisor for this organization, we submit this article on behalf of the Atlantic Vegetation Management Association and the authors.

HISTORICAL PERSPECTIVE

The herbicidal activity of 2,4-D was discovered during the "early 40s". Its major uses are to control certain broad-leaved weeds in important agricultural crops such as wheat, barley, oats, rye and corn. 2,4-D is also effective in controlling various woody plants growing on industrial rights-of-way, and for conifer release in various parts of Canada. It is one of the most economically important herbicides that has been developed and it has contributed significantly to agricultural productivity and to our Canadian standard of living. There are several economic benefits attributable to the use of 2,4-D and these were outlined recently by Dr. C. M. Switzer.²

EXPOSURE AND CROP RESIDUES

The recent studies, carried out under the direction of Dr. Terry Lavy of the University of Arkansas, show the pesticide applicators presumably the most heavily exposed to phenoxy herbicides, received only negligible doses. One of his studies was on 2,4-D applicators in the Pacific Northwest.⁴ In both studies, urine samples were collected from the applicators on the days of application and several days thereafter, and were analyzed for 2,4,5-T and 2,4-D respectively.

Using the pharmacokinetic data gathered from human volunteers in previous studies, the actual dose of herbicide received by the applicators was then calculated. These studies showed that the average dose was 0.06 mg/kg in the 2, 4, 5-T study, and a median of 0.028 mg/kg in the 2, 4-D study.

Earlier exposure estimates, such as the EPA estimate presented in Dr. Thurlow's article, were much higher. These estimates were based on guesses of how much herbicide applicators came in contact with, and are much less reliable than the data gathered in the Lavy study which actually measured the amounts of herbicide in the body. A more recent careful review of the data on 2,4-D, conducted by the United States Environmental Protection Agency (EPA), concluded that:

"The scientific evidence available at this time does not indicate the potential human exposure is sufficient to result in human health effects."⁵

Using recommended rates of 2,4-D on cereals and corn crops has resulted in no detectable residues in grain at levels at or below 0.1 ppm on straw, ensiled crops, stover or crop residues.² Residue levels in food commodities are regulated by Health and Welfare Canada and a negligible residue is considered to be 0.1 ppm or less.

TERATOLOGY, AND REPRODUCTION STUDIES ON 2,4-D

Tests have been conducted on rats, mice and hamsters to evaluate the possible reproductive effects (effects on the unborn) 2, 4-D.⁶⁻⁸ Based on the no-observable-effect levels in these animal studies, the United States Environmental Protection Agency (EPA) estimates that the level of exposure in a "worst case" situation (eg. a person standing directly under a spray plane) would be 500 to 1,000 times less than the dose level that might cause an effect.⁵

CHRONIC TOXICITY — CARCINOGENICITY STUDIES ON 2,4-D

Chronic toxicity and carcinogenicity studies on 2,4-D have been conducted in three species, the rat and dog⁹ and the mouse.¹⁰ The results have been carefully analyzed by the Joint Meeting of the Food and Agriculture Organization (FAO) Working Party of Experts on Pesticide Residues and the World Health Organization (WHO) Expert Committee on Pesticide Residues in Geneva, and the conclusion is as follows:

"A two-year feeding experiment is available in two species, the rat and dog, as well as a number of multigeneration reproduction studies. Despite certain statistical calculation on tumour incidence in rats fed on 2,4-D for up to two years, consideration of all the data from the two-year feeding study does not support the view that 2,4-D is carcinogenic in these species. The fact that mice receiving the substance orally for their lifespan exhibited no increase in incidence of neoplasms of any site or type was regarded as reinforcing view that 2,4-D is not a potential carcinogen".¹¹

Dr. Melvin D. Reuber claimed that he had reviewed the 2,4-D studies and according to his personal opinion, 2,4-D was carcinogenic in rats and mice. However, Rueber's viewpoint is contrary to the conclusions arrived at by the original investigators of the 2,4-D studies^{9,10} as well as the assessment of the data by the United States Environmental Protection Agency (EPA), Food and Drug Administration (FDA) and the World Health Organization (WHO) all of whom have come to the conclusion that 2,4-D is not a potential carcinogen.⁹⁻¹¹ Furthermore, the scientific objectivity and credibility of Rueber has seriously been called into question. Rueber, a pathologist, repeatedly involved with pesticide carcinogenicity studies and interpretation of study results and

*Diplomate, American Board of Toxicology Corporate Toxicologist, Dow Chemical Canada Inc. Modeland Road, P. O. Box 1012, Sarnia, Ontario. N7T 7K7

**Corporate Medical Director, Dow Chemical Canada Inc.

†Herbicide Marketing Manager, Dow Chemical Canada Inc.

††Technical Advisor, The Atlantic Vegetation Management Association (AVMA), Suite 702, Cogswell Tower Halifax, N.S., B3J 2A8.

slides, has been censured by his supervisor Dr. M. G. Hanna, Jr., Director of the Frederick Cancer Research Center, for general unprofessional conduct.¹²

GOVERNMENT AGENCY REVIEWS

After a thorough review the relevant toxicological and medical data on 2,4-D the United States Environmental Agency (EPA) has concluded that:

"Information from scientifically valid studies does not indicate that the continued use of 2,4-D poses an imminent hazard or unreasonable adverse effect when used according to label precautions and direction for use".⁵

Since 2,4-D has been commercially in use for over 36 years, some of the earlier studies are technically outdated. The industry is working with the U.S. Environmental Protection Agency, Agriculture Canada, and Health and Welfare Canada to update the toxicological data base of this important herbicide.

The Government of Australia has also examined and collated all available technical and scientific data on the question of the effects of the herbicides 2,4-D and 2,4,5-T on human health. This study came to the conclusion that:

"Research has shown that 2,4-D and 2,4,5-T are of low toxicity and the hazard to the user or bystander is no greater than that from an extremely large range of other industrial, agricultural and domestic products that are in common and undisputed use".¹³

This document went on to state that:

"Continuing public debate about the safety of 2,4-D and 2,4,5-T indicates that the scientific world has largely been unsuccessful in communicating its objective findings to the community that 2,4-D and 2,4,5-T have not caused the disabilities claimed".

CHLORINATED DIBENZO-P-DIOXINS

The presence of certain chlorinated dibenzo-p-dioxins in 2,4-D products were reported by Cochrane and workers at a dioxin workshop in Rome, October 23, 1980. Cochrane found 2,7 dichlorodibenzo-p-dioxin, 1,3,7 trichlorodibenzo-p-dioxin and 1,3,6,8 tetrachlorodibenzo-p-dioxin in Canadian produced products. However, it should be pointed out that 2,3,7,8 tetrachlorodibenzo-p-dioxin (TCDD) has never been detected in any 2,4-D product. Sources of 2,4-D have been screened during 1981 by Agriculture Canada and on the basis of this, Agriculture Minister Eugene Whelan said on September 28, 1981, and we quote:

"Through this review, it has been possible to identify certain basic 2,4-D products that can be expected to be virtually free of any form of the four dioxins which my scientists found just last year."

Based on this extensive analytical program by Agriculture Canada, the selection of 10 ppb for each form of dioxin was set as the maximum limit for all 2,4-D products registered and sold in Canada for 1982. Based on all relevant toxicological data, the dioxins found in 2,4-D are many thousands of times less toxic than 2,3,7,8-TCDD.²

At 10 ppb of each of the dioxins, the potential exposure of humans of these dioxins would be many thousand times below the no-observable-effect levels for the dioxins.

Consequently the hazards to humans exposed to 2,4-D containing 10 ppb of dioxins is negligible.

CONCLUSIONS

Dr. Thurlow has unfortunately not included in his review a large body of data supporting the safety of phenoxy herbicides. These data include several recent studies providing more useful and reliable data than studies relied upon by Dr. Thurlow.

Also not discussed in Dr. Thurlow's article are the numerous reviews carried out by government agencies throughout the world and by independent scientific groups which support the safety of phenoxy herbicides.

Space limitation did not permit a rebuttal of other points raised by Dr. Thurlow. The authors will be happy to answer questions relating to the safety of phenoxy herbicides. □

References

1. Thurlow W. H. A Review of the Newly Recognized Potential Health Hazards of Phenoxy Herbicides, *NS Med Bul* 1981; **60**:57-60.
2. *Notes on Agriculture*, University of Guelph, Volume XVII, No. 3, Oct. 1981.
3. Lavy T L, Shepard J S and Mattice J D. Exposure Measurements of Applicators Spraying (2,4,5-Trichlorophenoxy) Acetic Acid in the Forest. *J Agric Food Chem* 1980; **28**:626-630.
4. Lavy T L, Walstad J D, Flynn R R and Mattice J D. (2,4-Dichlorophenoxy) Acetic Acid Exposure Received by Aerial Application Crews during Forest Spray Operations. *J Agric Food Chem* 1982; **30**:375-381.
5. United States Environmental Protection Agency, *Fact Sheet on 2,4-D*. April, 1980.
6. Schwetz B.A, Sparchu G L and Gehring P J. The Effect of 2,4-D on Rat Embryonal, Foetal and Neonatal Growth and Development. *Fd Cosmet Toxicol* 1971; **9**:801-817.
7. Collins T F X and Williams C H. Teratogenic Studies with 2,4,5-T and 2,4-D in the hamster. *Bull Environ Contam Toxicol* 1971; **6**:559-567.
8. Bionetics Research Laboratories, Inc., Evaluation of the Carcinogenic, Teratogenic, and Mutagenic Activity of Selected Pesticides and Industrial Chemicals. Vol. III. Evaluation of the Teratogenic Activity of Selected Pesticides and Industrial Chemicals in mice and rats. Report to the National Cancer Institute, contracts PH 43-64-67 and PH 43-67-735, 1970.
9. Hansen W H, Quaife M L, Habermann R T and Fitzhugh O G. Chronic Toxicity of 2,4-Dichlorophenoxyacetic Acid in rats and dogs. *Toxicol. Appl Pharmacol* 1970; **20**:122-129.
10. Innes J R M, Ulland B M, Valerio M G, Petrucelli L, Fishbein L, Hart E R, Pallotta A J, Bates R R, Flak H L, Gart J J, Klein M, Mitchell I and Peters J. Bioassay of Pesticides and Industrial Chemicals for Tumorigenicity in mice: A Preliminary Note. *J Nat Cancer Inst* 1969; **42**:1101-1114.
11. Pesticide Residues in Food — Report of the 1971 Joint Meeting of the FAO Working Party of Experts on Pesticide Residues and the WHO Expert Committee on Pesticide Residues, *World Health Organization, Techn. Rep. Ser. No. 502*, FAO Agricultural Studies, 1972, No. 88.
12. Dr. Mel Reuber, Pathologist, Gets Sharp Censure, Warning from his Supervisor, *Pesticide and Toxic Chemicals News*, April 1981, pg 22-23.
13. Departments of Lands, Government of Australia, *Report on 2,4-D, 2,4,5-T and Human Health*. June 1981.

THE MEDICAL SOCIETY OF NOVA SCOTIA
PROCEEDINGS OF
18th MEETING OF COUNCIL
and
129th ANNUAL MEETING

November 18-19, 1982

INTRODUCTION

These Transactions are a summary of the decisions made by the Medical Society at its Annual Meeting. They are not a reprint of the Reports to Council. Should additional information and detail be required, the Reports are available through the Society office (453-0205).

The 18th Meeting of Council began as the Medical Society Officers accompanied by Dr. Marc Baltzan, President of The Canadian Medical Association, paraded through Council Chambers to the head table. Following call to order by Dr. G.H. Ross, Chairman of the Executive Committee and General Council, the Officers and Dr. Baltzan were introduced.

Dr. Ross 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. Ross extended the Medical Society's invitation of 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 October 1, 1981 as follows: Dr. Joseph B. MacDonald of Stellarton; Dr. S. Gordon MacKenzie of Truro; Dr. Arthur M. Marshall of Halifax; Dr. Lakshman S.C. Mendis of Halifax; Dr. Willard C. O'Brien of Yarmouth; Dr. Alan K. Stokes of Freeport; Dr. Harvey F. Sutherland of Sydney; and Dr. H. Harold Tucker of Moncton, New Brunswick.

The Transactions of the 17th Meeting of Council and the 128th Annual Meeting (1981) as printed in the December 1981 issue of The Nova Scotia Medical Bulletin were approved.

ANNUAL REPORT OF ALLIED HEALTH DISCIPLINES

COMMITTEE: This report was received for information on motion by Dr. A.H. Shears, Chairman, seconded by Dr. W.C. Acker. Dr. Shears spoke of the importance of the development of umbrella-type legislation noting that it was necessary, desirable, and urgent. As an illustration of the importance of such legislation, Dr. C.B. Stewart informed Council that when the now defunct Nova Scotia Health Council had first looked into the matter of licensing of allied health personnel there were some fifty allied health disciplines and now, ten years later, there are about one hundred allied health disciplines — all competing for health care dollars.

It was moved by Dr. A.H. Shears, seconded by Dr. J. Kazimirski "THAT Council confirm actions of the Executive Committee in authorizing this Committee to pursue the development of such legislation that would provide a most appropriate legal framework within which allied health professions could operate for the greatest benefit of the patient, and in keeping with the C.M.A. Policy on the Practice of Medicine in relationship to other health care occupations." CARRIED.

ANNUAL REPORT OF ARCHIVES COMMITTEE: Dr. W. A. Ernst, Chairman, reported on progress being made by the Provincial Archives in relation to cataloguing and displaying medical archival material.

ANNUAL REPORT OF BILLING ABOVE TARIFF COMMITTEE:

Dr. B.J. Steele, Chairman. This report was presented to Council for Dr. Steele by Dr. W.F. Mason, a committee member. Dr. Ross reminded Council that this was a committee that had been set up in conjunction with the Department of Health to investigate any problems that may occur relating to balance billing. He made reference to the first sentence of the report "No matters were referred to the committee from the Department of Health during the past year." adding that it spoke for itself in showing the responsibility of Nova Scotia physicians.

ANNUAL REPORT OF THE BY-LAWS COMMITTEE:

This report was presented to Council on the Chairman's, Dr. C.H. Reardon, behalf by Dr. A.S. Dill, a committee member. It was moved by Dr. A.S. Dill, seconded by Dr. M.A. Smith "THAT Article 8.4.1. of the Amended By-Laws of The Medical Society of Nova Scotia be amended to read: 'Bourinot's Rules of Order, Third Revised Edition, shall be the guide for conducting all meetings of the Society.'" CARRIED. It was moved by Dr. A.S. Dill, seconded by Dr. B.S. Ignacio "THAT Article 6.3.1. of the Amended By-Laws of The Medical Society of Nova Scotia be amended as follows: Line three delete 'seventy', insert 'sixty-five'; line seven delete 'two' insert 'four'." CARRIED. It was moved by Dr. A.S. Dill, seconded by Dr. R.J. Muise "THAT Article 6.1 of the Amended By-Laws of The Medical Society of Nova Scotia be amended as follows: Line 4, delete 'and Student Members', insert 'Student Members and Courtesy Members', and THAT Article 6.5. be amended as follows: (i) delete title and insert new title 'Special and Courtesy Members', (ii) add Article 6.5.2 'Courtesy Members of the Society shall be members of the profession who have practiced in Nova Scotia, who are no longer licensed to practice in Nova Scotia for reasons other than set out in Article 6.7.3, and who have been members in good standing of The Medical Society of Nova Scotia immediately prior to relinquishing their license.'" CARRIED. It was moved by Dr. A.S. Dill, seconded by Dr. N.L. Mason-Browne "THAT Article 12.3 of the Amended By-Laws of The Medical Society of Nova Scotia be amended as follows: Delete Articles 12.3.1., 12.3.1.1, 12.3.1.2, and 12.3.1.3 and insert new Article — '12.3 The Nominating Committee' and '12.3.1 The Nominating Committee shall be composed of one member from each Branch Society. This member shall be the immediate Past President of the Branch Society. Each Branch Society is entitled to appoint an alternate member who shall be the President of the Branch Society. The President of The Medical Society of Nova Scotia, if present, shall be Chairman thereof. In the absence of the President the Committee shall elect its own Chairman, THAT Article 12.3.2.1 be amended by deletion of '(b) Nominating Committee SEE 12.3.1', and THAT Article 12.3.2.3 be deleted." CARRIED. It was moved by Dr. A.S. Dill, seconded by Dr. W.C. Acker "THAT the Finance Committee review the membership dues for members who have attained the age of 65." CARRIED.

ANNUAL REPORT OF CHILD HEALTH COMMITTEE —

Dr. R. F. Gunn, Chairman. This report was not presented at Council — received for information.

ANNUAL REPORT OF COMMUNITY HEALTH COMMITTEE: Dr. D.C. Brown, Chairman, informed Council that the year had been a very busy one for his Committee, with the main activity being preparation of a Brief for presentation to Judge McCleave's Inquiry into Uranium Exploration and Mining in Nova Scotia. He told Council that this Brief will appear in the December issue of the Nova Scotia Medical Bulletin. Responding to a question about the Brief's 5th recommendation — "We maintain the belief that uranium mining would be an unacceptable health risk for Nova Scotians.", Dr. Brown confirmed that 'using present technology' was understood.

Dr. R.J. Muise, referring to the Cancer Subcommittee report's statement that this subcommittee is working on the plaque for non-smoking in restaurants, noted that smoking continues to be a real health problem facing society today. He stressed the point that the issue should not be allowed to fall by the wayside.

Dr. Brown informed Council that the Society has received a request to present a Brief to the Royal Commission on Forestry. He urged any members with special expertise in spraying, use of herbicides, etc. to come forward and assist his Committee. He noted that because of the special technical nature of this question, an ad hoc committee has been formed to prepare the Brief, which will be approved by the Executive Committee of the Society before presentation.

NUTRITION SUBCOMMITTEE: Dr. Noel Williams' report informed Council of his subcommittee's activities relating to diet development, where lowering of the serum cholesterol level is the objective.

PHYSICAL FITNESS SUBCOMMITTEE: Dr. Barry Wheeler's report urged continuing support for skiing and orienteering, pointing out the public relations value in so doing as being a valuable spin-off benefit. On motion by Dr. D.C. Brown, seconded by Dr. R.J. Muise it was moved "THAT Grants to the Orienteering Association of Nova Scotia and Nordic Ski Nova Scotia in the amount of \$500.00 each, be made by The Medical Society of Nova Scotia." CARRIED.

DRUG AND ALCOHOL ABUSE SUBCOMMITTEE: Dr. Savage informed Council that the main item of consideration of this subcommittee was 1980 Council's recommendation that this subcommittee look into the possible establishment of a register of patients who are drug abusers, and who are involved in "double doctoring". He highlighted his subcommittee's activities in this regard, pointing to the numerous unexpected difficulties which would result — expense and operation being two.

It was moved by Dr. J.P. Savage, seconded by Dr. M. Kazimirski "THAT the idea of a Drug Register of patients involved in "double doctoring" not be proceeded with at this time." CARRIED. As an alternative to such a Register, Dr. R.J. Muise outlined for Council how in Yarmouth there is close liaison between the physicians and pharmacists, who can be of great assistance to physicians, concerning the problem of "double doctoring".

