

Should Drainage Be Established?*

By Sir Henry M. W. Gray, K.B.E., C.B., C.M.G., LL.D., M.B.
(Aberd.) F.R.C.S., (Ed.), Montreal.

WITHIN a few months of my arrival in Canada, I addressed a meeting in Ottawa on the subject of "Some problems in drainage."

The past five years' experiences have consolidated my attitude regarding these problems so the remarks made then are embodied in the present address to you. It may be that even to-day some of my views are regarded as unorthodox and not applicable to the ordinary surgeon's work. But perfect technique and sound therapy should be more apparent with each year of experience, as well as realization of responsibility to our patients. Expert surgeons in busy practice can dare more than men who have few opportunities for surgical work, however good their opinion of their own capacity may be. It is striking that in an old country like Great Britain, there are comparatively few men who do major surgery, even though they be possessed of sound knowledge of anatomy and physiology, unless circumstances force surgery upon them. Their sense of responsibility restrains them.

My very simple remarks concern what seems to many a very simple business. It is easy enough to say, "When infection is present or is threatened, drain the wound!" But the recent war made some of us think about the matter a little more than we had thought about it before, because it was found that in war wounds, drains might even do harm rather than good.

It is a good thing always to keep in mind the truth of the statement that the success of large problems depends on proper appreciation and application of often apparently insignificant details.

In directing your attention to the question of drainage I should like to point out that I have for a very long time thought that surgeons as a rule do not give nearly enough credit to a patient's natural recuperative powers, and that they do not have enough faith in these in the ordinary run of cases which come under their care. Indeed, it was many years before the war that I began to wonder whether, in the matter of drainage, we were not sometimes interfering with natural processes of healing actually in a deleterious and unnecessary way. It is over 20 years ago that, as a result of such cogitation, I desisted

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from employing drainage of the abdominal cavity in cases of what might be called simple gangrenous peritonitis; and now I drain the peritoneal cavity only in rare cases, it matters not whether localized abscess or spreading peritonitis is present.

For every detail of procedure in a surgical operation one should always have a sound reason! I think that the use of drains at the present time is still too indiscriminate. The question, "Why should I drain in this case?" is too seldom asked. Few seem to get away from a routine which was instituted at a period when pus was a source of dread, instead of a thing to be thankful for, to be regarded as evidence that the patient's resisting powers had put up a good fight and that the surgeon was lucky to have a patient left on whom he could operate *ante mortem*. The problem is a difficult one in many cases, but I believe that in the majority of localized inflammations we may look upon pus really as a "laudable" thing. We should probably all be dead if pus had not formed within us at one time or other in our history. Further, if we provide free exit for the cause of the suppuration, that is, if we can accomplish thorough exposure and evacuation of all the deleterious material in an abscess, we shall get quicker and better results if we do not employ drainage by tube in the way it is so frequently applied. In some parts the natural powers of repair are so strong that we can often dispense with drainage altogether. In these parts, especially in the peritoneal and pleural cavities and in joints, the employment of drains actually may lead to very troublesome sequelae and complications.

What happens when an acute local infection occurs, one which is amenable to surgical treatment? When I think of the offensive and defensive processes which come into action I feel that they can be likened in most ways to those which occur in a war between nations. There is the initial cause, whether it be an apparently insignificant disturbance or a gross insult, which may become so magnified that it may ultimately call into play all the available resources of the nation or of the individual in order to cope with the attack. Where the original boundary line has been forced, neighbouring fighting phagocytes are hurried into the breach, local tissue cells are enlisted to repel the invader, and a first line of defense filled with reinforcements is rapidly thrown up to take the place of the dead and dying which lie inert in the abscess cavity where the attack began. Messages are dispatched from the scene of action to headquarters by nerve impulses; and by various other methods of signalling danger, all the tissues of the body are called into activity. Poisonous influences may filter through—enemy agencies may develop—to such an extent that this reaction may be too feeble or too long delayed to save the situation, and the patient is overcome or permanently maimed. But in the prospect of success the resistant forces accumulate locally and are well supplied with potent counteractives and good food. Thus encouraged they overcome the enemy and cast him out. After a period of soreness, of

disability, of impaired functions, convalescence sets in and, according to the degree of the local devastation and of the drain on general resources, conditions may or may not be speedily restored to pre-war levels.

In how far does the use of the old fashioned drainage tube help the local condition? In different situations in which I have seen it used it has frequently caused serious complications, chiefly due to pressure, such as sloughing of skin, for example of the scalp, sloughing of vessels, sloughing of bowel, and so forth, so that healing has been greatly retarded. To say that in the situations mentioned tubes should not be used or used only with the greatest care so as to avoid these complications, is no criticism. These things have occurred and are still occurring and therein lies one reason for my choice of subject.

Along with the use of drainage tubes goes usually, hand-in-hand, the fault of making too small incisions. To revert to my allegory, the wider the line of retreat for an enemy the quicker will he quit. I do not advise senselessly large incisions, but they should extend where possible from end to end of an acute abscess. I would point out that in most situations it is usually sufficient to open a way freely by which the invader can be cast out forthwith and unless there has been great local destruction nature will do that successfully without much aid. If local destruction has been severe, as in the case, for example, of a carbuncle, the surgeon can prove a valuable ally by encouraging the separation of sloughs in various ways. Even if the general resisting powers have been greatly enfeebled, the free riddance from the field of the main mass of the enemy and facility for disposal by extrusion of dead tissue will enable the defender to recuperate quickly and to clear out the remnants, which may be lurking in odd corners, all the quicker if wise help be given by his ally in supplying what he lacks. The combatant who has borne the burden and heat of the fight is usually capable of making a final effort and should get the credit and honor of putting in the finishing blows. If he does, things will usually settle down better afterward. The well meaning but often too brusque methods of a fresh ally may do damage to friend and foe alike and are resented afterward.

If the tissues have had enough vitality to form an abscess or even, as is manifest so often, for example, in the peritoneal cavity, if they have enough vitality to create a decided reaction in the presence of spreading infection, I maintain that nature will bring about cure more rapidly without officious help from us, provided we facilitate, or better still actually bring about, the free removal of deleterious material, including of course, the cause of the suppuration.

During the formation of an abscess the tissues elsewhere are busied in production of antibodies. When the tension inside the abscess cavity is relieved, fluid laden with these antibodies exudes into the cavity. At the same time local resistance is raised because the local circulation in the previously compressed tissues of the abscess

wall improves. If the incision is large enough to provide free exit of noxious material hitherto confined in the abscess, and if there are no pockets in the cavity wherein stagnation may occur, the abscess will heal rapidly without further attention if the lips of the incision are merely prevented from uniting prematurely. If they do adhere exudate will accumulate in the depth. When it stagnates it is apt to lose its antitoxic property in contact with organisms and then it forms good pabulum for their growth. Usually however, such incisions gape. Dressings should be so built up around the incision that direct pressure over the gaping cavity is avoided, because such pressure will lead to retention. In certain cases the superficial insertion of a small strip of rubber dam is necessary. Klapp's suction glasses or ordinary cupping glasses are sometimes very helpful in removing thick pus and promoting the flow of curative lymph. The evil results which may attend the expression of pus through a small opening by forcibly squeezing the tissues surrounding an abscess are so well known that the procedure has only to be mentioned to be condemned.

If, as I have already said, stagnation of the exuding plasma or lymph occurs, the antitoxic substances in it are used up in neutralizing organisms and their poisons which are almost certainly present in the abscess wall for some time after the cavity is opened. The inert fluid then forms an excellent pabulum for the resuscitation and growth of any remaining organisms, with the result that inflammation persists or recrudesces, possibly in a modified degree, and may spread. Therefore in some deep abscesses, especially in muscular parts, the use of artificial drainage, even by tubes, may be compulsory. In ordinary cases however, the comparatively unyielding drainage tube really defeats its own purpose. It provides recesses in which stagnation occurs, it prevents active phagocytes getting at organisms which thrive in these recesses, it exerts deleterious pressure on tissues which are already in a precarious state and, as previously mentioned, may even cause sloughing thereof. In the treatment of war wounds Sir Almroth Wright introduced the use of hypertonic salt solution to act as a lymphagogue, to stimulate the flow of antitoxic plasma to the inflamed part. Where there is excessive swelling and oedema around an abscess, indicating that the invading organisms are probably being fought deep in the abscess wall, I believe that there is no better method of reducing such inflammation and paving the way for rapid cure than by using what was known during the war as the "salt pack," i.e., by carefully filling the abscess cavity in every part with good absorbent gauze in the folds of which are evenly distributed tablets of salt. These are slowly dissolved in the exuding plasma and keep up, to a usually requisite extent, and for sufficient time, the supply of hypertonic saline solution. The gauze conducts the exudation to the surface where it is absorbed by superficial dressings and thus maintains the flow of lymph in an outward direction.

Many years ago I used similar treatment in cases of extensive peri-articular abscesses, with great satisfaction to both patient and

surgeon. The abscess cavities were laid open from end to end and after clearing away pus and sloughing material, they were carefully and equally packed with gauze. Antiseptic dressings were bound over this packing. After 3 to 6 days, the gauze pack was found to be so slack that it almost fell out of the wound. Any loose sloughs were removed. The wound was then sutured, firm supporting dressings and splints were applied, and healing took place by what has come to be known as "delayed primary union." This treatment had its corollary in the treatment of war wounds by "delayed primary suture." That is, in cases of wounds in which it was doubtful whether excision had been successful in getting rid of infection, the wounds were packed or treated by Carrel's method and then if clean and free from inflammation after several days, were stitched up.

In a few cases of abscess, for example in the calf of the leg, I have adopted Willems' treatment with satisfactory result. That is, after free incision I have encouraged the patient to use the limb voluntarily, so that the pressure of the actively contracting muscle squeezes out pus from the depth and prevents stagnation. As you know, Willems of Belgium introduced this treatment during the war for cases of suppurating arthritis.