It was moved by Dr. J.P. Savage, seconded by Dr. D.C. Brown "THAT a subcommittee of the Community Health Committee be set up to liaise with the Federal Bureau of Dangerous Drugs, and those physicians known to the Bureau of Dangerous Drugs as "over prescribers" be assessed on an ongoing basis." Before this resolution was voted on lively debate ensued with the consensus being that this indeed was a serious problem. Cases were cited on people being on Diazepam for extended periods, sometimes years without being adequately monitored. There were many comments on the serious problems and effects of this drug. One member, in agreeing that there is a problem, recommended that a case of careless prescribing habits should go to the Discipline Committee of the Provincial Medical Board. Dr. Savage explained that there had to be a real "case" before the Discipline Committee could really do anything and it was therefore the feeling of his subcommittee

that the setting up of such a subcommittee as described in the above resolution would be beneficial in this instance. Speaking against this resolution, one member expressed the opinion that it is really the patient who is at fault here and not the physician as it is him/her who is doing the "double doctoring".

Mr. D.A. Geekie of The Canadian Medical Association advised Council that the C.M.A. Council on Health Care had set up a subcommittee that had been looking into this problem for some time and it has come to light that the Federal Bureau of Dangerous Drugs can do little regarding monitoring of minor tranquilizers. He added that within the City of Edmonton the physicians liaise closely with the pharmacist and this has been a great success.

As a result of the above discussions the initial resolution was WITHDRAWN and it was subsequently moved by Dr. D.A. Gass, seconded by Dr. M.S. McQuigge "THAT a subcommittee of the Community Health Committee be set up to liaise with the Federal Bureau of Dangerous Drugs and other appropriate organizations, and THAT physicians known to those organizations as "over prescribers" be assessed on an ongoing basis." CARRIED.

At this point a resolution against Nuclear War was introduced to Council, the preamble of which read as follows:

WHEREAS nuclear war represents the world's greatest potential health hazard, and living in the shadow of 50,000 American and Soviet nuclear weapons creates an unprecedented threat to individual human beings everywhere;

WHEREAS medical and scientific analyses have revealed that a one megaton thermonuclear bomb exploded on a city like Halifax would create a fireball one kilometer in diameter, with temperatures reaching twenty to thirty million degrees fahrenheit vaporizing everything in the downtown area, leaving a crater several hundred feet across, killing all persons within three miles of the centre by a huge, silent heat flashing, travelling at the speed of light, blast waves, and winds between two hundred and four hundred miles per hour, killing 50 percent and injuring 40 percent in a six mile radius, and even at ten miles from the centre, killing or injuring 50 percent of the people by direct thermal radiation and blast pressures;

WHEREAS medical care for the millions of victims with severe burns, traumatic injuries, and radiation sickness would be virtually non-existent, with most hospitals destroyed, most medical personnel dead or injured, most supplies unavailable, and most transportation impossible;

WHEREAS there is no effective civil defense as the blast, thermal and radiation effects would kill even those in shelters, and the fallout would reach those who had been evacuated, as a 10,000 megaton exchange between the superpowers would blanket a ten million square mile area with radiation;

WHEREAS longer term effects on the climate and the ozone layer would endanger crops and blind animals, and global fallout would settle on the northern and southern hemispheres, increasing the likelihood of genetic mutations in generations to come;

WHEREAS the social fabric upon which human existence depends would be irreparably damaged, and tens of thousands would live with the fear of developing cancer or of transmitting genetic defects, for they would understand that nuclear weapons, unlike conventional weapons, have long, radioactive memories, and children are known to be especially susceptible to these effects;

WHEREAS a sense of deep anxiety is already affecting the mental and physical health of many, interfering with the ability of young people to plan for a meaningful future; it was moved by Dr. D.C. Brown, seconded by Dr. M.E. Churchill "BE IT RESOLVED THAT The Medical Society of Nova Scotia, as a matter of high priority: (1) directs the President to write to the Prime Minister officially expressing the Society's concern regarding the inevitable and grave consequences of nuclear

war to the health of Nova Scotians, (2) directs the Secretary of the Society to forward copies of the President's letter to the United States and Soviet Ambassadors to Canada, and (3) encourages members of the Society to join and support local and national organizations dedicated to the prevention of nuclear war in order to stay abreast of efforts to prevent nuclear armageddon." CARRIED. Dr. Churchill, speaking as a seconder to the motion, noted the fact that deep anxiety is already affecting the mental and physical health of many, interfering with the ability of young people to plan for a meaningful future and that this is concern that doctors must address.

Dr. Joe Clark, who had recently returned from a C.M.E. Seminar at McGill University informed Council that at that Seminar he had heard that the chance of nuclear war before 1990 stands at fifty percent. Dr. M.S. McQuigge, Nova Scotia's representative to the C.M.A. Council on Health Care, stated that at the C.M.A. Annual Meeting in September a similar resolution had been passed.

ANNUAL REPORT OF THE EDITORIAL BOARD COMMITTEE:

Dr. J.F. O'Connor, Acting Editor of the Nova Scotia Medical Bulletin, in presenting this report expressed appreciation to Dr. A.C. Irwin and Mrs. Tove Clahane for their untiring efforts in maintaining the high standards the Bulletin has achieved.

It was moved by Dr. J.F. O'Connor, seconded by Dr. D.C. Brown "THAT financial support be continued for the following year on the understanding that every effort will be made to keep costs down to an acceptable level." CARRIED.

ANNUAL REPORT OF ETHICS COMMITTEE: This report was received for information on motion by Dr. Roger T. Michael, Chairman, seconded by Dr. R.J. Muise.

ANNUAL REPORT OF CHAIRMAN OF THE EXECUTIVE COMMITTEE:

In presenting his report Dr. G.H. Ross highlighted a number of the more important decisions of his Committee, observing that he would be requesting of Council endorsement of the actions of the Executive Committee during the past year. Topics singled out included the Statement on Electronic Fetal Heart Monitoring in Labour, the Income Ratio Time Study, the Statute of Limitations Legislation, (Dr. Ross reminded Council that this is an excellent example of what the Society has been doing for physicians), and Senior Membership in The Medical Society of Nova Scotia, noting that Drs. Eleonore Bergman-Porter of Yarmouth and Abraham Gaum of Sydney had been so honored.

It was moved by Dr. G.H. Ross, seconded by Dr. J. Kazimirski "THAT Council endorse the actions of the Officers and Executive Committee during the past year and accept the Chairman's Report to Council." CARRIED.

Council gave Dr. Ross a unanimous vote of admiration for the super way in which he always chaired the meetings of the Executive Committee and Council during his three years as Executive Committee and Council Chairman.

Dr. Ross informed Council that 1982 Council Transactions would appear in the 1983 Reports to Council.

It was also agreed that Council 1983 would have available an overhead projector for displaying motions on the floor.

Dr. V.M. Hayes personally commended Dr. Ross for his fine efforts on behalf of the Officers during his term as Chairman of the Executive Committee.

ANNUAL REPORT OF EXECUTIVE SECRETARY: Mr. D.D. Peacocke noted that the opportunity to report to Council allows him to publicly thank the Society staff for their support, to report on special items of interest that may not be covered elsewhere, and to provide Council with a resume of what resulted from decisions made a year ago at Council.

Mr. Peacocke highlighted his report referring to such topics as the Memorial Fund for Nova Scotia Physicians (expanding very slowly), good communications with the media, very good relations with Government, computerization of membership listings in the Society office, as well as a complete detailed resume of action taken by staff as a result of resolutions passed last year at Council.

Mr. Peacocke reported that arising out of his attendance at Branch Society Meetings and discussions with members of the Society over recent years, he has perceived an increasing level of concern that so many active physicians do not support their professional association. Because of this and the request of many physicians his report included a proposal respecting compulsory membership in The Medical Society of Nova Scotia. It was moved by Dr. W.R. Stevenson, seconded by Dr. A.G. Cameron "WHEREAS The Medical Society is recognized by the Profession and Government as the legal representative body for the Medical Profession of the Province and THAT events over recent years signify the necessity for unity within the Medical Profession BE IT RESOLVED THAT all Physicians registered with the Provincial Medical Board of Nova Scotia shall pay to The Medical Society of Nova Scotia (a) within thirty calendar days of the time of registration, and (b) on or before the first day of October in each year thereafter, the annual membership dues of The Medical Society of Nova Scotia; THAT the license of any physician who fails to pay prescribed annual dues as required above shall be suspended in accordance with procedures set out in Regulations to the Medical Act, and THAT physicians having complied with the foregoing and being licensed to practiced medicine in the Province of Nova Scotia shall be deemed to be members of The Medical Society of Nova Scotia and entitled to all the rights and privileges set out in The Medical Society of Nova Scotia." CARRIED.

Dr. Stevenson elaborated on his motion by making reference to compulsory membership in Newfoundland and New Brunswick. He noted that he had been directly involved when this issue had come up in Newfoundland. He said that perhaps the President of the Newfoundland Medical Association might want to say a few words about this later. He added that professional associations in many cases require membership in their association as a prerequisite to practice their vocation.

Dr. D.C. Brown spoke on the financial advantages to the Society, the advantages compulsory membership afforded physicians through tax deductibility of their membership dues, and it provides full representation of the profession. He added that this is a real advantage when dealing with other bodies — e.g. — Government.

Dr. A.G. Cameron expressed the view that there was no need to go back to the Branches on this matter. They are all represented and in most cases, carry a mandate.

Dr. J.B. Ross, speaking very strongly in favour of the resolution, made reference to voluntary membership being totally out-of-date. He noted that after one year of compulsory membership Newfoundland physicians were very happy with the profession's decision in this regard. He urged everyone to vote in favour of the motion.

Dr. N.L. Mason-Browne commented as follows: "I am speaking here to a gathering of the converted. As members, we are converted to the principle that all Nova Scotia physicians should be members of our Society. We all agree that everyone, including non-members, benefits from the efforts of members. These benefits cover many areas of which the financial benefits are not the least. Additionally, if everyone were a member it is entirely possible that there would be no need for increases in our annual dues. Unquestionably, non-members are free-loaders. However, there is an opposite point of view. It is one which is held by many in my Branch and it is one which, in the interests of debate, it is necessary to consider. We belong to a free autonomous profession and we are proud of that. We cherish our freedom and we are proud of that. We fought vigorously for those freedoms such as the freedom to opt out or extra bill and we are proud of our fight. One of our most cherished freedoms is the freedom of choice.

Compulsory membership is not traditional in most jurisdictions. Compulsory membership cannot contribute towards our unity. Compulsory membership reduces our credibility.

"Erasure from the medical register for failure to join introduces an entirely new criteria as a qualification for medical registration. It is a criteria of questionable medico-legal validity. It is a criteria about socio-economic conformity not about adherence to medical codes of ethics or the welfare of the patient. It is a criteria reminiscent of the U.S.S.R. I heartily endorse the principle that everyone should be a member of The Medical Society of Nova Scotia but not for the reasons stated, therefore oppose this measure. Surely there must be other methods to improve our membership numbers."

Lively debate continued during which several Council members expressed their views. Dr. Pugsley of Truro noted that he agreed with the resolution but expressed concern about new members just starting practice. Mr. Peacocke clarified the Society's policy for new members — i.e. from the time they graduate in July until September 30 their membership in the Society is gratis. Therefore they would not be 'dinged' twice in one year for membership dues.

Dr. P.J. Littlejohn of New Waterford spoke against the motion in support of Dr. N.L. Mason-Browne's comments.

In speaking against the resolution, Dr. A.J. MacLeod expressed his opposition to compulsion in any form as it virtually leads to a 'closed shop'. He made reference to Britain and what has happened there.

Dr. J.F. O'Connor expressed concern as to whether or not this would require a change in the Medical Act of Nova Scotia. It was confirmed that a change would be required.

Dr. R.A. Nicholson of Pictou opened his remarks in support of the motion by stating that he was not a unionist but he expressed the feeling that the time had come to do something about non-members of the Society. He said that the issue must be taken by the 'horns' and that the Society must 'bite the bullet' in order to have a strong Society.

Dr. G.W. Horner wanted to know if a member delinquent in his membership dues would still be able to practice medicine, and would a member's name be able to not be on the membership list (if that were his choice) even though he contributes monetarily to the Society. He was informed NO to the first and not known yet to the second.

Dr. J.P. Savage expressed mixed feelings regarding this motion. He noted that he was in support of the intent of the motion but felt that it had not been researched fully. He expressed the need for legal counsel on this matter. He suggested that a special committee be set up to study this matter and that it be brought back to Council next year for future discussion.

Dr. R.N. Sers informed Council that he was in support of total participation in the Society, but expressed the view that in dealing with other bodies, an association with voluntary membership carries greater weight.

Dr. B.S. Ignacio questioned the percentage of non-members over 60 years of age, and noted that he felt it unfair to 'ram' compulsory membership down the throats of physicians in the 60 plus age bracket. Council was informed that various categories of membership would continue, thus resolving this concern.

Dr. I. Woolfrey, President of the Newfoundland Medical Association, noted that the debate going on at this time is similar to the one in Newfoundland when this subject was being discussed a few years ago. He spoke on the need for full physician participation (representation), and the changing role of the Society from a social one to one that now looks after the physicians' financial needs. He stressed the advantages — full physician participation, financial stability for the Society, and no favoritism among members — e.g. foreign/local; husband/wife; salaried/ordinary. He informed Council that Newfoundland physicians have not found compulsory membership detrimental to their lifestyle, and added that

compulsory membership is the one means by which a Society/Association can maintain a sound financial situation.

Dr. Robert Hennessy, President of the New Brunswick Medical Society, noted that his remarks would be directed in the context of the New Brunswick Medical Society. He noted that in his Society membership had only become legally compulsory within the last two years. Prior to that it was a foregone conclusion that a license to practice went hand in hand with membership in the Provincial Society, then about two years ago changes in the Medical Act had been made making it legally compulsory to be a member of the Provincial Society. All in all, this has been accepted very, very well by New Brunswick physicians.

Dr. G. Mack. Saunders made reference to this matter being discussed some fifteen years ago — the motion being one of long duration. His reason for bringing this to Council's attention was to bring to light that if something is not done now it will likely go another fifteen years without a decision being made.

ANNUAL REPORT OF THE FINANCE COMMITTEE: This report was received for information on motion by the Chairman, Dr. W.C. Acker, seconded by Dr. A.B.F. Connelly. Dr. Acker's report contained four resolutions reading: (1) *"THAT the Financial Statements of The Medical Society of Nova Scotia for Fiscal Year 1982 be approved."* CARRIED. (2) *THAT Doane Raymond (previously H.R. Doane and Company) be retained as the Medical Society auditors for Fiscal Year 1983."* CARRIED. (3) *THAT the Membership dues for Ordinary Members of the Medical Society for Fiscal Year 1984, which commences October 1, 1983, be increased from \$375.00 to \$475.00."* CARRIED. and (4) *"THAT the dues for the other categories of membership be increased by the same percentage as outlined in resolution (3) above."* CARRIED.

A number of members had various questions regarding the budget and financial statements. These questions were responded to appropriately and to the satisfaction of Council.

Dr. Acker received a hearty vote of thanks for his untiring work during the past three years as Treasurer.

ANNUAL REPORT OF HOSPITALS AND EMERGENCY SERVICES COMMITTEE: The Chairman, Dr. J.W.I. Morse reported that at a Canadian Symposium on Restraining Devices it was concluded that the only way to get people to buckle up is to make it mandatory. There is no evidence that buckling up puts persons at risk, in fact risks of injury have been found to be substantially reduced, most particularly in children, when seat belts are used. One Council member asked if this committee had looked into Belgium law where it is forbidden for children under 12 to sit in the front seat of a car. He added that it might be worthwhile sometime in the next year or two for this committee to look into the legislation of other countries to determine statistics to assess the validity of making it mandatory to have children in the back seats in restraints. It was moved by Dr. J.W.I. Morse, seconded by Dr. A.G. Cameron *"THAT the Province of Nova Scotia immediately proclaim the present seat belt legislation."* CARRIED.

The subject of smoking in health institutions was raised and discussed following which it was moved by Dr. J.W.I. Morse, seconded by Dr. D.F. Fay *"THAT the hospitals of Nova Scotia be urged to protect the rights of the non-smoking patient, THAT hospital patients who smoke only be allowed to do so alone or in the company of patients who agree to be subjected to and whose health is not adversely affected by cigarette smoke, and THAT visitors and hospital staff only be allowed to smoke in designated areas."* CARRIED.

ANNUAL REPORT OF MATERNAL & PERINATAL HEALTH COMMITTEE: The Chairman, Dr. Leo J. Peddle noted that protection for those dealing with the confidential matters coming to the Committee was still deemed to be inadequate, and that the Government believed it is adequate. He urged the Society to continue to press for improvements in the related laws. Dr. Peddle proudly made reference to the low perinatal mortality rate in Nova Scotia.

Council was reminded that the Executive Committee, on April 24, 1982, had endorsed the Reproductive Care Program's Statement on Electronic Fetal Heart Monitoring in Labour, and this endorsement had been reconsidered, at a member's request, by the Executive Committee on October 23, 1982. The Executive Committee referred the matter to Council. In seeking Council's support and endorsement of this Policy Statement, Dr. Peddle cited scientific data which indicates that there is no scientific benefit to the use of E.F.H.M. in Labour in normal and low risk pregnancies. He added that there are some beneficial effects in high risk. He added that in normal obstetrics E.F.H.M. in Labour does not have a place. Literature continues to accumulate and the answers come up the same.

As a result of debate of this subject, several motions were put forth. Following a recess it was moved by Dr. J.P. Savage, seconded by Dr. P.D. MacLean "BE IT RESOLVED THAT The Medical Society of Nova Scotia endorses the scientific validity of the Reproductive Care Program's Policy Statement on Electronic Fetal Heart Monitoring In Labour but wishes to underline that final decisions as to treatment methods and care of patients shall remain the responsibility of the attending physician in his/her community." CARRIED.

ANNUAL REPORT OF MEDICAL EDUCATION COMMITTEE: The Chairman, Dr. Wm. G. Gill noted that although his report contained no recommendations he urged that the Society's strong support of continuing medical education be continued.

ANNUAL REPORT OF MEMBERSHIP SERVICES COMMITTEE: The Chairman, Dr. D.M. Andrews, reported on the progress of negotiations with the Ontario Medical Association (O.M.A.) respecting participation in its Term Life Insurance Program. (Dr. Andrews read his Committee Report to the Executive Committee Meeting of October 23, 1982 reading as follows:

"Of primary concern to the Membership Services Committee is the assurance that any change in our insurance program would not result in a loss of coverage to any member of the Society. This provision is guaranteed in that we will negotiate a deal with the O.M.A. for participation in their plan that does not require our members to cancel their existing coverage. If the arrangement with the O.M.A. is finalized, the Society will terminate the present marketing agreement with Imperial Life on April 1, 1983 and those members wishing to retain their existing coverage will do so under direct arrangements with Imperial Life. The premiums for continuing coverage under this arrangement would likely be a little higher than the current premium.