I may be permitted to run over, in some detail, the actual treatment which I now carry out in certain other suppurating conditions. Let us consider first and as a type of intra-abdominal suppuration, that very common disorder, acute appendicitis and its immediate sequelae, abscess and spreading peritonitis. For the sake of brevity, I propose to deal only with the intra-abdominal condition. In such cases I make, practically always, a right para-central incision, five or six inches or even more in length, a good inch distant from the mid-line, and I displace the whole of the rectus muscle outward. The posterior sheath of the rectus and the peritoneum are opened in the same line and extent as the skin incision. Through such an incision I can *see* what I do. I do not care to grope blindly inside the abdomen in such cases. Under careful retraction of the abdominal wall I find out what the conditions inside are. If there is merely an inflamed or gangrenous appendix without surrounding pus or spreading peritonitis, it is removed in the ordinary way and the abdomen is closed forthwith.

Let us suppose an abscess surrounds the appendix. I pack dry gauze, prepared in long broad strips, several layers thick, around the area so as to protect the uninfected general peritoneal cavity. The parietal peritoneum is pulled up by forceps fixed around its cut margin, so that it helps to protect the raw surface of the abdominal wound from contamination. I then open the abscess cavity freely and dispose of the foul pus within it by suction and careful swabbing. The walls of the abscess are carefully wiped dry and temporarily packed with gauze. The appendix is freed from adhesions and removed in the ordinary way. The gauze is removed from the abscess cavity. It

is usually by this time more or less moist with exudation. When I see this I feel sure that the patient will not succumb to his intra-abdominal condition, although he may die from pneumonia, embolism, or other non-abdominal complications. If the gauze smells, the cavity is packed again for a few minutes. The pack is again removed, the surrounding parts are meticulously cleansed, possibly with moistened swabs, and if there is no haemorrhage the peritoneal cavity is closed completely.

If spreading peritonitis is present the procedure is similar. It may be necessary to enlarge the incision in order to obtain free access and supervision. In these cases foul pus is usually found in the pelvis or along the right flank. If a large amount of fluid is present, it should be sucked out, failing which it should be absorbed at once by strips of gauze placed loosely in the pelvis or flanks. The bowel covered by gauze in the meantime should be retracted, preferably by hand. When excess of stinking pus has been removed thus, the foully infected parts should be gently cleansed by swabbing with pads of gauze. Dry gauze strips are then packed into these infected areas. The appendix is freed and removed. The same procedure of repacking with gauze, as already described, is carried out, until the exudate moistening the gauze is found to be free from foul odor or very nearly so. Any large excess of *non*-smelling pus is soaked up gently. Adherent flakes of lymph are not interfered with. Loose flakes are removed. The peritoneum is then completely closed. I usually place a rubber dam drain at each end of the wound brought out through a stab-hole in the rectus, reaching to the preperitoneal tissue, in case the newly cut tissues have been infected.

If the superficial tissues have been fouled during the operation, it is probably best, in the long run, to suture only the peritoneum, and pack the rest of the incised wound loosely with gauze in which Carrel's tubes have been inserted. I find that Purol disinfectant fluid, a non-irritating and stable hypochlorite solution, is better than anything else I have tried for bringing the wound rapidly into a condition when it may be sutured with safety.

When these procedures are carefully carried out, it is extraordinary how well the peritoneum deals with such infection as must of course be left inside the abdomen. I have never regretted not draining in such cases. Absorption occurs so rapidly in the peritoneal cavity that postoperative accumulation of plasma is a very rare event, provided no source of irritation remains. I have almost invariably regretted the use of intraperitoneal drains. Between 1919 and 1923 I and my assistant treated several hundred cases of acute appendicitis in my wards in Aberdeen, Scotland. We felt compelled to resort to drains in about 1 in 14 cases. The mortality in the drained cases was 9 per cent., in the undrained cases 5 per cent. The three conditions which make me feel I should use drains are (1) persistent oozing of blood from the surface of an abscess cavity plus a condition of the patient

necessitating very rapid operation; (2) a shaggy irregular lining covering the surface of the abscess; and (3) such a free exudation of fluid from the intraperitoneal surface as is not likely to be absorbed with the same freedom.

I have repeatedly left small areas covered by gangrenous looking membrane when I have judged that the "discoloration" affected practically only the peritoneum. These cases recovered without complication.

During the after-treatment of cases which I have drained I have had much anxiety. Prolonged stinking suppuration sometimes with secondary abscess formation elsewhere, faecal fistula, septic pneumonia, etc., have complicated convalescence. I believe that non-drainage of the peritoneum prevents such complications to a large extent. Suppuration in the abdominal wall alone is usually of short duration. I believe further that intestinal trouble in the shape of partial or complete obstruction is much reduced in frequency. The irritation caused by a tube or other drain inside the abdomen tends to the formation of dense adhesions which may subsequently lead to serious trouble. If the results obtained without the use of intra-abdominal drains are as good or better than those obtained with the use of drains, as I assert from experience that they are, why use drains?

Intra-abdominal drains do not drain the abdominal cavity except the small part which they themselves are irritating. The rest of the cavity is quickly shut off by the formation of adhesions. I have often observed this gluing together of contacting peritoneal surfaces even before the operation was finished.