The tentative agreement to participate in the O.M.A. plan incorporates the following provisions:

- (i) 75% of Medical Society members having existing coverage under the Society's plan must indicate their intention to join the O.M.A. life insurance program. (If members join the O.M.A. plan they will not be required to cancel their existing coverage.)
- (ii) The Medical Society of Nova Scotia would be required to terminate its Master Agreement with Imperial Life to market the plan. This notice would be issued prior to April 1, 1983 (six months notice required) to be effective October 1, 1983.
- (iii) After April 1, 1983 the Society would cease to write new coverage for members. The O.M.A. agrees to accept new coverage (not transferred) applications after April 1, 1983 with medical evidence required.
- (iv) The issue of new coverage as per item (iii) above would not prejudice the October 1, 1983 arrangement to obtain O.M.A. coverage equal in amount to the coverage under The Medical Society of Nova Scotia plan without medical evidence.
- (v) Notwithstanding the foregoing provisions, the maximum O.M.A. life coverage permissible to any member is \$400,000.00 total.
- (vi) Only members of The Medical Society of Nova Scotia will be

permitted to participate in the O.M.A. plan. Medical Society of Nova Scotia coverage presently issued to clinics, staff and other non-members will have to be continued on a private basis with Imperial Life.

- (vii) The O.M.A. require the premiums to be paid annually. This may present some difficulty for those with large premiums but there will be at least six months notice of the change which will allow for advance financial planning.
- (viii) Tentative agreement for the O.M.A. to take over the life insurance commitment to the Internes/Resident Contract has been reached with the O.M.A.
- (ix) Students would be eligible for regular insurance coverage.
- (x) A deposit fund reserve comprised of unpaid commissions held by Imperial Life will be turned over to the O.M.A. If such a deal can be negotiated by Wm. Mercer with Imperial Life.
- (xi) O.M.A. life insurance is issued in units of \$50,000.00. Coverage guaranteed to The Medical Society of Nova Scotia members would be equal to The Medical Society of Nova Scotia coverage or the next higher unit level. (i.e. — if you have \$25,000. coverage with The Medical Society of Nova Scotia you would be eligible for \$50,000.00 coverage on October 1, 1983 without medical evidence. If you have \$75,000.00 you would be eligible for \$100,000.00, etc.)
- (xii) The O.M.A. term plan reduces in coverage from age 60 to age 75. The Medical Society of Nova Scotia plan remains level to age 65 reducing to age 75. There may be a few members who might experience a reduced level of coverage between ages 60 and 65, depending on circumstances. Should this occur, the member could elect to retain existing coverage to bridge the difference.
- (xiii) The O.M.A. plan does not permit third party ownership. Where this feature is needed, arrangements should be made to suitably revise beneficiaries.
- (xiv) Where The Medical Society of Nova Scotia plan is assignable for loans, the O.M.A. plan is not. Again, this provision can be overcome by making the lender (bank) the irrevocable beneficiary for the outstanding indebtedness.

Dr. Andrews requested the Executive Committee to accept the tentative agreement with the O.M.A. Insurance Committee and further requested approval for the Membership Services Committee to finalize an agreement with O.M.A. for presentation to Council in November.

It was moved by Dr. G.W. Horner, seconded by Dr. Rolf Sers

"THAT the Membership Services Committee proceed with negotiations with the Ontario Medical Association respecting the proposed "transfer" to its life insurance program, and to conduct the required polling of members of the Medical Society." CARRIED.

In response to a question as to whether a person could remain in the existing program and transfer to the Ontario Medical Association's Plan, Dr. Andrews informed Council that this could be done so long as limits are not exceeded — a mix is allowed. Dr. Acker, outgoing Treasurer, wanted to know if a finders fee would be paid to the Medical Society from the Ontario Medical Association; Dr. Andrews replied that unfortunately this would not be the case.

It was moved by Dr. J.B. Ross, seconded by Dr. A.B.F. Connelly "THAT Council authorize the Membership Services Committee to conclude an Agreement with the Ontario Medical Association for Society members to participate in the Ontario Medical Association Life Insurance Program as outlined in Dr. Andrews' Report." CARRIED.

Following on, Dr. Andrews outlined for Council existing services available to members through the Society — Personal Lines Insurance, the Hertz Car Rental Services, Dental Insurance, and Malpractice Insurance.

ANNUAL REPORT OF OCCUPATIONAL MEDICINE & REHABILITATION COMMITTEE:

Dr. Prossin, Chairman, reported that his committee's concerns during the past year related to development of educational programs for students and doctors, and rehabilitation of injured employees. Following interesting discussion, it was moved by Dr. A. Prossin, seconded by Dr. R. Stokes "BE IT RESOLVED THAT The Medical Society of Nova Scotia Executive Committee consider a meeting between the Workers' Compensation Board physicians, the psychiatry group of physicians, other appropriate medical specialists, and the Occupational Medicine Committee to discuss improved liaison between these groups in the areas of industrial rehabilitation, as this liaison seems to be lacking at the present time." CARRIED.

ANNUAL REPORT OF PHARMACY COMMITTEE: Dr. D.B. Carruthers, Chairman. This report was not presented at Council but received for information.

ANNUAL REPORT OF THE PRESIDENT: Dr. M.A. Smith highlighted various items in his report. He informed Council that the Officers had met eighteen times during the past year, and that the year had been an extremely busy one for the Officers and Executive Committee. Three rounds of Branch Meetings had been held and the Officers had participated in all three rounds.

Dr. Smith stressed the necessity for remaining flexible, especially in view of changing economic circumstances which further complicate already difficult matters on which decisions have to be made. Dr. Smith reminded Council that the Executive Committee runs the Society between meetings of Council and that the Society Officers run the Society between Executive Committee Meetings. He stressed that it is very important in an organization such as the Medical Society for the membership to put its trust in its Officers.

In speaking on economic matters, Dr. Smith brought Council's attention to the frustrating, unrewarding period the Economics Committee had experienced during the past year. He noted that the Economics Committee's role has changed somewhat. A Task Force Committee on New Fees has been struck under the chairmanship of Dr. G.C. Jollymore; a Workers' Compensation Board Negotiating Committee has been set up under the chairmanship of Dr. John L. Sapp; and a new Economics Committee is now in place under the chairmanship of Dr. W.C. Acker.

Dr. Smith noted that another area in which the Society had demonstrated flexibility during the past year was in its decisions regarding the Income Ratio Study. Dr. Smith reminded Council that it was at Council 1981 that the decision had been made regarding the Income Ratio Study. He added that this decision was NOT made by the Officers or the Executive Committee. The Officers agreed that the Study could not profitably continue in the absence of an agreed ratio. Following several attempts to obtain agreement on this point it became clear that the various Sections could not do so, thus the full support of the Society would not be forthcoming. As a result it was agreed to terminate the Study BUT continue the search for improved mechanisms for distributing a tariff settlement.

In speaking to the addendum to his report, Dr. Smith outlined for Council the Commission offer that the Officers, on behalf of the Medical Society, had accepted. He outlined the Officers' reasons for not having brought the offer before Branches, Sections, or a special meeting of the Executive Committee, or placing it before Council on this occasion before its acceptance. Dr. Smith reported that the reason for doing this was that it had been the belief of the Officers, after very careful and lengthy discussion, that the quicker the offer was responded to the better it would be for the Society.

In speaking to the Internes/Resident problem Dr. Smith made reference to his November 5, 1982 President's Letter and outlined how the confusion regarding this issue had arisen — i.e. — the Internes/Residents belong to two separate organizations, IRANS and the Section for Internes and Residents. He added that the

Society cannot live with representing the Internes and Residents through IRANS, and that the Internes and Residents cannot live with the Society controlling their Contract. Dr. Smith stressed that there is absolutely no anomosity on the Society's part as a result of this situation.

In an effort to resolve this dilemma, the following motion was moved by Dr. V.M. Hayes, seconded by Dr. R.D. Saxon — "THAT WHEREAS the Internes and Residents through IRANS have indicated they do not wish The Medical Society of Nova Scotia to represent them in contract negotiations within the guidelines of Medical Society Policies, AND WHEREAS The Medical Society of Nova Scotia stands ready to represent its members through its Sections: (1) BE IT RESOLVED THAT at the end of the current Contract The Medical Society of Nova Scotia will discontinue negotiating on behalf of IRANS, (2) BE IT RESOLVED THAT The Medical Society of Nova Scotia represent the Internes and Residents Section in Collective Bargaining if requested to do so by the Section."

The above motion received lengthy debate with many members responding to the Chair's request for comment. In opening discussion Dr. Saxon, as seconder of the motion, outlined for Council why the Society does not like the Agreement and reminded Council what happened last year at 1981 Council when the Agreement was signed at the 11th hour — the Internes and Residents were happy but the Society was not. Later on in discussions, this same point was brought to light when Dr. Hayes, speaking in favour of her motion, reminded Council once again that the Society had only signed the Agreement because of the matter of expediency, and with the assumption that the Society's areas of concern would be "ironed out" later. She added that the date as to when the Section could ask the Society to represent it had purposely been left open so that if the Section wished to come back at any time this would be agreeable to the Society. She stressed that there had been no attempt on the part of the Society to abandon the Internes and Residents. The dilemma results because the Internes and Residents themselves insist that they be represented by IRANS, therefore the Society cannot negotiate on their behalf.

Speaking on behalf of the Internes and Residents, Dr. Foran said that IRANS understood the Society situation and was grateful for the Society's past assistance, and noted that IRANS recognized their advantage here and would no doubt use it if backed against the wall. However, he added that IRANS is willing to co-operate with the Society and accept the Society's resolution with the following amendment (addition) to the above resolution — moved by Dr. R.B. Foran, seconded by Dr. G.P. O'Hanley "THAT the proposed resolution (Hayes/Saxon) be amended as follows: 'BE IT RESOLVED THAT The Medical Society of Nova Scotia represent the Internes and Residents Section in Collective Bargaining if requested to do so by December 1, 1982. If the Section for Internes and Residents wish IRANS to be their bargaining agent, The Medical Society of Nova Scotia will immediately assign all of its bargaining rights and obligations in Collective Bargaining for Internes and Residents to the Internes and Residents Association of Nova Scotia.'"

Dr. Foran informed Council that IRANS is willing to accept responsibility for bargaining now and forever and refuted (2) of the Hayes/Saxon resolution.

Dr. Rafuse spoke against the Foran/O'Hanley resolution stating that the bottom line is that the Officers have agonized over this situation for some time and that the Society cannot agree to an Agreement and be responsible for it when it does not have control over it. He noted that the Society MUST have some degree of control.

Dr. Judy Kazimirski spoke strongly in favour of the Hayes/Saxon resolution.

Speaking in favour of the Hayes/Saxon resolution, Dr. Rafuse informed Council that under the current Agreement The Medical

Society of Nova Scotia has designated IRANS rather than the Section and that we (the Society) do not want it in any further Agreements. He emphasized that the gist of the motion is that when the Agreement runs out the Society wants to change it.

Dr. R.B. Foran again stated that IRANS is happy to receive authority to negotiate on behalf of the Internes and Residents and that the purpose of his amendment to the original resolution was to make it crystal clear to the Minister of Health and the Council of Teaching Hospitals who will be the bargaining agent.

Following Dr. Foran's above comments Dr. Hayes spoke in favour of her motion. Her comments are stated above.

After Dr. Hayes' comments the Foran/O'Hanley resolution was DEFEATED.

As a result of the above, Dr. Foran moved and Dr. O'Hanley seconded a further amendment to the original resolution which reads: "THAT The Medical Society of Nova Scotia will not oppose the representation by IRANS in Collective Bargaining with the Council of Teaching Hospitals so long as this does not involve obligations on the Medical Society."

Discussion of the further amendment opened, with Dr. A.J. MacLeod expressing the view that in these changing circumstances the Society cannot say that it will NOT oppose anything.

Dr. M.A. Smith spoke in favour of the further amendment. He expressed the feeling that it goes without saying that the Society would not oppose IRANS in its bargaining endeavors and that if passing of this resolution would make them feel more secure he could see little harm in doing so.

Dr. J.D.A. Henshaw spoke against the further amendment.

Dr. B.M. Chandler, Past Chairman of the Economics Committee, said that he felt it would be a step backward for IRANS to withdraw from having the Society negotiate on behalf of the Internes and Residents, and it was his feeling that this should be looked at more carefully throughout the coming year.

The further amendment was voted upon and DEFEATED.

The initial Hayes/Saxon motion was voted upon and CARRIED.

It was moved by Dr. M.A. Smith, seconded by Dr. A.G. Cameron "THAT the actions of the Officers on behalf of the Medical Society as presented in the President's Report, with specific reference to the current Tariff Settlement be endorsed." CARRIED.

Dr. A.G. Cameron expressed the belief that the Society should receive good publicity by saying we are happy with our six percent increase, being responsible physicians in these hard economic times. Dr. Cameron reminded Council that six percent of physicians' incomes is a heck of a lot more than many citizens are getting across the Country. He added that he was personally pleased with the settlement and felt that other physicians should be as well.

Council expressed a hearty vote of thanks to the outgoing President.

Annual Report of Discipline Subcommittee: Dr. Smith reported that the Society had received information concerning over-prescribing by physicians and noted that this could become a serious problem. He added that several cases (without identities of doctor, patient, pharmacy) had been referred to the Provincial Medical Board of Nova Scotia with prompt and severe repercussions ordered.

He urged doctors to review with care their prescribing habits, not only to remain within the law but out of concern for their patients.

Annual Report of Mediation Subcommittee: Dr. Smith reminded Council that each year complaints are received and that they are always dealt with, regardless of their nature. He noted that some are frivolous, some are unfounded, and others are worse than that; however, occasionally there is a valid one. He said that when a complaint is investigated there is no accusation of guilt on the

physician's part, and added that it is fair to say that most complaints are known only to Mr. Peacocke, the President and the person(s) involved.

Responding to a question as to the number of written complaints received, Dr. Smith said he was pleased to report that during the past year they are down a bit from previous years.

Annual Report of the Medical Society/Faculty of Medicine Liaison Subcommittee: Dr. Smith reported that the Committee continues to be active and that a meeting had taken place on October 27, 1982 when Physician Manpower was discussed. The question was asked as to whether or not Dalhousie University had confronted Government regarding the issue of Residency Program cutbacks. Dr. W.F. Mason responded on behalf of the Dean advising Council that three studies had been done during the past few years to determine the number of residency positions required to fulfill the needs of the Maritime Provinces. He added that the residency cutbacks are purely a sign of the economic times, but noted that all the same they are of great concern to the University and should be to the Society as well, Council agreed that this problem is urgent and must be followed up.

ANNUAL REPORT OF SALARIED PHYSICIANS COMMITTEE: The Chairman, Dr. J.P. Welch, reported that the PA and MS groups had received increases of only three percent, not retroactive and that they appear uninterested in having the Society represent them. He added that he would be reporting to the Society Executive Committee on this matter in the near future. Dr. Smith informed Council that the Society is very interested in representing all members of the Society, and prepared to do so if a request is made.

ANNUAL REPORT OF WORKERS' COMPENSATION BOARD LIAISON COMMITTEE: Dr. A.B.F. Connelly, Chairman, reported to Council that during the year his Committee had raised concerns to the Workers' Compensation Board regarding treatment modalities and fees for certain services provided for the Workers' Compensation Board.

ANNUAL REPORT OF MSNS REP. TO C.M.A. BOARD OF DIRECTORS: Dr. G.C. Jollymore/Dr. M.A. Smith (9/82). Dr. Smith highlighted the activities of the C.M.A. Board during the past year on behalf of Dr. Jollymore who had attended all of their meetings. He noted that a Task Force on Family Practice had been established with terms of reference to determine the objectives of teaching primary care physicians and to examine pathways currently available to physicians preparing for primary care practice and to make recommendations for further training. Dr. D.A. Gass of the Division of Continuing Medical Education, Dalhousie University urged all interested physicians to make known their views.

Dr. Smith reported that General Council had approved a Board proposal that there be established a Task Force which will "Study the Existing Potential Effect of **Rationing** of Health Services as a result of Government Policies".

Dr. Smith reminded Council that in 1983 General Council will take place in Montreal, followed by the Annual Meeting of the C.M.A. in Monte Carlo. He urged anyone interested to take action now as space is becoming limited.

ANNUAL REPORT OF MSNS REP. TO C.M.A. COUNCIL ON HEALTH CARE: Dr. M.S. McQuigge reported to Council extensively but concisely on the wide range of his Council's activities during the past year. The range of subjects discussed was considerable so he highlighted but a few. In particular, he pointed to a resolution adopted by General Council concerning "No Resuscitation Orders". He urged accredited hospitals throughout Canada to adopt it. (Interested parties should contact the Medical Society office for precise wording.)

ANNUAL REPORT OF MSNS REP. TO C.M.A. COUNCIL ON MEDICAL ECONOMICS: Dr. A.H. Patterson/Dr. P.D. Muirhead. Dr. Muirhead highlighted topics that his Council had been discussing during the past year — e.g. — the Canada Health Act, Health Maintenance Organizations (HMO's), as well as some theoretical co-payment mechanisms — i.e. infusion of private monies into the health care system.

ANNUAL REPORT OF MSNS REP. TO C.M.A. COUNCIL ON MEDICAL EDUCATION: Dr. J.D.A. Henshaw provided Council with a comprehensive summary of several very important and critical topics being dealt with by his Council. These included: —Licensure Portability, Canadians Studying Medicine Abroad, Human Sexuality, Accreditation Programs, Emergency Medicine, C.M.E. Accreditation Programs, and the Task Force on the Provision of Primary Care Services.

He highlighted the problem of Canadians returning to Canada after studying medicine abroad and expecting to practice medicine and asked for comment or proposals for solution of the problem. As well he spoke to the C.M.E. Accreditation Program referring in particular to pharmaceutical company support and the guidelines for their involvement. With respect to Emergency Medicine he said his Council was dedicated to ensuring that family physicians will continue to participate fully in the care of patients in emergency rooms. In response to questioning, he conceded that portability has been a difficult nut to crack and will continue to be so and could give no forecast as to when it might be achieved.

ANNUAL REPORT OF MSNS REP. TO M.D. MANAGEMENT LIMITED: Dr. G.A. Sapp noted he was proud to inform Council that both the equity and annuity programs have continued to grow during the past year. He said the annuity program is one of the five top pension plans in Canada. He reviewed briefly the various plans available to C.M.A. members.

ANNUAL REPORT OF SECTION FOR ANAESTHESIA: Dr. W.D.R. Writer, the recently elected Chairman, presented this report which was submitted by Dr. J.P. Donachie. Regarding the establishment of an Anaesthetic Mortality Review Committee, Dr. Writer informed Council that there had been some question as to whether establishment of this Committee would necessitate a change in provincial statutes to provide protection for the participants. The Department of Health has stated there is no need for change so the Committee is proceeding with its work.