Since a drain provides direct communication from the surface with tissues in the depth, it is obvious that infection may gain access from the exterior along this track. Therefore, when a drain is used for any length of time it is more than advisable to use antiseptic dressings rather than inert plain gauze or wool. I should think that all of us have seen the following phenomena when drains have been left in an appendicular abscess for longer than a day or two. For the first 2 days the discharge is "sweet" and fairly clear. It then becomes more and more purulent, and smells as did the foul pus in the abscess cavity. In 4 or 5 days the pus has become brownish, like faeculent material, making one suspect that a faecal fistula has formed. Usually by the end of 8 to 10 days the discharge is free from odor and rapidly becomes sero-purulent, when the drain may be withdrawn. This course of events is, in my opinion, entirely due to the presence of the drain which stimulates a recrudescence of the activity of the micro-organisms which were the cause of the primary inflammation. I have already explained why this happens.

The experience of surgeons who did much abdominal surgery at the front during the war was such that they ceased to use drains. Their results in saving life and preventing complications were improved when they did so.

Remarks similar to the foregoing can be applied in cases of peritonitis from other causes, such as perforated ulcer or pneumococcal infection.

Briefly stated, the plan I adopt in all such conditions is: to deal thoroughly with the primary cause of the trouble, remove carefully secondary deleterious matter which may have formed in, or found its way into, the abdominal cavity; and close the peritoneum without drainage.

It was very interesting to note that during the war specialists in cranial and cerebral surgery went through a very similar experience. At the beginning of the war small credit was given to the powers of the brain in recovering from injury in the presence of sepsis. Some wonderful methods of "draining" wounds of this delicate structure were used. For example, I have seen tubes of perforated metal, half an inch or even more, in diameter, inserted deep into the brain along the track of the wounds in order to try to prevent or eradicate infection and also to do away with cerebral oedema which was thought almost inevitable in such cases. This really proved a very certain way of promoting the development of these evils which were meant to be avoided. More rational treatment prevailed before the end of the war and followed the lines which I discussed in connection with peritonitis. The primary cause of the trouble was dealt with, the missile, if it were still present, was removed if possible, secondary deleterious matter in the shape of fragments of bone, pulped brain and blood clot were removed by various methods and a drain was inserted "down to but not into" the wounded brain. Of course, as a preliminary the wounds of the scalp, bone, and dura were excised. The results of this treatment showed wonderful improvement on that which involved the use in the brain of crude artificial so-called aids in the shape of drains and irritating antiseptics. If the patient survived in spite of these "aids" he did so with a large amount of scar tissue in his brain and scar tissue there is a thing to be avoided.

Indiscriminating bullets or pieces of shell caused worse wounds than the surgeon's knife does! Here is a lesson for us in civil practice!

It is recognized by most surgeons who have studied the matter that it is impossible to drain such a complicated joint as the knee by ordinary methods. The ultimate results of treatment of wounds of the knee at the beginning of the war were appalling. At a meeting of French and British Surgeons in February, 1915, each speaker told practically the same dreadful story. Very few successes were recorded. Death or amputation (often followed by death) was the usual sequel of the various treatments employed. Later on, improvement followed excision of the wounded parts, both of soft tissue and bone, removal of the foreign body and other deleterious matter, and drainage "down to but not into" the affected synovial cavity. Then Willems, the Belgian surgeon, came into the field with the startling and novel suggestion that the only way to get rid of pus inside a joint was to

make the patient pump it out by his own efforts. He discarded drains in the wounds altogether. Passive movement was no good, it was probably harmful. During voluntary movements the muscles, tendons, and aponeurosis round the joint effectually obliterate potential cavities by their pressure so that there is no room for any extraneous material. If there is free exit for pus it is squeezed out. Furthermore, these movements stimulate the circulation of the joint so that the flow of autogenous antitoxic serum through it is increased. Stagnation is not allowed.

I saw many of Willems' cases and the results were certainly impressive. I have since employed this method of treatment with success in civil practice. It is so much opposed to that to which we have been educated that many difficulties present themselves. Its novelty and our innate conservatism tend to make us postpone its application too long. It should be applied at once when we are certain that such procedures as aspiration or washing out the joint are insufficient. The more acute the infection the earlier should the treatment be carried out. In the case of the knee, lateral incisions are made between the patella and edge of the condyle, about 2 inches in length, freely opening the joint. A loose antiseptic dressing to soak up discharge and to prevent access of sepsis from without is fixed over the wounds. It must not interfere with movement. The patient must be encouraged in every way to make voluntary movements immediately on recovery from the anaesthetic and to repeat them frequently during the days following. He should be made to walk as soon as possible. Nurses and indeed all concerned must create such an atmosphere that the patient will put forth every effort. After the first couple of days the pain caused by movement gradually lessens.

This method of treatment obviates the use of extension apparatus. The repeatedly altered position of the joint prevents undue pressure continuously on circumscribed opposing parts of the softened articular cartilage so that erosion of cartilage is avoided.

The last region to which I shall refer is the thorax. During 1915 and 1916 I acted as consultant in an area of France which comprised from 20,000 to 25,000 base hospital beds. During a period of 15 months I saw not more than ten really serious wounds of the chest. We had patients in ghastly abundance who had limbs or pieces of skull or even abdominal wall blown away, but only very rarely did men arrive who had gaping wounds of the chest wall. In our ignorance we looked upon chest wounds as "cushy" injuries. We saw only comparatively simple ones caused by "through and through" bullets or small lodging missiles. When I went up to the front to act as consultant surgeon to the Third Army I realized why serious cases of staved-in smashed ribs with lacerated open wounds of the chest wall and injured lungs did not reach the base. Practically all of them died. To show you what a sacrifice of life was entailed, I quote you statistics of this type of injury in the Third Army during the

Battle of Arras in April, 1917. In one month, 1,500 patients with chest wounds were admitted to the casualty clearing stations of that army. Of these, 500, one-third, were of the serious type which we had not hitherto seen at the base hospital. Remember this number concerned only one month of the war period and only one army out of the five British armies in France.

The development to success in thoracic surgery during the war was the result chiefly of two methods of treatment of which "no drainage" was one. Quite early in the war it was found that open or "sucking" wounds, those in which a free communication was established with the pleural cavity, were accompanied by great respiratory distress until the hole in the chest wall was closed either by gauze packing or by suture. When this was done the relief of respiratory distress was almost immediate and the patient's condition rapidly improved in other respects also. Of course, this procedure was adopted as a "first aid" to enable the wounded man to bear transport more successfully. It was in 1917 that the operative surgery of such wounds was chiefly developed. It was found that patients had to be operated on as early as possible after admission to the casualty clearing stations, otherwise they rapidly succumbed. The lacerated soft tissues and bone of the chest wall were excised, the wound of the lung was attended to, foreign bodies were removed, the pleural cavity wiped clean, and the chest wall closed without drainage. Discarding of drainage made all the difference to the mortality rate. Some surgeons who adopted the procedures I have detailed sent down the line as many as 70 per cent. of the cases they operated on and these cases showed every prospect of becoming useful citizens. Later events prove that they have done so. It was one of the bright spots in the surgery of the war. "No drainage" was probably the chief contributory cause once the wound had been cleansed by excision of lacerated and infected tissue. It was found that collapsed lung expanded in an incredibly short time. Even in 24 hours it might be impossible to tell by auscultation alone which side had been operated upon. All that was necessary after operation was to ensure that fluid did not collect in the pleural cavity; therefore, for diagnosis an exploring syringe, and thereafter if necessary an aspirator, was used every day or second day until no fluid could be demonstrated.

The success which attended the treatment of these infected wounds of war has already stimulated many to apply the same principles of treatment in civil life with conspicuous success in some cases.

In certain cases of empyema, for example, it has been shown that convalescence has been made much easier for the patient. In these cases, the chest has been laid open freely usually by resecting a long piece of rib, adherent lung has been freed, the pleural cavity carefully cleared, and the wound closed without drainage. Want of success in some cases treated in this manner may be due to faint-heartedness in procedure and in other to selection of the wrong time

for operation. Why should some cases heal without trouble while the wounds in others break down or the pleural cavity have to be re-opened? We must remember that the conditions in the thorax differ widely from those in the abdomen. When the matter is viewed from our old standpoint that the great indication in treatment of inflammation is to give an inflamed part rest, it is very evident that the abdomen has the advantage over the thorax. One can get along quite well for a few days even though movement in the intestine does occur, but the heart *must* beat and the lungs *must* be inflated periodically in order to maintain life. War surgery has shown that recovery may be very prompt in spite of such movement. In certain types of infection rest, at one time or other of the development of the resultant inflammation, may be essential for cure. For example, from clinical observation alone, I should judge that resistance in a streptococcal infection requires a longer time to develop successfully so that the inflammation becomes localized, than it does in the case of a staphylococcal infection.

Therefore for combatting a streptococcal infection conditions must be very favorable. Pleural effusion may be looked upon as a wise provision of nature in such cases. It limits the amount of movement especially of the lung and thus may turn the scale in favor of success. One may further suppose that if in the general mechanism of resistance to infection, the circulating plasma has not been filled with appropriate antibodies, it is of little use to withdraw fluid from the chest at this stage. The infective process may still be in full swing and, as it will still stimulate exudation, any radical interference may result simply in the provision of fresh nutrient material which is more suitable for the growth of organisms than was the more or less inert fluid which was removed. The influenza epidemic, which occurred toward the end of the war, furnished numerous cases of pneumonia accompanied by acute empyema due to streptococcal infection. There was much evidence to show that such empyemata did not respond satisfactorily to the ordinary pre-war treatment by immediate drainage. The experience indicated that it is not always wise to make an immediate vigorous attack on the pleural cavity when acute suppurative inflammation is diagnosed. It is wise to ascertain the type of infection present. All the same it may be necessary to remove enough fluid to relieve threatening symptoms caused by pressure on the heart or mediastinum. In a day or two the resistance may be so increased that radical measures will be successful. Examination of the blood constituents may help us to decide when to interfere.

It is different in the abdominal cavity. *If* rest is necessary then, when the focus of infection and the accompanying deleterious matter have been removed, the quiescent, sometime paralytic state of the intestine provides rest while the wonderful powers of absorption of the peritoneum will likely prevent accumulation of nutritive fluid for development of any remaining infection.