ANNUAL REPORT OF SECTION FOR GENERAL PRACTICE: The Chairman, Dr. Paul D. MacLean's report provided Council with a review of the activities of the Section during 1982. The Section's increased involvement in Society affairs was extensive and notable.

The Section is concerned about the precarious situation that the Dalhousie Family Medicine Centre finds itself in as a result of the continuing funding cutbacks for its Residency Program. Dr. MacLean read to Council a Department of Health letter to the Department of Family Medicine stating that in 1983-84 and 1984-85, funding for all Residency positions will be reduced by fifteen in each year, that the Health Department would be meeting with the President of Dalhousie, Maritime Provinces Higher Education Commission and the other provinces concerned to settle what specialties would be funded, and that in terms of priority the Family Medicine Residency Program is at the bottom of the list.

The following motion was put before Council — moved by Dr. P.D. MacLean, seconded by Dr. J.P. Savage "THAT The Medical Society of Nova Scotia opposes decreased funding to the educational system provided to family physicians in this Province, including decreased funding to the present Family Medicine Residency Program." **CARRIED.** This resolution gained strong support from Council with many members speaking in support of the motion. The consensus was that the Family Medicine Centre is an important nucleus of family physicians which has raised the status of family physicians, and the Department of Health should not be allowed to destroy this Residency Program, which serves as

an important link between general practice and the Faculty of Medicine. Speaking as a seconder of the motion, Dr. J.P. Savage said that Dalhousie Family Medicine Centre should recognize the need for cutbacks in these economic times, but not to the total loss of the second year Residency Program. He urged Council to support this motion to the fullest extent.

ANNUAL REPORT OF SECTION FOR INTERNAL MEDICINE: Dr. J. Barrie Ross, Chairman, brought to Council's attention that upon the recommendation of the Section Economics Committee Chairman it was decided to appoint an Economics Committee Chairman who would serve for three years with the idea that there be a central nucleus committee and corresponding members in each of the major regions of the Province.

ANNUAL REPORT OF SECTION FOR INTERNES AND RESIDENTS: This report was presented to Council by Dr. G.P. O'Hanley on behalf of the Past Chairman, Dr. R.B. MacDonald. In presenting this report Dr. O'Hanley reminded Council that for a number of years the Medical Society had acted on behalf of the Internes and Residents and the relationship with the Society had been beneficial to the Internes and Residents, especially in their efforts to gain binding arbitration for one year which enabled them to gain wage parity with other provinces. He elaborated on the benefits of binding arbitration. Dr. O'Hanley reminded Council that in spite of the lengthy discussion that had occurred earlier in the day regarding the Interne/Resident situation, there was still the matter of who would represent the Internes and Residents in their Collective Bargaining. He added that IRANS looked forward to continued talks to resolve this negotiations problem, and also looked forward to long and fruitful relationships with the Medical Society. It was then moved by Dr. O'Hanley, seconded by Dr. Foran "THAT The Medical Society of Nova Scotia support the principle that Collective Bargaining for Internes and Residents be subject to democratic control by the individuals directly affected."

Following debate, with particular reference to the precedent-setting aspects of such a policy, the motion was **DEFEATED.**

ANNUAL REPORT OF SECTION FOR LABORATORY MEDICINE: Dr. O. Ikejiani. Received for information.

ANNUAL REPORT OF SECTION FOR OPHTHALMOLOGY: Dr. J.H. Quigley, Chairman. Received for information.

ANNUAL REPORT OF SECTION FOR ORTHOPAEDIC SURGERY: Dr. A.B.F. Connelly, Chairman. Received for information.

ANNUAL REPORT OF SECTION FOR PAEDIATRICS: Dr. J.G. Gatten, Chairman. Received for information.

ANNUAL REPORT OF SECTION FOR PSYCHIATRY: Dr. Doris L. Hirsch, Chairman, was questioned about the lack of locked units to detain dangerous mentally ill patients, with concern being expressed that there are none. Dr. Hirsch said action is being taken to resolve the problem, inferring that perhaps the issue of patients' rights might be involved. If so, Dr. Brown asked "what about the rights of society?", and went on to point out the need for such facilities.

ANNUAL REPORT OF SECTION FOR RADIOLOGY: Dr. J. Rees, Chairman. Received for information.

ANNUAL REPORT OF MSNS REP. TO COMMUNICABLE DISEASE CONTROL (Advisory Committee): Dr. J.P. Savage reiterated Department of Health Policy on Rubella which remains: (1) initial vaccination to be done between 13 & 15 months mainly by family doctors and by Public Health; and (2) a second "catch" will be made by continuing to immunize all eleven year old females, done primarily through the school system.

He spoke about the Department objective of eliminating Measles entirely from Nova Scotia, asking the Society to support the

concept of elimination of indigenous measles. Points to be stressed he stated were: (1) raising all patient's consciousness about immunization procedures through literature in the office, etc., (2) offer the vaccine to young patients and discuss it with their parents; and (3) **REPORT ALL CASES.**

At this point lively debate ensued regarding reporting of all cases. Dr. Smith reminded Council that Nova Scotia physicians had fought long and hard to get measles vaccine free of charge in doctors' offices, and that they had agreed to fill out forms regarding immunization to assist the Department in compilation of immunization data. He urged all members to honour their agreement regarding reporting. Dr. Savage assured Council that the Registry is being set up and that he would discuss the various complaints raised with Dr. Sullivan of the Department of Health.

ANNUAL REPORT OF MSNS REP. TO COUNCIL ON SMOKING AND HEALTH: Dr. D.F. Fay spoke to the dangers of smoking and presented a comprehensive review of the Council's activities regarding this problem area. It was moved by Dr. Fay, seconded by Dr. D.C. Brown "THAT The Medical Society of Nova Scotia recommend again that cigarette advertising be prohibited and express concern that neither provincial nor federal government has shown enough activity in this area, THAT Municipal By-Laws concerning non-smoking in public places should be more vigorously applied and enforced, and THAT smoking in hospitals is incongruent with the purpose of these institutions and should be limited to areas where non-smokers are not affected." **CARRIED.**

ANNUAL REPORT OF MSNS REPS. DIAGNOSTIC IMAGING COMMITTEE: Drs. J.A. Chadwick and H.R. Roby. This report was received for information.

ANNUAL REPORT OF MSNS REPS. TO DRUGS & THERAPEUTICS COMMITTEE (Formulary): Drs. Jean Gray and G.C. Jollymore. This report was received for information.

ANNUAL REPORT OF PRESIDENT OF MARITIME MEDICAL CARE INC.: Dr. D.A. MacFadyen informed Council that a working committee comprised of Maritime Medical Care and Health Services and Insurance Commission representatives continues to work on revisions to the Maritime Medical Care Agreement with the Minister of Health and it is hoped that this will come to fruition within the next couple of months.

Dr. MacFadyen highlighted for Council the marked improvement in the Corporation's financial situation. The hope was expressed by Council that M.M.C. would keep up the good work.

ANNUAL REPORT OF MSNS REPS. TO MEDICAL ADVISORY COMMITTEE ON DRIVER LICENSING: Drs. C.C. Giffin & L.P.M. Heffernan. This report was received for information.

ANNUAL REPORT OF MSNS REP. TO NOVA SCOTIA SAFETY COUNCIL: Dr. R.A. Perry. This report was received for information.

ANNUAL REPORT OF MSNS REP. TO NOVA SCOTIA LUNG ASSOCIATION: Dr. R.T. Michael. This report was received for information.

ANNUAL REPORT OF MSNS REP. TO PHYSICIAN MANPOWER SUBCOMMITTEE: This report was presented by Dr. J. Barrie Ross on behalf of Dr. J.F. Hamm who had extended his regrets. Dr. Ross spoke about the growing problems of Residency Training Programs following which it was moved by Dr. J.B. Ross, seconded by Dr. W.F. Mason "THAT The Medical Society of Nova Scotia express to the Minister of Health of the Province of Nova

Scotia its alarm at the increasing reduction of Residency Training Posts at Dalhousie University and the long term effect that this will have on skilled medical manpower in the future, taking into account the current disadvantaged position." **CARRIED UNANIMOUSLY.**

Prior to the vote, Dr. Mason outlined for Council the nature of studies undertaken by Dalhousie and other bodies which clearly showed the need for not only maintenance of the establishments, but in fact increases which will be required to fulfill future needs.

ANNUAL REPORT OF MSNS REP. TO PROVINCIAL MEDICAL BOARD: Dr. G. MacK. Saunders. This report was received for information.

ANNUAL REPORT OF DIRECTOR OF RH COMMITTEE: Dr. Leo J. Peddle. Dr. Peddle's report was received for information.

ANNUAL REPORT OF MSNS REPS. TO REHABILITATION COMMITTEE FOR PHYSICIANS: Drs. H.J. Devereux and W.G. Gill. This report was received for information.

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. The Presidential Valedictory Address 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 1983 EXECUTIVE COMMITTEE:

Antigonish-Guysborough — Dr. Rolf Sers; Bedford-Sackville — Dr. M.J. Flemming; Cape Breton — Drs. B.S. Ignacio and M.E. Lynk; Colchester East Hants — Dr. C.F. Bridge; Cumberland — Dr. D.M. Rippey; Dartmouth — Drs. G.W. Horner & R.A. Oliver; Eastern Shore — Dr. W.C. Brown; Halifax — Drs. J.B. Ross, A.G. Cameron, and V.P. Audain; Inverness-Victoria — Dr. R. Stokes; Lunenburg-Queens — Dr. A.D. Doucet; Pictou — Dr. H.S. Murray; Shelburne — Dr. D.H. Wilson; Sydney — Drs. N.L. Mason-Browne and B.C. Trask; Valley — Drs. A.S. Dill and M. Kazimirski; and Western — Dr. L.J. D'Entremont.

APPOINTMENT OF BRANCH REPRESENTATIVES TO THE 1983 NOMINATING COMMITTEE:

Antigonish-Guysborough — Dr. Rolf Sers; Bedford-Sackville — Dr. R.A. Taylor; Cape Breton — Drs. M.E. Lynk and P.K. Cadegan; Colchester East Hants — Dr. J.McG. Archibald; Cumberland — Dr. R.A. Burden; Dartmouth — Drs. G.W. Horner & M.F. Moriarty; Eastern Shore — Dr. P.D. Muirhead; Halifax — Drs. J.B. Ross, I.A. Cameron and V.P. Audain; Inverness-Victoria — Dr. R. Stokes; Lunenburg-Queens — Dr. G.C. Jollymore; Pictou — Dr. R.A. Nicholson; Shelburne — Dr. J.H.L. Robbins; Sydney — Drs. G.A. Gracie and W.A. Crooks; Valley — Drs. A.B.F. Connelly and Y.M. King; and Western — Dr. D.M. Deveau.

The following nominations were confirmed: President-Elect — Dr. R.D. Saxon of Antigonish; Chairman of Executive Committee — Dr. Vonda M. Hayes of Amherst; Vice-Chairman of Executive Committee — Dr. R. John Fraser of Musquodoboit Harbour; Treasurer — Dr. W.H. Lenco of Liverpool; and Honorary Secretary — Dr. Judy Kazimirski of Windsor.

The 129th Annual Meeting of The Medical Society of Nova Scotia adjourned at 4:00 p.m.

Presidential 'Valedictory' Address — 1982

Murdock A. Smith, M.D.,
Sydney, N.S.

Thank you for giving me the opportunity of serving as your President for the past year. It has been a most enjoyable experience for me and it is not without a little regret that I step down. It is the sure knowledge that Ed Rafuse will be a most capable successor that makes it easier.

I would like at this time to thank the Officers and Executive Committee for their untiring dedication to duty over the past year. They have worked long and hard and their support is much appreciated.

I would also like to take this opportunity to publically thank Doug Peacocke and Doc Schellinck for their help and dedication. These men certainly serve the Society above and beyond the call of duty. They have always given 110% on your behalf. I also thank the office staff for their help and loyalty — Shirley, Tove, Marion, Sherry, Jane and Judy — thank you all.

I would also like to thank two institutions back in Sydney for their support during the past year — my colleagues in the Sydney Family Practice Centre who have taken extra call and allowed me the time to be away as much as I have been, and secondly, the Ashby Bridge Club — a collection of straight plain thinkers who have given me the benefit of other points of view.

I have taken as my theme for this address the concept of RESPONSIBILITY and would like to make a few remarks on the application of that word to the field of medicine in Nova Scotia.

Certainly doctors in this Province are responsible citizens in the usual sense but I believe we have some responsibilities that others perhaps do not have.

We are first and foremost responsible to our patients. To provide the best care possible to our patients is our number one aim, care which is available — appropriate — and of high calibre. There are no barriers to care in this Province and that must remain so. Doctors have a responsibility to keep up-to-date AND refresh their knowledge. The attendance at this week's Dalhousie Refresher Course and the record of participation in Continuing Medical Education show that doctors take this responsibility seriously, often at great personal expense.

Our members are responsible to hospital boards. We welcome opportunities to participate in decisions affecting health care delivery at that level. We need to work closely with Administrators and Hospital Boards in these tough economic times to help plan economies and cost savings if the system is to survive.

Our members are responsible to governments and the people of Nova Scotia. I believe we have shown this in the lack of confrontation and reasonable attitude we have taken in our negotiations. We have taken into account the Province's ability to pay and have not held the people up to ransom. We enjoy good relations with government — not always easy, at the best of times. We will continue to act responsibly in the future.

We must not forget our responsibilities to ourselves — we need to be a strong, united Society to represent the interests of organized medicine. The running of the Society is becoming more and more expensive in terms of both time and money. We must give both our talents and our monetary support if we are to remain effective.

But what of others' RESPONSIBILITY??

Patients need to be responsible in their demands on the system. An uncaring, totally irresponsible demand for more and more service can only result in collapse of the system. The demand for instant care, no matter what time of day or night must be tempered with common sense. We are currently seeing a good program, "Pharmacare", in danger of financial ruin because of abuse. I believe it is only a matter of time before some sort of patient participation is necessary or the whole system will be lost.

In summing up all these responsibilities, we all, collectively, have a major one — the future of Canada as an economically vibrant nation. I have concerns here and would sound a warning.

We live in a time when public expectations in almost every area have been encouraged to expand, often well beyond society's ability to meet them.

Television, for instance, expends a great deal of time and money promoting so-called "magic" products and services which are guaranteed not only to perform wonders, but also, somehow, to transform the user into a brand new person.

We have done very much the same thing to ourselves with our social and health services — making decisions on their expansion, extension and improvement without too much thought about how we are going to pay for them when times get tough.

Unfortunately times *are* getting tough — and they may well get a lot tougher before the current recession — or, if you like, depression — works itself out.

The fact is, we — patients, doctors, politicians and all health workers — simply cannot continue to demand all things from our system and still expect to receive a 100% efficiency and effectiveness in return.

The money just isn't there.

The problem is compounded when Canadians are encouraged to believe that there is a free lunch and there is no limit to health services. That's when we, the physicians and, by extension, all medical workers begin to catch the flak — and that's when a confused and angry public starts to make its voice heard — and when we tend to join the chorus because we're just as confused and angry as our patients.

The question is: having recognized a very real potential for trouble in the system and in the way we misuse it, what do we do about it? The answer lies in the exercise of responsibility — and in its exercise by physicians and patients alike.

But the financial crunch is with us today — and now is not the time to unleash a litany of real and perceived misuses and abuses of the system. Now is the time for us to act responsibly and provide the leadership so badly needed.

We must be looking at effective ways in which we — not just physicians, but all Nova Scotians — can avoid irreparable damage to what I have called the best system in the country — and because it is the best system, we owe it to ourselves to protect it.

Unfortunately, that will mean getting tough — with ourselves and with the structure of the system itself.

It will mean recognizing that there are some things we have to pay for out of our own pockets, and that there are some things that, as patients, we can handle on our own.

We must recognize that we hold a joint responsibility for each specific instance of required medical service.

Let us not forget Governments — the carriers of our health insurance programs. They, too, have major responsibilities. They have a responsibility to provide enough funds to see that the system continues to work as well as it does. Priorities have to be such that health care workers are no longer treated as shabbily as they sometimes are. Hospital budgets have to be considered of higher priority than they are currently. Nurses and other health care workers need to be paid better than starvation wages.

Provincial Governments need to continue to be responsible for health care in their provincial jurisdictions. The Federal Government is wrong to try and lessen the Provincial role. To try and force a system on everyone across the Country is folly. The Federal Government is mistaken in its attempt to institute a "Canada Health Act". They do not know the individual peculiarities of each Province and they should stay out of it. Our Provincial Government must intensify its efforts to ensure retention of our existing programs, and not let them fall prey to those who must see other systems as their model.

If there is one essential task I, as outgoing President, would ask you to address yourselves to in the year to come, it is the need to convince yourselves, to convince governments and hospital boards, and to convince patients that, in spite of tough economic times, good health and medical services are available in this Province and will continue to be available if we grit our teeth, get rid of the "free lunch" complex, and exercise some responsibility.

No Nova Scotian need go without required medical care provided efficiently, effectively and in the manner best suited to his or her needs.

By the same token, no Nova Scotian should stand by and see a basically good medical services insurance system threatened because reality is a little too difficult to face.

Well, my mother always wanted me to be a Minister and this is my first opportunity to deliver a sermon!

This year has been a lot of fun for me and I thank you all for that. □

ANNUAL MEETING EXHIBITS

The Medical Society of Nova Scotia wishes to express its sincere appreciation to those firms who exhibited at or made contributions to its Annual Meeting in November 1982 at the Hotel Nova Scotian.

Anca Incorporated
Boehringer Ingelheim (Canada) Limited
Can-Med Surgical Supplies Limited
Dalhousie Medical Alumni Association
Department of Health
Glaxo Laboratories
Hoffman La Roche Limited
Horner, Frank W. Inc.
McNeil Laboratories (Canada) Limited
M.D. Management Limited
Merck Forst Canada Inc.
Ontario Medical Association
Pennwalt of Canada Limited
Pfizer Continuing Education
A.H. Robbins Canada Limited
Rorer Canada Inc.
Winthrop Laboratories

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

"... It is tragic to witness the successful doctor who works tirelessly for thirty years — only to end up with nothing, financially, to show for it."



Peter R. Arnold, CLU, CFC
(902) 429-6727

Your financial future —
professionally planned

P.R. ARNOLD & ASSOCIATES
FINANCIAL PLANNING CONSULTANTS LTD.

Suite 421/Trade Mart/Scotia Square
Halifax / Nova Scotia / Canada B3K 2Y5

Practice and Financial Management
Services for Health Professionals in Atlantic Canada

Doane Raymond

Chartered Accountants

Halifax	Amherst	Fredericton	Port Hawkesbury
St. John's	Antigonish	Grand Falls	St. Stephen
Saint John	Bathurst	Hamilton	Summerside
Charlottetown	Bridgewater	Kentville	Sydney
Montreal	Campbellton	Marystown	Truro
Toronto	Corner Brook	Moncton	Windsor
Vancouver	Dartmouth	Newcastle	Woodstock
	Digby	New Glasgow	Yarmouth

Medical Estate Planning Services

Donald R. Cox

Suite 3006
Mumford Tower II
Halifax Shopping Centre

Phone: 422-6314

Estate Planning Directed to the Medical Profession

HALIFAX PROFESSIONAL CENTRE SUB-LEASE



Atlantic Trust

Atlantic Trust Company
of Canada

1500-2000 sq. ft. of prime professional office space available immediately, with the possibility of up to 4,100 sq. ft. in total for eventual sub-lease.