In view of these considerations, you may appreciate my hope that, with increased knowledge and scientific application thereof it may prove in future that drainage of the pleural cavity may be dispensed with as safely as drainage of the abdominal cavity is at present. Meantime we have apparently reached a half way house represented by various modifications of what might be called "closed drainage."

I hope that I have been able to show you that the same type of treatment can be applied successfully in apparently widely differing disorders. When this is demonstrated then, it can be said that definite principles have been established. The main idea of a principle must be right. It remains for us to improve the application of the principle.

Nova Scotia Notes—for February number, *C. M. A. Journal*.

Dr. E. R. Davies, of Londonderry, is acting temporarily as medical officer of the cable ship Cambria.

Dr. J. W. Reid, Junior, of Newport, is spending several months in special study at Guy's Hospital, London, where he is attached to the clinic in gastro-enterology.

Dr. J. G. MacDougall and Dr. R. A. H. MacKeen have been elected president and secretary, respectively, of the Halifax Branch of the McGill Graduates Society.

Dr. A. MacD. Morton, M.P.P., was recently a patient at the Victoria General Hospital, where he was relieved of a troublesome appendix. His many friends will be delighted to know that he has made an excellent recovery.

More than fifty members of the original Dalhousie Unit (Seventh Stationary Hospital, C. E. F.) were present at the annual dinner of the Unit, at Halifax, on the seventh of December. Colonel John Stewart presided, and among those who made addresses were Colonel E. V. Hogan and Captain John Rankine.

Mental Hygiene

Dr. W. H. Hattie, Halifax.

ARTICLE I*

ON the sixteenth of October, 1844, a special meeting of the Halifax Medical Society was called for the consideration of an offer made by the Hon. Hugh Bell to donate his year's salary as mayor of the city, three hundred pounds, towards the erection of "a lunatic asylum or other public charity." This seemingly is the first recorded evidence of an awakening of general interest in the care of the mentally afflicted in Nova Scotia. In the following February the House of Assembly was petitioned by the Mayor, Aldermen and Common Council of the City of Halifax for "aid towards a Lunatic Asylum or General Hospital in said City, for which large subscriptions have been made." This petition was referred to a select committee, "to examine the merits thereof and to report thereon to this House." Some days later a despatch received from the Lieutenant-Governor of New Brunswick and proposing that the provinces of Nova Scotia, New Brunswick, Prince Edward Island should co-operate in the establishment of a lunatic asylum, was referred to the same select committee

The First Committee

This committee reported within a few weeks that, in addition to Mr. Bell's contribution, £540 had been subscribed; that they had found 42 insane persons under care at the city poor asylum and had estimated that at least 200 other insane persons were to be found in the province. They commented upon the sufferings of these people, the unwillingness of others to care for them, the ignorance prevalent relative to their treatment and the necessity for confining many of them in jails where they had little chance of being restored to reason and society. They were favorably impressed with the suggestion of a joint institution for the three provinces and recommended that full information be procured relative to both a joint and an independently controlled institution.

A commission was promptly appointed by the Lieutenant-Governor, Lord Falkland, of which Mr. Bell was a member. The commissioners went first to New Brunswick and then proceeded to a

*Being an historical article written some three years ago and published in the September 1929 of THE BULLETIN, the official organ of the Canadian National Committee for Mental Hygiene. Two further articles will appear in subsequent issues, these being by other writers.

study of asylums in the United States. Their report, presented to the Legislature early in 1846, was a very comprehensive document. The need for a proper institution was urged and supported by a mass of evidence; a joint institution for the three provinces was regarded as inadvisable; a detailed description was given of the architectural features, provisions for treatment, staff and organization of a hospital proposed for the province, together with an estimate of costs.

This report was referred to a committee of the House, which after consideration favored immediate action, but as the session of the Assembly was about to close it was decided to go no farther than appoint another committee to investigate the matter of a site and to secure more details relative to costs. The new committee reported within a year, recommending immediate erection of a hospital to accommodate 120 patients, so designed as to permit of enlargement. For reasons the validity of which cannot be estimated now, this recommendation was not made effective for several years. Lord Falkland and his successor, Sir John Harvey, urged action without immediate effect, and among others who protested against delay was Miss Dorothea L. Dix, who memorialized the Legislature early in 1850, and of whom the select committee to which her memorial was referred spoke admiringly as a "noble lady who, endowed with every quality calculated to advance society, dedicates her time and thoughts solely to the cause of those who cannot appreciate her efforts."

It was not until 1856 that construction was commenced. Then, however, work began on a beautiful site selected by Miss Dix, to which Mrs. Hugh Bell gave the name "Mount Hope." The plans were those of Dr. C. H. Nichols, then superintendent of the Government Hospital for the Insane at Washington, D. C., and resembled very closely those of that institution.