Attractive assumable lease expires Aug. 31, 1985, with a five-year renewable option.

Indoor parking available, plus use of tenants' boardroom/lounge.

I.C.I. DIVISION

422-1701

Peter F. Ryan 477-7581

David Brown 479-2977

Gerry Moore 895-8736

John Shaw 429-4075

Gestational Trophoblastic Disease

INCIPIENT MOLAR PREGNANCY WARRANTS STUDY*

B. Pierce, **R.N., R.C. Fraser, † M.D., F.R.C.S.(C) and
I. Zayid, †† M.D., F.R.C.P.(C),

Halifax, N.S.

Fifty patients were registered as having gestational trophoblastic disease in 1981. Forty-one patients had hydatidiform molar pregnancies and nine fell into the category of the "questionable mole".

QUESTIONABLE MOLE

In May 1981, the Department of Pathology, Victoria General Hospital, in conjunction with the GTD Registry and Surveillance Clinic, formulated a policy concerning the "questionable mole". It was commenced in an attempt to answer the question as to whether or not the partial mole, incipient mole, or incomplete mole carry the same significance as a true hydatidiform mole. Three entities were identified as follows:

1. **hydatidiform mole:** where there is diffuse villus hydrops with stromal liquefaction and vesicular formation, accompanied with dimorphic trophoblastic hyperplasia of varying severity.
2. **hydatidiform degeneration:** microscopic diffuse hydropic swelling seen with trophoblastic hyperplasia, generally mild, but no macroscopic vesicular formation of "cystic" degeneration is seen. (questionable mole)
3. **hydropic change:** where there is focal hydropic swelling only. This is not associated with trophoblastic hyperplasia and no vesicles are seen macroscopically.

Pathologists throughout the province have been requested to send representative slides of all patients with trophoblastic disease falling into Group 1 or Group 2 to Dr. I. Zayid, Pathologist at the Victoria General Hospital, thereby ensuring that reporting will be uniform. It is hoped that an answer to the question will be forthcoming within the next several years.

All the "questionable moles" registered to date have had uneventful follow-up. All have had Beta Subunit HCG titres which returned to normal within 15 weeks — usually less.

The geographical breakdown of the 50 patients registered in 1981 are as follows:

Nova Scotia	21
New Brunswick	11
Prince Edward Island	6
Newfoundland	12

*Submitted by: Gestational Trophoblastic Disease Registry, Department of Obstetrics and Gynecology, Division of Gynecologic Oncology and Department of Pathology, Dalhousie University, Halifax, N.S.

**Co-ordinator, Gestational Trophoblastic Disease Registry.

†Director, Gestational Trophoblastic Disease Registry and Professor, Department of Obstetrics and Gynecology.

††Pathologist, Gestational Trophoblastic Disease Registry and Professor, Department of Pathology.

GLOSSARY:

M.G.T.D.—Metastatic gestational trophoblastic disease
N.M.G.T.D.—Non metastatic gestational trophoblastic disease
T.A.—Therapeutic abortion
M.A.—Missed abortion
Spon. A.—Spontaneous abortion
Inc. A.—Incomplete abortion
HCG—Human chorionic gonadotropin (serum) Beta sub unit assay)

Of the 41 patients diagnosed as having hydatidiform molar pregnancies, 1 was not far enough along in follow-up to be included in this report and 2 moved out of the area. Of the remaining 38 patients, 34 were confirmed to have benign moles, 2 had metastatic gestational trophoblastic disease, 1 had non-metastatic gestational trophoblastic disease, and 1 was subsequently found to have choriocarcinoma. These last 4 patients required adjunctive chemotherapy to eradicate their disease completely and in one instance (patient with choriocarcinoma) a hysterectomy was necessary to eradicate the disease.

Benign mole	34 (89%)
M.G.T.D.	2 (5%)
N.M.G.T.D.	1 (3%)
Chorion post mole	1 (3%)

DIAGNOSIS

Twenty-seven patients were diagnosed by ultrasound; one patient with a suspicious ultrasound was diagnosed clinically. Eleven cases were diagnosed histologically following D&Cs which were performed for the following reasons:

T.A.	2
M.A.	3
Spon. A.	2
Inc. A.	4

It is of interest that 1 patient was picked up following examination of placenta after a normal delivery. She presented with a minor degree of bleeding in the second trimester of pregnancy and developed mild fluid retention at 36 weeks. Subsequently, she delivered a normal baby (small for gestational age) who developed some hypoglycemia and some neonatal jaundice which responded to phototherapy. The baby has done very well. When the placenta was delivered a peculiar area was noted and described as a "fleshy clot". This was later confirmed by pathology to be a hydatidiform mole.

ULTRASOUND

A total of 31 ultrasounds were performed. Twenty-seven were positive, 3 were suspicious, and 1 was negative. All 31 were later confirmed by pathology to be hydatidiform molar pregnancies.

FOLLOW-UP

Of the 34 patients diagnosed as having benign molar pregnancies, 6 did not have HCG titres done on a regular basis and therefore cannot be assessed with regard to the following.

Of the remaining 28 patients

- 1 had normal HCG titres 4 wks post evacuation
- 7 had normal HCG titres 8 wks post evacuation
- 11 had normal HCG titres 12 wks post evacuation
- 8 had normal HCG titres 15 wks post evacuation
- 1 patient took longer than 15 wks to return to normal

Therefore 96% were normal within 15 weeks post evacuation

FOUR CASE HISTORIES are briefly outlined below. All four required adjunctive chemotherapy and, in one instance, hysterectomy to completely eradicate their disease.

The first case presented with persistent and non-metastatic disease. Four weeks post-evacuation of the uterus, her HCG titres began to plateau and by eight weeks had risen from an original HCG of 1470 IU/L to 1790 IU/L. At this point the patient was admitted to hospital for one course of single agent chemotherapy (methotrexate and calcium leucovorin rescue). Her HCG titres declined and twenty weeks post treatment this patient had her first normal HCG. All subsequent titres have been normal.

The second case demonstrated metastatic gestational trophoblastic disease with metastasis to the lung. Between six and twelve weeks post-evacuation, her HCG levels began to plateau. Her chest x-ray was positive for metastatic disease. She was admitted to hospital on week thirteen and had her first course of chemotherapy. She subsequently received six treatments of alternating methotrexate and calcium leucovorin rescue, and actinomycin D. Two courses of triple agent therapy (Mtx, Act D, Cytosan) were required due to persistent low levels of HCG. Sixteen weeks post her initial treatment she had demonstrated three consecutive normal HCG levels and her chest x-ray was normal. She remains in remission.

The third case (also M.G.T.D. with metastasis to the lung) demonstrated HCG titres which rose dramatically (from 17,865 IU/L to 30,585 IU/L) between three and five weeks following initial evacuation. A second curettage was done at three weeks which showed persistent molar disease. Her chest x-ray was positive for metastatic disease. She was admitted to hospital on week eight for her first course of chemotherapy with methotrexate and calcium leucovorin rescue. She subsequently received two further courses of single agent chemotherapy with alternating Act D and Mtx. Eleven weeks post initial treatment she had demonstrated three consecutive normal HCG levels and her chest x-ray was normal. She remains in remission.

The fourth case was diagnosed as having choriocarcinoma ten months following evacuation of a benign hydatidiform mole. This patient was under surveillance for seven months following the original diagnosis of hydatidiform mole. Her HCG titres remained normal throughout this period and follow-up was therefore terminated and contraception discontinued.

Three months later she was found to be amenorrhic but urine pregnancy tests on two different occasions proved to be negative. She developed intermittent bleeding and was treated with provera with no effect. Beta subunit HCG was 50 IU/L. (Normal HCG is less than 10 IU/L.) These symptoms continued and her HCG levels began to rise.

She was admitted to hospital for investigation 14 months after the original diagnosis of hydatidiform mole. Her uterine ultrasound was abnormal, and a pelvic arteriogram and uterine curettings suggested choriocarcinoma with extensive myometrial involvement. Further extensive investigations were normal. (The disease was non-metastatic.) Over the next five months she received four courses of chemotherapy (triple agent), but her HCG titres remained elevated. Subsequently an abdominal hysterectomy was performed under chemotherapy coverage, and within two weeks her HCG titres had fallen to within normal limits. Histology confirmed the diagnosis of choriocarcinoma. One further course of chemotherapy was administered. The patient remains in remission.

The total experience of this clinic from 1965 to 1981 is as follows. The numbers in parenthesis indicate the patients who developed NMGTD, MGTD, or choriocarcinoma (post mole or normal pregnancy), and required adjunctive chemotherapy and/or hysterectomy. (1 case only)

	1965-1970	1971-1975	1976-1980	1981
Nova Scotia	13(4)	27(6)	105(12)	14(2)
New Brunswick		8(6)	30(1)	10(1)
Prince Edward Island			4(0)	5(0)
Newfoundland			15(4)	12(1)
St. Pierre			1(0)	
Total patients registered			244*	
Total patients requiring Rx			37(or 15%)	

*The "questionable moles" are not included in these figures.

CONCLUSIONS

This year has brought about some revisions with regard to the follow-up protocol for patients with gestational trophoblastic disease. These alterations in protocol have become necessary as a result of several reported cases of patients who have developed either a recurrence of their trophoblastic disease following a normal pregnancy with an interval of several years from the preceding molar pregnancy, or the development of N.M.G.T.D. after the original six months of follow-up subsequent to the evacuation of a "benign" hydatidiform mole. These changes effect the length of time for follow-up and are as follows:

After hospital discharge:

- a) HCG weekly until three consecutive normal levels are achieved.

b) HCG monthly for one year. Pregnancy is permissible after 6 months of normal titres. If pregnancy is suspected, an ultrasound is indicated for early confirmation.

b) HCG once a month for two years. Pregnancy is permissible after two years of normal titres. Again if pregnancy is suspected an ultrasound is indicated.

c) HCG once every three months for the third year.

d) HCG once every six months for the fourth year.

e) Yearly thereafter.

If chemotherapy was required then the follow-up is:

a) HCG weekly until three consecutive normal levels are achieved.

b) HCG monthly for one year.

c) HCG once every three months for one year. Pregnancy is permissible after 12 months of normal titres. If pregnancy is suspected an ultrasound is indicated for early confirmation.

All patients with a previous history of trophoblastic disease must have a Beta Subunit HCG Assay performed six weeks following all subsequent pregnancies irrespective of outcome.

If chemotherapy was administered for high risk trophoblastic disease the follow-up is:

a) HCG weekly until three consecutive normal levels are achieved.

We at the clinic would like to extend our sincere thanks to the patients, physicians and pathologists for their continued support and co-operation.

□

A Natural...

NOW 30 trails... **SUTTON**

65 miles east of Montreal, **Mont Sutton** is the largest complex in the **Ski East** region. 7 lifts in a natural snow belt... 3,000' elevation, over 1,500' vertical... long runs... sous-bois (glade) skiing... a choice for all categories of skiers... 5-day lift ticket (Monday-Friday) \$59. Snow condition reports, 24 hour TAS (514) 866-7639.

For reservations:

514/538-2646 - 538-2537
Sutton, Quebec J0E 2K0

ski
EAST
DANS L'EST

A Case of Giant Retrofemoral Synovial Cyst

Ahmet M. Slomic,* M.D., F.R.C.P.(C),
George A. Lawrence,** M.B., B.S., F.R.C.S. (Edin), F.R.C.S., and Chu-Ying Khor,*** M.D.,

Amherst, N.S.

A case of giant retrofemoral synovial cyst is reported with emphasis on the differential diagnosis. The arthrogram of the knee was crucial to diagnosis.

The retrofemoral synovial cyst (RFSC) is a rare location of synovial cyst! We have recently seen a case, and we have found only 10 cases in the literature. The RFSC may mimic different conditions. The available clinical diagnostic tests are meagre except for radiological examination. The arthrogram has an important role to play, showing the cyst and its connection with the knee joint. Furthermore, in some cases, it may help to elucidate the etiology.

CASE REPORT

E.Y., an 82 year old white male had been complaining of vague discomfort and increasing swelling in the left thigh for three years. He otherwise was in good health for his age. On examination, a large, firm swelling was noted at the posterior aspect of the distal half of the thigh. There was a small amount of patellar crepitus, but no effusion in the knee joint. There was also pitting edema of the lower leg. Peripheral pulses were present and there was no evidence of diminished blood flow. In spite of the edema of the leg, the Homan's sign was negative. The clinical impression was of a soft tissue tumor.

The X-rays of the left thigh (Fig. 1 and 2) show an opaque large soft tissue mass which ruled out a lipoma. The possibility of an aneurysm was not considered in view of the absence of a bruit or pulsation in the mass. When punctured, 30 ml of clear yellowish fluid was obtained. The same quantity of Hypaque M 60 was injected flowing freely into the mass without trace. Thereafter, the single contrast arthrogram of the knee was performed (Fig. 3 and 4) showing a small popliteal cyst as well as an ascending branch of this tractus connecting the knee joint to the soft tissue mass. The diagnosis was that of a double synovial cyst. One was popliteal and the other a giant RFSC measuring 16 by 20 cm on the film. In addition, the arthrogram (not shown here) showed some degenerative changes of the knee joint.

The laboratory investigation showed normal CBC and ESR. The cytology smear of the aspirated fluid showed an amorphous material with scanty amount of polymorphonuclear and round cells. There was no evidence of malignant cells.

The excision of the cysts was carried out two months later. The wall of the giant RFSC was very thin and adherent in part to the popliteal vessels, nerves, and muscles. The cyst was removed after more than 1500 ml of yellow clear fluid being aspirated. There was no apparent connection with the knee joint. One saw no obvious cause for this cyst. The smaller popliteal cyst which measured 5 cm in diameter was also removed. A hemovac was inserted and the wound closed including the deep fascia. It drained fluid for several days. The surgical site had to be aspirated on four occasions within a month postoperatively. It remained dry thereafter.

Microscopically, the lining cells of the two cysts were flattened cells in most areas and cuboidal synovium in others. Elsewhere, there were no definite lining cells. Both cyst walls were composed of dense fibrous tissue. The wall of the smaller cyst was rather hyperemic and edematous. Infiltrates of histiocytes, plasma cells, and lymphocytes were evident within the cyst walls.

The patient was well twenty five months after the operation.

DISCUSSION

Baker described formation of synovial cysts in the knee² and other joints³. The popliteal synovial cyst, also called Baker's cyst, is very common. The RFSC, a higher location of the popliteal synovial cyst, is very rare. Pallardy *et al.*¹ found the retrofemoral location of synovial cysts in only 5%. Table I gives a list of authors who have described RFSC. In our case we have not only encountered a double popliteal synovial cyst but also a rare RFSC of giant form containing 1500 ml of fluid.

TABLE I
LIST OF THE 10 PUBLISHED CASES
WITH RETROFEMORAL SYNOVIAL CYSTS

Authors	Year of Publication	Number of Cases
Pallardy ¹	1971	5
Grepl ⁴	1973	2
Hall ⁵	1966	1
Hench ⁶	1966	1
Meurman ⁷	1978	1*

The age distribution of the popliteal cysts shows two peaks, one at 5 years and the other at 50 to 60 years⁸. The RFSC however is observed in adult age only. Our case is that of an 82 year old man.

The main manifestation of our case is a retrofemoral swelling. The differential diagnosis of this retrofemoral

*Radiologist, **Surgeon, and ***Pathologist of the Highland View Regional Hospital, Amherst, N.S.

Reprint requests: Dr. Ahmet M. Slomic, Department of Radiology, Highland View Regional Hospital, Amherst, N.S. B4H 1N6



Fig. 1
Left knee, a-p view: large dense mass at the lower half of the thigh.

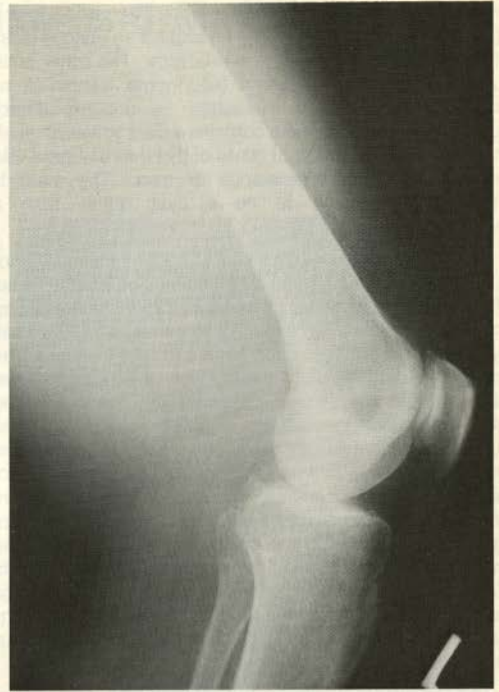


Fig. 2
Lateral view of the left knee: the lower limit of the soft tissue mass is better visualized.



Fig. 3
Single contrast arthrogram of the knee, lateral view: there is a small popliteal synovial cyst and an ascending tractus leading to the large soft tissue mass.

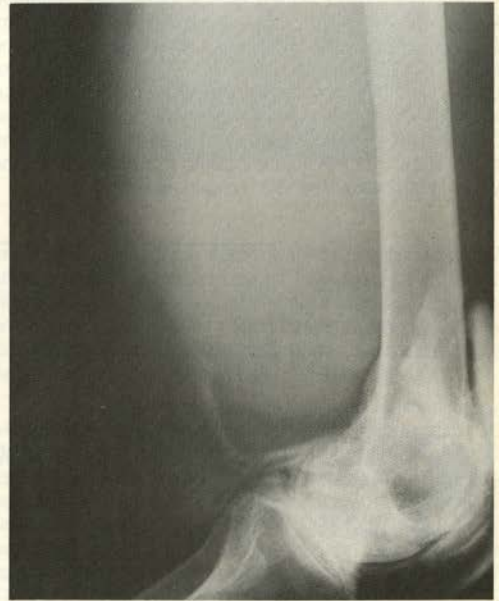


Fig. 4
Arthrogram, lateral view after exercise of 1 min.: the small popliteal cyst is now empty. The ascending tract is connecting the RFSC with the knee joint.

swelling includes solid or cystic tumors. The diagnosis of a lipoma is ruled out by the X-ray findings of an opaque mass of the soft tissue without hyperlucency. The other solid tumors, benign or malignant (neurinoma, xanthoma or fibrosarcoma etc.) are eliminated by the exploratory puncture of the mass which contains a clear yellowish fluid. In addition, the injection of 30 ml of dye into the mass was done without either resistance or trace. The mass is therefore considered to be a cyst rather than a lymphangioma.