A Memorable Anniversary

The date selected for the laying of the corner stone was the natal day of Halifax—"the ever memorable anniversary of the landing of Cornwallis and his adventurous compatriots on the shores of 'Old Chebucto'." There is a reference to the event in Frederick S. Cozzens' book "Acadia, or a Month with the Bluenoses," which is worth quoting, although the reader may wish to know that Mr. Cozzens erred in at least two particulars. The peace celebration which he mentions had been held some time previously; perhaps he was deceived by the official welcome extended on the day of which he writes to the 62nd and 63rd Regiments which had just arrived at Halifax from the battlefields of the Crimea. There is no excuse for his libel on the weather, which was all that the heart of man could desire. Otherwise his reference is not inconsistent with the official records: "It was my fate to see next day a great celebration. It was the celebration of peace between England and Russia. Peace having been proclaimed, all Halifax was in arms. Loyalty threw out her bunting to the breeze,

and fired her crackers. The civic authorities presented an address to the royal representative of Her Majesty, requesting His Excellency to transmit the same to the foot of the throne. Militia-men shot off municipal cannon; bells echoed from the belfries; the shipping fluttered with signals; the Citadel Hill telegraph, in a multitude of flags, announced that ships, brigs, schooners, and steamers, in vast quantities, were below. Nor was the peace alone the great feature of the holiday. The eighth of June, the natal day of Halifax, was to be celebrated also. For Halifax was founded, so says the *Chronicle*, on the eighth of June 1749, by the Hon. Edward Cornwallis (not our Cornwallis), and the 'Alligonians' in consequence made a specialty of that fact once a year. And to add to the attraction, the Board of Works had decided to lay the corner-stone of a Lunatic Asylum in the afternoon; so there was no end to the festivities. And to crown all, an immense fog settled on the city.

Corner-Stone Is Laid

"As I said before, to make the festivities complete, in the afternoon there was a procession to lay the corner-stone of a Lunatic Asylum. But, Oh how the jolly old rain poured down upon the luckless pilgrimage. There were the Virgins of Masonic Lodge No.—, the Army Masons in scarlet; the African Masons, in ivory and black; the Scotch piper Mason, with his legs in enormous plaid trousers, defiant of Shakespeare's theory about the sensitiveness of some men when the bagpipe sings i' the nose; the Sons of Temperance and the band. Away they marched, with drum and banner, key and compass, Bible and Sword, to Dartmouth in great feather, for the eyes of Halifax were upon them."

The first section of what is now the main building of the hospital was opened for the reception of patients late in 1857, and extensions were made from time to time until it was completed, according to the original design, in 1874. It was to accommodate 330 patients, but this was soon found to be insufficient. By 1878 the situation was such that the government was compelled to give it attention. On account of the state of the provincial finances the government felt unable to add to the hospital and gave the municipalities authority to erect and maintain local asylums for their "harmless" insane. Consequent upon this, a system has developed which is not without many disadvantages. Most of the municipalities have established institutions, to which patients who are unlikely to benefit by hospital treatment are referred. Several of these asylums are very well maintained, but in others a type of economy is practised which, in the opinion of the writer at least, is in the interest of neither patient nor public.

One result of the county care system has been to restrict the ministrations of the hospital almost entirely to cases likely to be benefitted and to chronic cases of so troublesome a character as to

render them unsuitable for local institutions. Even so, the demand for accommodation at the hospital has continued to increase. This demand has been met by making provision for the resident staff in other buildings and the utilization of space thus made available for the accommodation of patients; and by the erection of an annex, designed particularly for the treatment of cases of recent development. At present the hospital can accommodate upwards of five hundred patients, while in local asylums more than a thousand insane and defective persons are being cared for.

While the hospital lacks in some desirable equipment, it nevertheless makes comfortable provision for its patients and the clinical work being done there compares favorably with that of other similar institutions. The county asylums are under the inspection of the Department of the Public Health, and through the urge of that department have, almost without exception, been greatly improved within recent years. Perhaps the greatest criticism that can be offered is that they are permitted to shelter under a single roof not only insane persons but also "normal" paupers, normal children of paupers, and defective children. Only the very best of supervision can prevent more or less mingling of these various classes.

About twenty years ago a movement was initiated looking towards a provincial institution for the feeble minded. A society for the protection of the feeble-minded was organized under the presidency of the late Sir Frederick Fraser, which later became the Nova Scotia Society for Mental Hygiene. Other organizations interested in social betterment have also been active in the advocacy of a provincial institution. A small "home" was maintained at Halifax for a number of years by the I. O. D. E., which demonstrated the usefulness of such an institution. The report of a mental survey of the province by Drs. C. K. Clarke and C. M. Hincks, submitted to the Legislature in 1921, led to the introduction of bills which were intended to permit the province to take over the care of all the insane and to establish psychopathic hospitals and also an institution for the feeble-minded. The bill relative to the insane, however, was enacted with the provision that all municipalities should consent to the proposed changes, and this consent could not be secured. The other bills were enacted as drafted, but no action was taken as the government was in process of re-organization and preparations for a provincial election were in progress.