In retrospect, the 30 ml of the dye is obviously not sufficient to opacify the giant RFCS of 1500/ml. volume. The arthrogram (Fig. 3 and 4) demonstrates one bifurcating tractus, one branch connecting clearly the knee to the small cyst, the other leading to the large retrofemoral mass. The connection between them is established only after exercise. We, as Pallardy *et al*¹ assume that the communication exists. We therefore incline to classify these two cysts as double synovial cyst rather than as bursal because of the presence of these communications. The surgeon has not been able to find these two communications at operation. This is not surprising because the communication was not established in about 24% of the popliteal cysts reported in the large series⁹. The non-communication was attributed to cicatrization of the tractus or inspissation of the cystic content. In our case, there was a lapse of two months between the arthrogram and the operation. The tractus might have been obliterated by cicatrization.

The synovial cyst is the result of any synovial expansion due to meniscal derangement, rheumatoid arthritis, osteoarthritis etc.¹⁰. In our case the knee showed only mild osteoarthritis.

The formation of the cyst is attributed by some authors to pumping of effusion from the knee into the cyst in addition to a valvular mechanism.¹¹ In our trial of cystography, 30 ml of hypaque apparently was not sufficient to opacify the giant RFCS. In future, in order to prove that the fluid is not flowing from the cyst to the knee, due to the valvular mechanism, we should opacify completely the synovial cyst after the synovial fluid has been aspirated. The arthrogram should show that the fluid is flowing from the knee to the cyst as in our case.

In conclusion, the arthrogram was crucial in the diagnosis of the double synovial cyst showing the cysts and their connection to the knee joint. □

ACKNOWLEDGMENTS

We would like to thank Dr. M. Azouz for his help and encouragement, and Mrs. I. Slomic for secretarial assistance.

References

1. Pallardy G, Fabre P, Ledoux-Lebard G, Renoud JP, Delbarre F. Diagnostic des bursites et kystes poplites par arthrographie du genou. *Revue du Rhumatisme* 1971;**38**: 345-360.
2. Baker WM. On the Formation of Synovial Cysts in the leg in Connection with Disease of the Knee Joint. *St. Bartholomew's Hosp Reports* 1877;**13**: 245-261.
3. Baker WM. The Formation of Abnormal Synovial Cysts in Connection with the Joints. *St. Bartholomew's Hosp Reports* 1885;**21**: 177-190.
4. Grepl von J. Beitrag zur positiven Arthrographie bei pathologischen Veränderungen der Bursa popliteae. *Fortschr Röntgenstr* 1973;**119**: 84-90.
5. Hall AP, Scott JT. Synovial Cysts and Rupture of the Knee Joint in Rheumatoid Arthritis. An Arthrographic Study. *Ann rheum Dis* 1966;**25**: 32-41.
6. Hench PK, Reid RT, Reames PM. Dissecting Popliteal Cyst Simulating Thrombophlebitis. *Ann Int Med* 1966;**64**: 1259-1264.
7. Meurman KOA, Luppi A, Turunen MJ. A Giant Retrofemoral Baker's Cyst. *Brit J Radiol* 1978;**51**: 919-920.
8. Gristina AG, Wilson PD. Popliteal Cysts in Adults and Children. *Arch Surgery* 1964;**88**: 357-363.
9. Kirpila J, Ripatti N. On Baker's Cyst and its Treatment. *Acta Rheum Scand* 1958;**4**: 296-302.
10. Moore PT. Popliteal Cysts. *Sem Roentgen* 1982;**17**: 3-4.
11. Jayson MIV, Dixon ASTJ. Valvular Mechanisms in Juxta-Articular Cysts. *Ann Rheum Dis* 1970;**29**: 415-420.



ALFRED J
BELL & GRANT Limited
INSURANCE SPECIALISTS

bank of montreal tower, george street, (p.o. box 8)
halifax, nova scotia (902) 429-4150, telex 019-21713

"INSURANCE — THAT'S ALL!"

MICHAEL RITCHIE B.Sc., M.C.P.A.

SCOTIA PHYSIOTHERAPY

Office Hours 8 a.m.-7 p.m. Mon.-Fri.

6389 Coburg Rd.,
Halifax, N.S. B3H 2A8

(902) 425-3065

Charles Dickens: Halifax and Medicine*

J.A.R. Tibbles,**M.B., F.R.C.P.(C),

Halifax, N.S.

INTRODUCTION

Charles Dickens was born in Portsmouth, in the South of England in 1812. Before he was 30 he had visited Halifax on his way to the United States and was acclaimed in a manner usually reserved for Royalty. Between these dates his character and potential had been formed by the combination of an extraordinary upbringing and his own remarkable talents.^{2,3} His background also accounts for his passionate sense of justice and his very active social conscience which, in the long run, was responsible for his having been more effective in preventing ill health than would have been likely as a physician.

His father, John Dickens, was a clerk in the Navy Pay Office which accounts for the family moves in his childhood from Portsmouth to London, to the naval dockyard at Chatham and later back again to London in less happy circumstances. John Dickens was an expansive man who loved life, generally lived beyond his means, and had a unjustified faith that silver linings to the clouds of his life would always appear at the right time. He later flowed from Dickens' pen as Mr. Micawaber. His father's love of books and his library must have started Dickens' love of reading.

Poverty in the Dickens' family lead to Charles working as a 12 year-old labelling pots of blacking, and lack of money meant that he could not attend school and so would wander the streets of London drinking up the sights and sounds of the city. Fortunately for him, his mother's family connections enabled Charles to get a position as office-boy to an attorney's firm which gave him early experience of the law courts and, during this time, he learned shorthand. Again, through his mother's connections, he became a reporter in the Houses of Parliament and was considered one of the very best for his accuracy in reporting and speed in transcription. It was here that Dickens saw the actors on the stage of Parliament although he was not greatly impressed by them.

When he was merely 22 he began both to report "Street Sketches" in the paper *Morning Chronicle* as well as articles for a monthly magazine. It was in the former that his nickname of "Boz" became known: *Sketches by Boz* became popular and led to a proposal that Dickens should write a series of stories to accompany illustrations by a well-known artist. With typical panache Dickens negotiated that the artist should provide illustrations to the stories that he would write and thus the *Pickwick Papers* was born.

It was with these and other successes already behind him that Dickens, reluctantly accompanied by his wife, Kate, set sail for America in January 1842. "Two passengers' wives (one of them my own) lay already in silent agonies on the sofa. A heavy sea and a headwind. The water jug is plunging



"Charles Dickens 1839" by Maclise.

and leaping like a lively dolphin, all the smaller articles are afloat, except my shoes. Suddenly I see them spring into the air. At the same time the door entirely disappears, and a new one is opened on the floor. Then I begin to comprehend that the stateroom is standing on its head . . . the ship rights. Before one can say "thank heaven" she wrongs again".

" . . . we were running as we thought into Halifax Harbour, with little wind and a bright moon . . . when suddenly the ship struck upon a bank of mud . . . for a few minutes we were in as lively a state of confusion as the greatest lover of disorder would desire to see. After throwing up a few rockets and firing signal guns in the hope of being hailed from the land . . . it was determined to send a boat onshore. Our Captain had foreseen from the first that we must be in a place called the Eastern Passage; and so we were."

But Dickens' brief visit of less than 24 hours to Halifax was a pleasant contrast to his experiences on the *Britannia*.

"But, I carried away with me a most pleasant impression of the town and its inhabitants, and have preserved it to this

*From an address given to the Ballona Club of Halifax 1982.1

**Associate Professor, Department of Paediatrics, Dalhousie University Medical School, Halifax, N.S.

hour. Nor was it without regret that I came home, without having found an opportunity of returning there and once more shaking hands with the friends I made that day."

"The Governor, as her Majesty's representative, delivered what may be called the Speech from the Throne. He said what he had to say manfully and well. The military band outside the building struck up "God Save the Queen" with great vigor before his Excellency had quite finished."

"The Ins rubbed their hands; the Outs shook their heads. The Government party said there never was such a good speech: the Opposition declared there never was such a bad one."

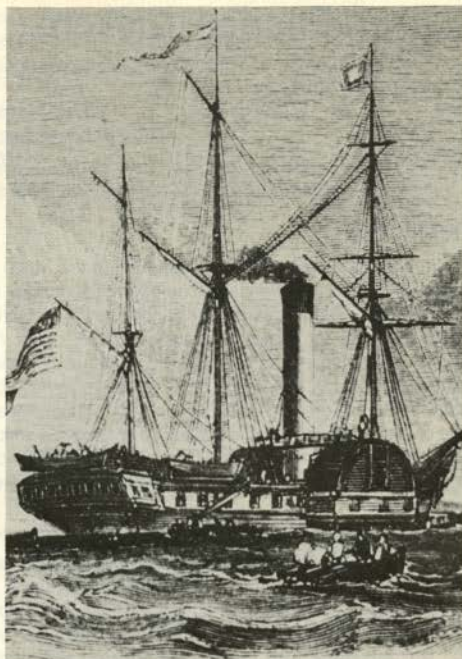
It was indeed fortunate that Dickens' arrival coincided with the opening of the Legislature and that none other than Joe Howe was there to greet the famous young author and take him to hear the ceremony. That Dickens' account of his rough voyage is not exaggerated is borne out by the papers of the day. From the *Halifax Morning Post*, January 22, 1842: "The steamship Britannia arrived this morning at 11:00. The Britannia experienced very heavy weather, having had her paddle boxes much injured and her lifeboat stove to pieces during a tempestuous gale. During the dense fog which enshrouded the coast last evening she grounded off the Harbour, but was got off again in a few minutes".

The impression made by the handsome author is best conveyed by the descriptions in the local papers.

Halifax Morning Post, January 22. "We have enjoyed the pleasure of an interview with the immortal Boz. We have grasped the hand . . ." and "the best looking man I ever saw" and, from the *Nova Scotian* of February 10, 1842 "an elegant young man over whose brow it may be some 30 summers had passed", "delightfully, but swiftly passed the moment in which I gazed upon the living picture of him".

While Speeches from the Throne are generally not memorable, there is a certain contemporary note to the one that Charles Dickens would have heard, read by the Lieutenant Governor, Viscount Falkland. In it he says "Any step which you will consider as having a tendency to ameliorate the condition of the Indian population of Nova Scotia will, I am convinced, meet with your ready concurrence".

Dickens' brief trip to Halifax lasted less than 24 hours. He dined at the old European Hotel in Halifax that was but three years old then: this was on Upper Water Street and was demolished in the 1930s. His short stay, however, impressed Dickens: he likened our legislature as being "so closely copied from Britain's Parliament that it was like looking at Westminster through the wrong end of the telescope". He planned to return, but unfortunately never did. The *Acadian Recorder* for December 9, 1867 notes that "The mayor had received a letter from Charles Dickens in which he intimated his wish to give 1 or 2 readings in Halifax in late April or early May 1868". However, this was not to be, and the meeting between Halifax and Dickens remained a single brief encounter. From here the author travelled to Boston, down the Eastern seaboard and through a number of the States of the Union which were duly recorded in his "American Notes" but aroused ire. He also returned to Upper Canada on his way home and wrote somewhat less warmly of one city, "Indeed it may be said of Kingston that one-half of it appears to be burnt down and the other half not yet built up".



"S.S. Britannia in which Dickens sailed to Halifax".

It is exciting to view Dickens' accomplishments as a pediatrician and as a neurologist.

DICKENS AS PEDIATRICIAN

Early accounts of *dyslexia* generally fail to mention the classic early description of Dickens' characterization of Pip in *Great Expectations* (1861). "I struggled through the alphabet as if it had been a bramblebush, getting considerably worried and scratched by every letter. After that, I feel among thieves, the 9 figures, who seemed to disguise themselves and baffle recognition".

Blindness. In his *American Notes*, describing his visit to Boston immediately after leaving Halifax (1842), he writes "It is strange to watch the faces of the blind: and see how free they are from all concealment of what is passing in their thoughts. Observing which, a man with eyes may blush to contemplate the mask he wears".

He also describes one of the children in the Perkins' Institution for Blind, a girl called Laura Bridgman. "At the end of a year a report of her case was made. It was determined that she cannot see a ray of light, cannot hear the least sound and never exercises her sense of smell". "She seems to reason and reflect and argue. If she spells a word wrong with the fingers of her right hand she instantly strikes it with her left as her teacher does. She sometimes purposely spells a word wrong, looks roguish for a moment and then laughs".

Mental Retardation. From *Barnaby Rudge* (1841). No modern clinician reaches the insight of Dickens.

"Starting as his aspect was the features were good and there was something even more plaintive in his wan and haggard aspect. But the absence of the soul is far more terrible in the living man than in a dead one and in this unfortunate being its noblest powers were wanting. . . . The fluttered and confused disposition of all the motley scraps that formed his dress bespoke, in a scarcely less degree than his eager and unsettled manner, the disorder of his mind, and by a grotesque contrast set off and heightened the more impressive wildness of his face".

The feelings of the mother of a mentally retarded child are poignant. "Two and twenty years. A boy's whole life and history. The last time she looked back upon those roofs among the trees, she carried him in her arms as an infant. How often since that time has she sat beside him night and day, watching for the dawn of mind that never came; how had she feared and doubted and yet hoped, long after conviction forced itself upon her! The slow and gradual breaking out of that one horror in which before his birth his darkened intellect began; how in the midst of it all she had found some hope and comfort in his being unlike another child, and had gone on almost believing in the slow development of his mind until he grew a man, and then his childhood was complete and lasting".

Kleine Levin Syndrome. From the *Pickwick Papers* (1837) Mr. Wardle unconsciously changed the subject, by calling emphatically for Joe.

"Damn that boy" said the old gentleman "he is gone to sleep again".

"Very extraordinary boy that" said Mr. Pickwick "Does he always sleep in this way?"

"Sleep!" said the old gentleman "He is always asleep. Goes on errands fast asleep, and snores as he waits the table".

"How very odd!" said Mr. Pickwick.

"Ah! Odd indeed" returned the old gentleman "I am proud of that boy — wouldn't part with him on any account — damn, he is a natural curiosity! Here, Joe — Joe — take those things away, and open another bottle — do you hear?"

The fat boy rose, opened his eyes, swallowed the huge piece of pie that he had been in the act of masticating when he last fell asleep, and slowly obeyed his master's orders — gloating languidly over the remains of the feast."

MacDonald Critchley⁴ applied the eponym Kleine Levin Syndrome to patients who had episodic drowsiness, morbid hunger or compulsive eating, an incidence of onset in adolescence and a predominance in males. To this may be added irritability when roused and sexual aggressiveness in a percentage, but not apparently in Dickens' fat boy.

Critchley later gave the rather Dickensian title of "The Syndrome of Periodic Hyper-somnia and Megaphagia in adolescent males" to the Kleine Levin Syndrome in order to emphasize the periodic nature of the condition and also the distinction between compulsive eating which is characteristic rather than excessive hunger and appetite. It is a pity that the term Pickwickian Syndrome was applied by Burwell⁵ to the syndrome of severe obesity with secondary alveolar hyper-ventilation and drowsiness because the Kleine Levin Syndrome could have been better christened.

Social Pediatrics. Of Dickens' novels, most of them give a prominent if not the main place to children. The harshness of life for children was thrust before the public and served as a catalyst to the social conscience of England.⁶ The Hospital for Sick Children in London benefited by Dickens' speaking on its behalf, the horrors of poverty which Dickens' saw firsthand in his childhood were exposed by him and his sense of outrage at cruelty is well brought out by this account of solitary confinement (*American Notes*, Chapter 7). "I hold this slow and daily tampering at the mysteries of the brain to be immeasurably worse than any torture of the body: and because its ghastly signs and tokens are not so palpable to the eye and sense of touch as scars upon the flesh; and his wounds are not upon the surface, and it extorts few cries that human ears can hear; therefore I the more denounce it, as a secret punishment which slumbering humanity is not roused up to stay."

DICKENS AS A NEUROLOGIST

Sir Russell Brain⁷ offers the suggestion that Dickens may have been the first to describe the Argyll Robertson pupil. From *Little Dorrit*, describing Maggie "She was about 8 and 20, with large bones, large features, large feet and hands and large eyes. Her large eyes were limpid and almost colourless; they seemed to be very little affected by light and to stand unnaturally still."

In *Great Expectations* (1861), one of the most complete novels in the English language, there is a superb and accurate clinical description of a head injury. Mrs. Joe Gargery, Pip's sister, was the victim. ". . . and so I became aware of my sister — lying without sense of movement on the bare boards where she had been knocked down by a tremendous blow on the back of the head, dealt by some unknown hand . . ." "My sister lay very ill in bed. Her sight was disturbed so that she saw objects multiplied, and grasped at visionary teacups . . .; her hearing was greatly impaired, her memory also; her speech was unintelligible."

"A tremulous uncertainty of action of all her limbs soon became a part of her regular state, and afterwards, at intervals of two to three months, she would often put her hands to her head and would remain there for about a week at a time in some gloomy aberation of mind."

Again there is an excellent clinical description of post-traumatic aphasia which also affected the unfortunate Mrs. Gargery.

"Her speech was unintelligible . . . When at last she came around so far as to be helped downstairs, it was still necessary to keep my slate always by her, that she might indicate in writing what she could not indicate in speech. As she was, bad handwriting apart, a more than indifferent speller . . . Again and again my sister had traced upon the slate a character that looked like a mysterious letter "T" . . . I had in vain tried everything producible that began with "T" from tar to toast. . . . At length it came to my head that the sign looked like a hammer, and on my calling that word in my sister's ear she had begun to hammer on the table . . . Orlick (her assailant) without a doubt! She had lost his name and could only signify him by his hammer." There could be no better description of aphasia without agraphia and with the patient having preservation of intellect. Indeed since it was only in 1861 that Broca described the localization of aphasia

in which he stated that it was due to a lesion of the third frontal convolution of the left hemisphere, it is arguable that Dickens might be given credit for this description!¹⁸

The Miss Havisham Syndrome is the description given to a condition also first described by Dickens in *Great Expectations*. The index case, Miss Havisham, was an attractive young woman, the spoiled child of a wealthy brewer who was jilted by her fiancé on the wedding day. Following this catastrophe she continued to live as a recluse, clothed perpetually in the fading satin of her bridal dress. She had stopped the clocks at twenty minutes before nine, the moment of her calamity. She did not put foot outside her house or allow sunlight to filter through the shutters onto the dust and cobwebs around her. Twenty-five years later young Pip came to the scene and found this strange lady. She had bridal flowers in her hair, but her hair was white: she had jewels sparkling on her neck and hands, but half-packed trunks were scattered around the room and everything was lack-luster faded and decaying.

This, though a fictional description, anticipates other well-described cases in which a severe emotional shock, generally to well-born and dominating young women, is followed by them attempting to freeze events and to deny the passage of time. Other well-known examples include Jane Elgee who was the mother of Oscar Wilde. Cumulative problems including a dissolute husband, who was an E.N.T. surgeon, the scandal of a Dublin prosecution, her son Oscar and other disasters became an insupportable stress. She became progressively eccentric in dress and manner and it had been said that she received her friends with blinds drawn and shutters closed, that none might see her withered face. She sat brooding in a darkened room day after day occupying herself with the memories of seventy years.

The syndrome is not always irreversible. The most famous patient was Queen Victoria who was widowed in 1861 — the year of *Great Expectations*. Lytton Strachey described a suite of room within Windsor Castle perpetually excluded from the gaze of all except the most privileged. There all remained as it had been at the time of her husband's death. On the Queen's command Prince Albert's clothing was laid pressed and ready on the bed each evening with basins filled with fresh water as though he were still living. Such a ritual was carried out with regularity for nearly 40 years while the widow of Windsor was immured within the palace walls. Ultimately, as is known, the Queen emerged from her semi-retirement bowing to the pressure of mounting public protest.

CONCLUSION

In conclusion, it can fairly be argued that, while Dickens was not a licenced physician, his clinical skills exceeded those of most of us. It can also be claimed that his social conscience and deep knowledge of the injustices of Victorian England combined with his accurate descriptive powers and sense of drama did more to change unhygienic cruel and degrading conditions than one physician would ever have achieved. It is therefore fitting that from the first part of the New World on which Dickens ever set foot we from Nova Scotia should pay tribute to the master storyteller of our time. □


References

1. Bellona Club. From *"The Unpleasantness at the Bellona Club"*. Dorothy L. Sayers. 1929. Gollancz.
2. *Dickens of London*. Wolfe Mankowitz, Macmillan. 1976.
3. *The World of Charles Dickens*. Angus Wilson, Viking Press 1970.
4. *The Divine Banquet of the Brain and other Essays*. MacDonald Critchley. Raven Press 1979.
5. Burwell CS, Robin ED, Whaley RD, Bickelmann AG. Extreme obesity associated with alveolar hypoventilation — a Pickwickian syndrome. *Am J Med* 1956; **21**:811-818.
6. Jones PG. Dickens' literary children. *Aust Paediat J* 1972; **8**:233-245.
7. Brain R. Dicksonian diagnoses. *Brit Med J* 1955; **2**:1553-1556.
8. Strachan CG. The medical knowledge of Charles Dickens. *Brit Med. J* 1924; **2**:780-782.

TIME TO QUIT
REMEMBER WEEDLESS WEDNESDAY
January 26th

The Night Watch

The restaurant in town.
With a nautical air and a chef
who's inspired. A birds-eye
view of the city and harbour.
At Night, it all turns on
for you and twinkles while you dance.

CP Hotels 

Chateau Halifax

1990 Barrington St.,
Scotia Square, Halifax B3J 1P2
Telephone (902) 425-6700



CP and  are registered trade marks of Canadian Pacific Limited

Appreciations

DR. ARTHUR M. MARSHALL

With the death of Arthur Marshall on September 6, 1982, the medical profession has lost one of its outstanding members.

Dr. Marshall graduated from Dalhousie Medical School in 1922. He was a general practitioner in Petitcodiac, N.B., and later in Halifax, and then studied in Vienna and Edinburgh, receiving an F.R.C.S. in 1934. He subsequently returned to Halifax, where he developed a large general and surgical practice; he had a very busy life until his retirement in 1972. His associates have remarked that it was not unusual for him to see fifty to seventy-five patients daily in his office, and make house calls as well. He provided exceptional service to patients and responded cheerfully to night calls.

He was a member of the Active Surgical Staff of The Children's Hospital, and of the Courtesy Staffs of the Victoria General Hospital, the Halifax Infirmary and the Grace Maternity Hospital. He was a Past President of the Halifax Medical Society and in 1975 was elected a Senior Member of The Medical Society of Nova Scotia.

He had been Vice-Commodore of The Armdale Yacht Club and was a keen curler.

He is survived by his wife, Gertrude, a son, Dr. Cleland, daughters Mary Ann and Ruthie, to whom the profession extends deep sympathy.

His contribution to medicine has been great, and we will probably meet few to equal his devotion to his patients and his profession — a gentleman of the "Old School". □

E.F. Ross, M.D.

DR. L. S. CYRIL MENDIS

Dr. L. S. Cyril Mendis, 64 of Halifax, died October 1, 1982 at the Victoria General Hospital, after a brief illness.

Born in Ceylon (now known as Sri Lanka), he was the son of Dr. George and Mrs. Mary Lillian Mendis. He graduated from the Ceylon Medical College in 1941. After a brief stint in government service, he established his own private practice in Ceylon. He underwent post-graduate training in internal medicine at the Royal Infirmary, Edinburgh, Scotland and obtained the Membership of the Royal College of Physicians. He was subsequently conferred the Fellowship of the Royal College of Physicians, Edinburgh, Scotland. On his return to Ceylon he resumed his private practice. He was personal physician to many senior members of the diplomatic corps, including the then Canadian High Commissioner in Ceylon. He started a private hospital in Ceylon and also established the first private blood bank and the first intensive coronary care unit. He also founded the Electro Medics Ltd. to provide radiological and laboratory services to patients.

Dr. Mendis moved to Halifax, Nova Scotia in 1972 where he had a medical practice until the time of his death.

Dr. Mendis' many hobbies included carpentry, gardening, music and in recent years he became very interested in the

harnessing of solar energy for use as an affordable alternative in private homes.

Dr. Mendis was gracious, gentle and gifted. He quiet, kind, humble, unassuming and generous manner endeared him to his patients. He did not choose to raise his voice to put forth his point of view and yet he was the undutiable leader of the growing Sri Lankan community in Nova Scotia. He was a guide, philosopher and friend to these expatriates.

Dr. Mendis attended the Trinity Anglican Church in Halifax. He was a deeply religious man even if he did not wear his religious conviction on his sleeve.

To his widow, Cynthia and his sons, Talak and Kumar, we offer our deepest sympathies and heartfelt condolences on their irreparable loss. □

P. Gujral-Newman, M.D.

DR. H. HAROLD TUCKER

Dr. H. Harold Tucker, 58, died September 13, 1982 at the Moncton City Hospital after a brief illness.

Born in West Newbury, Mass., Dr. Tucker was the son of the late Herbert and Leona (Steele) Tucker. He received his B.Sc. from Mount Allison University in 1946 and his M.D.C.M. from Dalhousie University in 1951. He underwent post-graduate training in Neurosurgery in Halifax, Toronto and Boston and received his F.R.C.S.(C) in 1955 and his F.A.C.S. in 1958.

Dr. Tucker joined the staff of the Department of Neurosurgery at Dalhousie University in 1956, where he continued to practise until 1972. At that time he moved to Moncton, New Brunswick and developed a Department of Neurosurgery at the Moncton City Hospital where he continued in active practice until his death. Active in Neurosurgical Societies he was a member of the Canadian Neurosurgical Society, The American Association of Neurological Surgeons and the Atlantic Neurosciences Society.

During the Second World War, Dr. Tucker served with the First Special Services Force as a Commander. An avid sailor he was a member of the Nova Scotia Yacht Squadron and the Shediac Yacht Squadron where he was Commander in 1978.

He is survived by his wife, Sally (Diamond) Tucker and five daughters: Mrs. Catherine Standfield, Dartmouth, Nova Scotia; Jane Tucker, Toronto; Mrs. Annette Gillis, Calgary; Jacqueline Tucker, Edmonton, Alberta; Mrs. Victoria Sullivan, Kelowna, British Columbia; two sons: William, Goose Bay, Newfoundland; Brent, Riverside; and two adopted children, Karelyn and Ben Vickers, both in Moncton.

Dr. Tucker gave selflessly of his energies and talents to the people of the Atlantic Region and will always be remembered by his colleagues and patients for his devotion to the practise of Medicine. He will be sorely missed. □

W. S. Huestis, M.D.

Pictorial Highlights 129th Annual Meeting



1.



2.



3.



4.



5.



6.



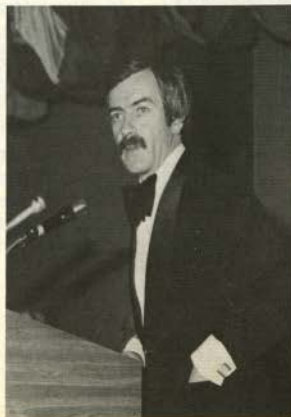
7.



8.



9.



10.



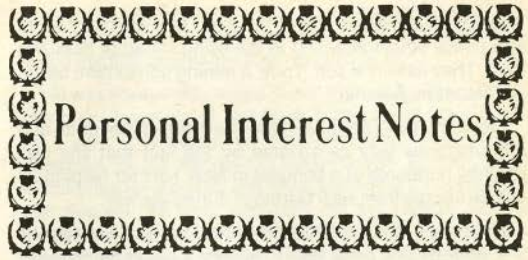
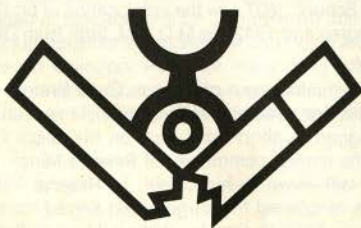
11.

CAPTIONS

1. The Minister of Health for Nova Scotia, Dr. Gerald Sheehy addresses the membership of the Medical Society. His denunciation of the proposed Canada Health Act was well received assurance of continuing co-operation between the Government of Nova Scotia and the Medical Profession.
2. Dr. Murdock A. Smith accepts Halifax Medical Society contribution of \$2500.00 toward furnishing the Medical Society's new office suite.
3. Dr. Marc Baltzan, speaking as President of the Canadian Medical Association, comes down hard on Monique Begin's Proposed Health Care Act.
4. The Eastern Provinces Presidents confer with Dr. Marc Baltzan, C.M.A. President, during Reception at the Society's Annual Meeting. Shown are: Dr. Ivan Woolfrey, Dr. Marcien Fournier, Dr. Baltzan, Dr. M.A. Smith, Dr. Bob Hennessy. Missing is Dr. Tom Cottreau of P.E.I. who was unavoidably delayed.
5. Classmates of Murdock gather round as his term of Office as President of The Medical Society of Nova Scotia comes to an end. Shown are — David Andrews, Alan Covert, Vince Audain, Brian Byrne, Murdock, Sandy Cameron, Paul LeBrun, Wayne Putnam and Ian Cameron.
6. Dr. Eleonore Bergmann-Porter is confirmed as a Senior Member of The Medical Society of Nova Scotia by Dr. Murdock A. Smith, having been presented by Dr. Diane Deveau, President, Western Branch Medical Society.
7. Dr. Art Titus, widely known and respected as the Medical Director of M.M.C. receives Honorary Membership in the Society and congratulations from Dr. Jack Charman and Dr. Murdock A. Smith.
8. Laura Jardine, Art Shears and Phil Jardine are shown enjoying themselves at the Reception preceding the Society's Annual Meeting at the Hotel Nova Scotian.
9. The installation of Dr. E.V. Rafuse as Medical Society President now complete, he is congratulated by the President of The Canadian Medical Association, Dr. Marc Baltzan, who performed the ceremony.
10. Greetings from the Government of Nova Scotia were extended to the Medical Society by the Hon. Terence Donahoe, Minister of Education on behalf of Premier J. Buchannan.
11. Dr. E.V. Rafuse of Halifax, having just been installed as President of The Medical Society of Nova Scotia receives congratulations from his predecessor, Dr. Murdock A. Smith of Sydney.

NATIONAL NON-SMOKING WEEK

JAN. 23-29, 1983



SENIOR MEMBERSHIP CITATIONS THE MEDICAL SOCIETY OF NOVA SCOTIA

Dr. Eleonore Bergmann-Porter

Dr. Eleonore Bergmann-Porter was born on the 12th of May, 1907 in Laupheim, Wurttemberg, West Germany. She graduated in Ulm, as a registered nurse in 1925, and obtained her medical degree in 1933 in Munich. In July 1933, she left Germany, to escape Nazism, and under went another year of training in Edinburgh, receiving her English qualifications.

After a brief assistantship in General Practice in Manchester, she spent one year in the Italian Hospital in London as house surgeon. She then entered a private general practice in London until 1961, with a large maternity practice. At the same time, she conducted a private practice in gynecology and obstetrics at Harley Street.

On the 18th of May, 1961, Eleonore arrived in Yarmouth, and opened a General practice office, and had the distinction of being the first lady doctor in the area.

Since that time, she has been an active member of the Medical staff of Yarmouth Hospital, a member of the Canadian College of Family Physicians, and was made an honorary member of this College in 1977. In addition she was a member of the Nova Scotia and Canadian medical association since 1961, and became an honorary member on her 70th birthday.

Eleonore was also doctor in charge of residence at Riverside Home from 1962 until it became Harbourside Lodge, which is part of the Yarmouth Regional Hospital Complex. Since this time, she is still involved with patient care at Harbourside Lodge.

In spite of her busy general practice, she found time to become involved in several community projects, including Past Matron of Key Stone chapter (#5), Order of the Eastern Star; a member of Holy Trinity Anglican Church; and still involved in St. John's Ambulance courses, and until recently, one of the doctors who answered medical emergencies at the local jail. She was also of great assistance to her husband in his role of E.M.O. Director for Yarmouth area (1964 to 1972), in charge of the portable hospital.

In her younger days, her hobbies were skiing, mountain climbing, breeding her own horses to ride in horse shows, and for fox hunting. She is now an avid reader.

Eleonore is married to Lofty Porter, who spent 25 years as a police officer attached to the flying squad of Scotland Yard. They have one son, Tony, a mining consultant, based in Edmonton, Alberta.

Eleonore has always been the champion of freedom, and a courageous lady as attested by the fact that she was recently honoured at a banquet in New York for helping 24 people escape from Nazi Germany during the war.

Eleonore's attitude is that the patient is and always will be first priority. She never fails to answer a call at the office or house any hour of the day or night. At the age of 75, she is still active in medical practice and can be found each morning at the Yarmouth Hospital at 8 a.m. visiting her patients prior to answering house calls, and her office practice.

The Western Branch recommends highly, that Dr. Eleonore Bergmann-Porter should be honoured as a Senior Member of The Medical Society of Nova Scotia.

Dr. Diane M. Deveau
President, Western Medical Society

Dr. Abraham R. Gaum

Dr. Abraham Gaum was born in Sydney on February 23, 1910. He received his early education in the Sydney school system and went on to do his undergraduate study at Dalhousie University graduating with a B.Sc. He obtained his degree in Medicine in 1934.

He returned to Sydney to do general practice and obstetrics. He set up the Gaum Clinic in 1937. At many times, especially during the war years, he was the sole means of medical support for the majority of Sydney. He returned for postgraduate training and received a fellowship in surgery in 1949, and also has since undertaken postgraduate study at the University of Toronto and at the George Washington University in Washington D.C.

Dr. Gaum has been a member of the active staff of both the Sydney City Hospital and St. Rita Hospital in Sydney. He has served at various times in many capacities as Chief of Staff and President of Staff, and on the numerous committees that abound. He is currently a member of the Provincial Medical Board of Nova Scotia and has been active in this position for some years now.

In his long years of practice, he has always had the full support of his family, especially his wife Reta.

His busy schedule has left him little time for hobbies, except for travel which has been his major source of relaxation over the years.

Mr. President, I am very happy and pleased to present Dr. Abraham R. Gaum to you for honor of Senior Membership in The Medical Society of Nova Scotia.

Dr. Glenn Gracie
President, Sydney Medical Society

SENIOR MEMBERSHIP CITATIONS THE CANADIAN MEDICAL ASSOCIATION

Dr. John Rae McCleave

Dr. John Rae McCleave was born in 1902 and brought up in the small town of Lower Stewiacke, N.S. He attended its elementary and secondary schools. His later schooling was also obtained in Nova Scotia, in Truro and at Dalhousie University, Halifax, from which he graduated in 1930 with B.Sc. and M.D., C.M. degrees. After residency at Hillcrest Hospital in Pittsfield, Mass., he opened his office in Digby, N.S. in July 1931 and has been practising there ever since, in general practice with emphasis on general surgery.

Dr. McCleave has been active in communal and medical affairs locally and provincially. He served on the Digby Town Council for 15 years and as chairman of the Digby School Board for 15 years. He was president of the Digby Recreational Commission for several years. He was a member of the Digby General Hospital Board for many years and its president for 3 years. He was Chief-of-Staff of Digby General Hospital for several years. He was President of The Medical Society of Nova Scotia in 1957-58. Dr. McCleave was a member of the Provincial Medical Board for several years and its president from 1964 to 1967. He has been active in the Digby Kiwanis Club for 37 years and in the United Church.

Dr. McCleave has been honoured by the medical and non-medical community. The McCleave Medical Centre was named after him even though he was never a member of it. He was Digby's first Citizen of the Year.

He enjoys reading, golf and bridge.

Dr. and Mrs. McCleave have four children and twelve grandchildren. Their oldest son, a radiologist at the Everett Chalmers Hospital in Fredericton, N.B. carries on the medical tradition.

Dr. William MacKay Nicholson

Dr. William MacKay Nicholson was born December 12, 1914, to the late Rev. D.J. Nicholson and Mrs. Dolera MacKay Nicholson in Reserve Mines, Cape Breton. Early schooling was obtained in Reserve Mines and in the Glace Bay High School. 1937 saw the convocation of his Bachelor of Arts degree and 1942, his M.D.C.M. both from Dalhousie University.

The coal mining town of Donkin, Cape Breton, was the locale of his first general practice, where he worked with Dr. J.J. McKiggan. A short drive west on the Glace Bay coal field, to the mining community of Reserve Mines, was the first and last move in his career. In Reserve Mines, Dr. Nicholson re-opened the surgery that served his maternal grandfather, the late Senator William MacKay, from 1874 until his death in 1915.

Dr. Nicholson has been Chief of Staff of the Glace Bay General Hospital from 1970 to the present. Head of the Departments of Anaesthesia at both the Glace Bay General and Glace Bay Community (formerly St. Joseph's) hospitals since 1948. He has served in all executive offices of the Glace Bay Medical Society; and in 1955, has served on the Executive of The Medical Society of Nova Scotia, where he had represented Cape Breton.

Currently, general medical and anaesthetic practices require his full attention. While he no longer practices obstetrics, gynecology, or assists with surgery, a regular turn on the anaesthesia rotation is taken for which he is invariably readily available. He is in regular attendance at the local Continuing Medical Education meetings.

Gardening offers pleasure and relaxation in his off time, as does time spent with his nieces and nephews. Near fanatic loyalty to the New York Yankees, requiring a regular pilgrimage to the Big Apple, represents a major distraction from time he spends in his extensive library or cottage in fog bound Gararus.

With quiet humility and wisdom he has practised his profession. This has won the love and respect of his peers and patients. His adherence to the traditional values of medicine has made him an important component of the moral fabric of his community and an important model to other physicians.

**HONORARY MEMBERSHIP CITATION
THE CANADIAN MEDICAL ASSOCIATION**

Dr. Arthur W. Titus

Dr. Arthur Titus was born in Yarmouth, Nova Scotia a few years ago. Since that time he has accomplished many achievements. After attending school in Yarmouth he went to Mount Allison University where he received a Diploma of Commerce in 1939. He then came to Dalhousie University and received a Bachelor of Science Degree in 1942 and then graduated from Dalhousie Medical School in 1947 receiving an M.D., C.M.

While at Dalhousie University, Art was President of the Student Council in 1942; President of the Society of Medical Students in 1945, and served terms as President of the Sigma Chi and Phi Chi Fraternity.

After graduation from medical school he became associated in practice with Dr. John Merritt and soon built up a very large general practice. He and I were associated in practice on Quinpool Road for many long happy years. When I retired from general practice, Art became associated with Dr. Burke Fullerton. Over the years, as well

as carrying on a very large busy general practice, Art found time to contribute a great deal more of his time and energy to the medical profession than do most of us.

He was always very active in the Medical Society. He was Honorary Treasurer of The Medical Society of Nova Scotia for a year; Chairman of the Fee Committee for two years; chairman of the Workers' Compensation Board Liaison Committee for a period and served on other committees of our Society. He was Secretary of the Halifax Medical Society for one year; President of the Society's Section of General Practice; President of the Nova Scotia Branch of the College of General Practitioners of Canada; President of the Medical Staff of the Halifax Infirmary; a member of the Board of Directors and the College of General Practitioners of Canada and also of Maritime Medical Care Inc. His counsel, often solicited, was always highly respected by members of the Society.

Since 1964, as you know, Art has been Medical Director for Maritime Medical Care Inc. I think one of the events which precipitated his taking this position occurred about 4:00 a.m. one morning when he was awakened by a phone call from a recently delivered patient who announced that she just happened to be awake and thought this would be a good time to have him change the baby's formula. Art was not always known for his diplomacy at such a time and I think his response ended a previously happy doctor-patient relationship.

As Medical Director of Maritime Medical Care, Art, as always, has done an outstanding job. As Chairman of the Fee Committee for many years I can testify that when a Fee Schedule was to be revised he was always there to help and again gave freely of his time and advice.

We, as members of the profession, have always received a sympathetic hearing from him. Without him in this position I am sure the transition to the current system would have been much more traumatic for us.

Over the years Art has taken a great interest in sports. In his youth he was a great swimmer and diver who helped make the name of TITUS synonymous with the sport in Nova Scotia.

He was an excellent golfer shown by the fact that his name appears as Champion on The Medical Society of Nova Scotia's Golf Trophy several times. He is an avid curler and fisherman. He filled the balance of his spare time with gardening and woodworking.

He is a past member of the Halifax Curling Club; Ashburn Golf Club, Royal Nova Scotia Yacht Squadron, and was the first Commodore of the Hubbards Yacht Club. He belonged to the Halifax Rotary and was on the Executive of the Halifax Wildlife Association for many years.

Art Titus has led a rather full and productive life and there is no one whom I believe more richly deserves Honorary Membership in this Society.

Dr. J.H. Charman.
Halifax, N.S. □

Correspondence

NEW MEMBERS

To the Editor:

RE: FAMILY MEDICINE TRAINING

The article "A Personal View of Family Medicine Training" by Doctor Carlyle Phillips in the last issue of the *Bulletin* hits the nail squarely on the head (and, I suspect, many who oppose the need for additional training for family physicians squarely between the eyes).

As one who also did not have the advantage of such training in medical school, and the years immediately following, I became aware very quickly of the short comings of the training in Dalhousie University for potential family physicians. The lack of training in ambulatory care problems was such a glaring omission I wondered if those in the University hierarchy had any idea of what went on in a family physician's office. How could they have paid so little attention to that aspect of medicine that represents the most work and the most manpower?

It wasn't until I became acquainted with and joined the College of Family Physicians of Canada that I began to acquire the knowledge, attitudes and philosophy of family medicine with its commitment to continuing comprehensive care of families rather than the crisis and disease orientation of medical school training. It is to the College's credit that we have in this country today under graduate and postgraduate programs for family physicians and an increasing awareness of the needs and benefits for such appropriately trained physicians. And this is in spite of the negative and cynical attitudes of many physicians, including those with vested interests in medical schools, who do not understand, or who do not want to understand, these advantages.

Yours sincerely,

D. G. Dewar, M.Sc., M.D.,
Truro, N.S.

□



Professional Economic Consultants Ltd.

*Financial Planning and Practice
Management for Medical and
Dental Professionals across
Canada, since 1971.*

Suite 730, 5991 Spring Garden Rd.
Halifax, N.S. B3H 1Y7
(902) 423-1369

The Physicians listed below have joined The Medical Society of Nova Scotia between September 1, 1982 and November 30, 1982. A most cordial welcome is extended by the Society.

Dr. David Alexander	Halifax
Dr. M.T. Aquino-Fawcett*	U.S.A.
Dr. C.W. Baugh	Port Hawkesbury
Dr. M.C. Buchholz	Armdale
Dr. P.S. Cappon	Halifax
Dr. D.E.C. Cole	Halifax
Dr. A.A. Covert	Halifax
Dr. K.R. Darbyshire	Shelburne
Dr. G.E. Farrell	Pictou
Dr. H.D. Fawcett*	U.S.A.
Dr. R.A. Harding	U.S.A.
Dr. C.E. Hope	Halifax
Dr. E. Jones	Halifax
Dr. J.V. Jones	Halifax
Dr. Satinder Kaur	Halifax
Dr. D.W.F. King	Halifax
Dr. D.V. Knight	Chester
Dr. C.D. Lo	Dartmouth
Dr. A.P. Lockwood	Cornwallis
Dr. G.B.E. Montgomery	Elmsdale
Dr. W.M. MacDonald	North Sydney
Dr. K.J.C. MacKinnon	Halifax
Dr. G.M. O'Hanley	Lunenburg
Dr. G.M. Patey	Digby
Dr. I.M. Slayter	Halifax
Dr. J.M. Sullivan	Shubenacadie
Dr. D.H. Wilson	Shelburne

*Recent graduate of Dalhousie University Program

LOCUM AVAILABLE

LOCUM FOR ONE OR TWO YEARS. BUSY ALL-ROUND GENERAL PRACTICE CENTRAL HALIFAX, SOME OCCUPATIONAL MEDICINE.

CONTACT: Dr. Bob Napier or
Mrs. Jean Tompkins,
423-7973

ADVERTISERS' INDEX

A. T. C. Properties Limited	144
Arnold P. R. and Associates Ltd.	xiii
Atlantic Trust Company of Canada	xii
Bell and Grant Limited	156
C Realty Limited	144
Chateau Halifax	160
Doane — Raymond	xii
Insurance Program — The Medical Society	141
Manuge Galleries	148
Medical Estate Planning Services	xii
Mont Sutton	153
Professional Economic Consultants	166
Scotia Physiotherapy	156
Classified	166

GENERAL INDEX

VOLUME 61, 1982

- Acid Rain, The Potential Health Effects of, (Shires), 23.
Appreciations: Dr. Willard C. O'Brien, 29; Dr. Joseph Baxter MacDonald, 57; Dr. Arthur M. Marshall, 161; Dr. L. S. Cyril Mendis, 161; Dr. H. Harold Tucker, 161.
- BEAZLEY, R. W.: The History and Philosophy of the Dartmouth General Hospital and Community Health Centre, 36.
BEERING, S.C.: Medical Education in Ferment, 138.
BERALL, M.: Economic Advantages of Outpatient Meniscectomy, 81.
BEGG, Dr. Robert W. — Reminiscences (Stewart), 58.
Blauvelt, Barbara — Director Dalhousie Medical Alumni Association (Hines), 30.
Book Review: 133.
BROWN, B. St. J.: Ultrasonographic Diagnosis of Fetal Abnormalities in the Second and Third Trimester, 100.
BROWN, D. C.: Chairman — Brief on the Health Effects of Uranium Exploration and Mining in Nova Scotia, 145.
BUHR, J.: see MacArthur, D.
BURRILL, R. S.: Diet and Migraine Headaches in Children — A Preliminary Study, 85.
- CAMERON, D. G.: The Practical Art — Then and Now, 67.
CAPPON, I. D.: The Canadian Centre for Occupational Health and Safety — What It Is, and How Any Physician Can Use It, 92.
CASHEN, T.: see Sawyer L.
CHEN, W. L.: Toxicological Update on 2-4D, 149.
Child Abuse — Evolving a Protocol for a Community Hospital (Smith) (Smith), 52.
CLARKE, J. T. R.: Maternal PKU: The Problem of a Potentially Hostile Intrauterine Environment, 97.
Community Health, Current Topics in — An Announcement, 137.
Community Hospitals: Their Value and Purpose (ed) (O'Connor), 33; The Doctor's Legal Status in a Hospital (Young), 38; Quality Care in the Community Hospital (Shannon) (MacLeod), 39; Pulmonary Rehabilitation in a Community Hospital (Sawyer) (Cashen), 41; Comprehensive Care of COPD in a Community Hospital (Michael), 42; Role of the Family Physician in the Emergency Room (Nurse), 43; Child Abuse — Evolving a Protocol for a Community Hospital (Smith) (Smith), 52; A Community Hospital Programme of Continuing Medical Education (Gass), 54.
Continuing Medical Education, A Community Hospital Programme of (Gass), 54.
CORKUM, T. P.: Adolescent Pregnancies — A Review of Modern Medical Management 1971-1980, 7; Adolescent Menstrual Dysfunction — A Gynecologist's Viewpoint, 13; The Tovee-Cannell Syndrome — Revisited, 18.
Correspondence: (Brodie), 60; (MacLeod), 60; (Ross), 131; (Comer), 131; (Dewar), 166.
CUNNINGHAM, R. M.: Report on Radiation Oncology in The Peoples' Republic of China, 26.
- Dalhousie Medical Alumni Association, Director — Barbara Blauvelt (Hines), 30.
Dalhousie University's Kellogg Library (Nevill), 124.
Dartmouth General Hospital and Community Health Centre, The History and Philosophy of the (Beazley), 36.
Dickens, Charles — Halifax and Medicine (Tibles), 157.
Dickson Lecture, The Robert C., Practical Art — Then and Now (Cameron), 67.
- Editorials: The Woes of Young Women (Grogono), 1; Community Hospitals — Their Value and Purpose (O'Connor), 33; In Praise of Scholars (Grogono), 65; What Makes a Good Doctor? (ed) (Grogono) 88; Health Hazards — What is the Real Danger? (Grogono), 95; The Physician's Self-Image (O'Connor), 135; Environmental Hazards (Grogono), 136.
Emergency Room, Role of the Family Physician in the (Nurse), 43.
Environmental Hazards: The Potential Health Effects of Acid Rain in Nova Scotia (Shires), 23; Environmental Hazards (ed) (Grogono), 136; Brief on the Health Effect of Uranium Exploration and Mining in Nova Scotia (Brown), 145; Toxicological Update on 2, 4-D (Chen) (Lanham) (Haagsma) (Freer), 149.
- Family Medicine: Role of the Family Physician in the Emergency Room (Nurse), 43; What Makes a Good Doctor? (ed) (Grogono), 88; A Personal View of Family Medicine Training (Phillips), 89; Residency Training in Family Medicine (Nixon), 91.
FLYNN, P.: see Hicken B.
FRASER, R.C.: see Pierce, B.
FREER, D.: see Chen, W.L.
- GASS, D. A.: A Community Hospital Programme of Continuing Medical Education, 54.
Gestational Trophoblastic Disease — Incipient Molar Pregnancy Warrants Study (Pierce) (Fraser) (Zavid), 151.
GROGONO, B. J. S.: The Woes of Young Women (ed), 1; Roller Skating Injuries — A Nova Scotian Review, 47; In Praise of Scholars (ed), 65; What Makes a Good Doctor? (ed), 88; Environmental Hazards (ed), 136.
- HAAGSMA, T.: see Chen, W. L.
HAASE, D.: see Marrie, T. J.
HAGGETT, S.: see Marrie T. J.
HALDANE, E. V.: see Marrie, T. J.
Haloperidol, Rapid Neuroleptization With — A General Physicians Guide (Hicken) (Flynn), 79.
HAMILTON, J. D.: Learning About Nutrition in Nigeria, 142.
Headache, Management of Tension (MacBeath), 19.
Help Line, Hello (MacArthur) (Buhr), 130.
Hepatitis in the 80's, Viral (MacKiggan), 45.
Herbicides: Toxicological Update on 2, 4-D (Chen) (Lanham) (Haagsma) (Freer), 149.
HICKEN, B.: Rapid Neuroleptization with Haloperidol — A General Physician's Guide, 79.
HINDS, B.: Barbara Blauvelt — Director Dalhousie Medical Alumni Association, 30; Dr. Lea C. Steeves Retires, 56.
- Johnson, The Medical History of Doctor Samuel (Murray), 71.
- Kelley, Hugh Edgar — Doctor Extraordinary (Steele), 94.
KHOR, C-Y: see Slomic, A. M.
- LANHAM, J. M.: see Chen, W. L.
LAWRENCE, G. A.: see Slomic, A. M.
LEE, S. H.: see Marrie, T. J.
Legionnaires' Disease (Marrie) (Hasse) (Haldane) (Noble) (Martin) (Samarah) (Hagggett) (Lee), 111.
LENCO, W. H.: Failures Following Fimbrectomy, 16.

- MALEY, C. A: Female Sterilization, 17.
 MARRIE, T. J: Legionnaires' Disease, 111.
 MARTIN, R. S: see Marrie, T. J.
 Medical Society of Nova Scotia: New Members, 94, 133, 166; Page of Officers, 62; Notice — By-Law Amendments, 129; Dr. E. V. Rafuse — President 1982-1983, 137; Proceedings of 18th Meeting of Council and 129th Annual Meeting, 150 I; Presidential Valedictory Address — 1982 (Smith), 150 X; Pictorial Highlights 129th Annual Meeting, 162.
 Meniscectomy, Economic Advantages of Outpatient (Berall) (Yabsley), 81.
 Medical Education in Ferment (Beering), 138.
 MICHAEL, R. T: Comprehensive Care of COPD in a Community Hospital, 42.
 Migraine Headaches in Children, Diet and — A Preliminary Study — (Burrill) (Tibbles), 85.
 Multiple Sclerosis: The Dalhousie Multiple Sclerosis Research Unit (Weldon) (Murray), 119; The Dalhousie Multiple Sclerosis Unit — Why Patients Attend (White), 122.
 MURRAY, T. J: The Medical History of Doctor Samuel Johnson, 71; see Weldon, P.R.
 MACARTHUR, D: Hello. . . Help Line, 130.
 MACBEATH, L. S: Management of Tension Headache, 19.
 MACKIGGAN, J. J: Viral Hepatitis in the 80's, 45.
 MacLean, Dr. Ray — The Royal Way — A Recollection (Napier), 126.
 MACLEOD, S: see Shannon, M.P.
 NAPIER, R. W: The Royal Way — A Recollection, 126.
 NEVILL, A. D: Dalhousie University's Kellogg Library, 124.
 NIXON, M. D: Residency Training in Family Medicine, 91.
 NOBLE, M. A: see Marrie, T. J.
 NURSE, E. G: Role of the Family Physician in the Emergency Room, 43.
 Nigeria, Learning About Nutrition in (Hamilton), 142.
 Obituaries: 59, 96; 133.
 Obstetrics/Gynaecology: The Woes of Young Women (ed) (Grogono), 1; When Does a Girl Become a Woman? (Sherwin), 3; Adolescent Pregnancies — A Review of Modern Medical Management 1971-1980 (Corkum), 7; Adolescent Menstrual Dysfunction — A Gynecologist's Viewpoint, (Corkum), 13; Failures Following Fimbrectomy (Lenco), 16; Female Sterilization (Maley), 17; The Tovee-Cannell Syndrome — Revisited (Corkum), 18.
 Occupational Health and Safety, The Canadian Centre for — What It Is, and How Any Physician Can Use It (Cappon), 92.
 O'CONNOR, J. F: Community Hospitals — Their Value and Purpose (ed), 33; The Physician's Self-Image (ed), 135.
 Orthopaedics: Roller Skating Injuries — A Nova Scotia Review (Grogono) (Rabideau), 47; A Case of Giant Retrofemoral Synovial Cyst (Slomoc), 154.
 Personal Interest Notes: 31, 59, 95, 132, 163.
 PHILLIPS, C: A Personal View of Family Medicine Training, 89.
 PIERCE, B: Gestational Trophoblastic Disease — Incipient Molar Pregnancy Warrants Study, 151.
 PKU, Maternal — The Problem of a Potentially Hostile Intrauterine Environment (Clarke), 97.
 Pulmonary Disease: Pulmonary Rehabilitation in a Community Hospital (Sawyer) (Cashen), 41; Comprehensive Care of COPD in a Community Hospital (Michael), 42.
 Prenatal Diagnosis and Utilization of Services, Women's Attitudes Toward (Winsor), 108.
 RABIDEAU, A: see Grogono, B.J.S.
 Radiation Oncology in The People's Republic of China, Report of (Cunningham), 26.
 Rafuse, Dr. E.V. — President 1982-1983 — The Medical Society of Nova Scotia, 137.
 Retrofemoral Synovial Cyst, A Case of Giant, (Slomoc) (Lawrence) (Khor), 154.
 Roller Skating Injuries — A Nova Scotian Review (Grogono), 47.
 SAMARAH, S. see Marrie, T. J.
 SAWYER, L: Pulmonary Rehabilitation in a Community Hospital, 41.
 SHANNON, M. P: Quality Care in the Community Hospital, 39.
 SHERWIN, S: When Does a Girl Become a Woman? 3.
 SHIRES, D. B: The Potential Health Effect of Acid Rain in Nova Scotia, 23.
 SLOMIC, A. M: A Case of Giant Retrofemoral Synovial Cyst, 154.
 SMITH, J. A: see Smith, L. J.
 SMITH, L. J: Child Abuse — Evolving a Protocol for a Community Hospital, 52.
 SMITH, M. A: Presidential Valedictory Address — 1982, 150 X.
 STEELE, M. G: Doctor Extraordinary, 94.
 Steeves, Dr. Lea C — Retires (Hinds), 56.
 STEWART, C. B: Reminiscences — Dr. Robert W. Begg, 58.
 TIBBLES, J.A.R: Charles Dickens — Halifax and Medicine, 157; see Burrill, R.S.
 Ultrasonographic Diagnosis of Fetal Abnormalities in the Second and Third Trimester (Brown), 100.
 Uranium Exploration and Mining in Nova Scotia, Brief on the Health Effects of (Brown), 145.
 WELDON, P. R: The Dalhousie Multiple Sclerosis Research Unit, 119.
 WHITE, C.A: The Dalhousie Multiple Sclerosis Research Unit — Why Patients Attend, 122.
 WINSOR, E. J. T: Women's Attitudes Toward Prenatal Diagnosis and Utilization of Service, 108.
 YABSLEY, R. H: see Berall M.
 YOUNG, J. A: The Doctor's Legal Status in a Hospital, 38.
 ZAYID, I: see Pierce, B.