Royal Commission Appointed

After the election, the new government was approached, and the need for provision for the feeble-minded, emphasized. A Royal Commission was appointed under the chairmanship of Hon. W. L. Hall, Attorney General, to go into the matter and advise the Government. This commission called upon the Canadian National Committee for Mental Hygiene for aid, and the Committee made another survey

of the province under the direction of Dr. C. M. Hincks. The commission also made a careful investigation on its own account, and submitted a report to the 1927 session of the Legislature, recommending, inter alia, the appointment of a provincial psychiatrist, the establishment of a school for mental defectives and of psychiatric clinics, an increase in the number of special classes in the public schools, and the erection of a travelling psychiatric unit.

Since then Dalhousie has established a psychiatric clinic at the University Health Centre; Dr. Clyde S. Marshall has been appointed provincial psychiatrist and has conducted a survey of the schools with a view to the establishment of special classes; and a site has been purchased and plans drawn for the first unit of a training-school for mental defectives.

The Nova Scotia Mental Hygiene Committee is more active than at any previous time; the public is showing a more convinced interest; the medical profession continues consistent in its support of a suitable mental hygiene programme, and the government has given assurance of its continued sympathy.

Elsewhere we enquired as to curling members of the profession in Windsor. We are glad to note Dr. Shankel and Dr. A. R. Reid have been added to the list.

In recent inter-club matches in the Bluenose Club of New Glasgow, we notice that skip Dr. F. McGreggor defeated skip Dr Robbins 10-9. Yet the latter has his wonderful golf record to remember.

More Curling. In some inter-club games we note that Dr. Clarence Miller of the Bluenose Club of New Glasgow skipped a rink in such a competition winning by 11 to 10 score, while Dr. Ballem suffered defeat by an 8 to 14 score. One wonders why this Club is styled the "Bluenose" Club. It is not in our recollection that its members are of that distinctive facial appearance. Perhaps some of its medical members will give us the real reason for the name.

Nova Scotia Needs Physicians.

"This may be of interest to some of our younger doctors and further information may be secured from Dr. S. L. Walker, 183 Hollis St., Halifax."

This is what "Dr. Collectum" prints in its February issue. Evidently our advertisers read the BULLETIN as well as to check up their regular advertisements.

A Visit to Guy's Hospital

Dr. M. A. B. Smith, Dartmouth, N. S.*

TO leave Halifax and take up one's abode in London from the middle of October to Christmas is to shorten the winter by a month.

There was little or no frost in London during my recent visit there, and on the twelfth of November, when I drove through The New Forest, Windsor, to visit Mew Lodge Clinic, Dr. Hurst's Sanitarium, to which he had invited me, the trees were still clothed with their summer leaves.

Among the pleasures of my visit to England was this morning spent at Dr. Hurst's Hospital, and perhaps I may stop for a moment to say something about this noteworthy building in a beautiful situation. It was built seventy years ago by the father-in-law of the Belgian Minister in London as a home for his daughter. Queen Victoria frequently visited it. It is like a mediaeval castle set in the forest, with a handsome carved stone gateway and winding driveway up to a gray stone mansion, the pointed gables decorated with gargoyles and carving, and at one corner a castle tower. Here Dr. Hurst can treat all forms of medical disease, and was treating about thirty-five (35) cases of Gastro-intestinal conditions with the assistance of Dr. Venables, Dr. Turner and Dr. P. J. Briggs, the Radiologist, and one or two laboratory workers. The domain is about four miles from Windsor railway station, along which road I met a number of ladies and gentlemen on horseback; the gentlemen in pink, probably on their way to a meet, as fox-hunting was now in season.

My trip to England had for its chief object a visit to Guy's Hospital, London, to learn the most recent views on the diagnosis and medical treatment of Gastro-intestinal diseases, not to the exclusion of General Medicine.

I believe we must still obtain our knowledge of medicine from clinical teachers rather than from books. We are influenced far more by what we hear than by what we read. And as I concluded there were no better known clinical teachers in London in the line of work I wanted, than Dr. Arthur Hurst and Dr. John Ryle of Guy's, I wrote to Dr. Hurst telling him my needs. In due time I received a reply from the Dean, Dr. Johnston, informing me that I had been appointed Assistant to these men. This appointment was subsequently extended to six months.

*Read at the Annual Meeting of the Medical Society of Nova Scotia at Pictou in 1929.

Guy's Hospital, founded in 1722, situated on the south side of the Thames, near London Bridge, rightly enjoys a world-wide reputation as a medical school. It numbers among its former teachers a galaxy of men distinguished in the profession—Richard Bright, Thomas Addison, Sir Astley Cooper, (a colossal statue of whom is in Westminster Abbey), Golding Bird, father and son, Sir William Gull, Hodgkins and others.

I was impressed with the thoroughness of its teaching. There is a great wealth of material which passes through the wards of the Out Patients' Department and responsibility is given to every student from the outset of his career. At the close, certain men are appointed as Registrars after they have graduated, who conduct classes during ward visits and take up the different cases from the standpoint of diagnosis. So that the same patient would be examined by Dr. A. C. Hampson, Registrar, then by Dr. Ryle, then by Dr. Hurst. The class has the benefit of the opinion of these three men in the one case, and all the features of it are discussed.

An interesting feature is the combined clinic of Drs. Hurst, Ryle and Symonds, the Neurologist, which is held in "Mary" ward every Tuesday afternoon, lasting about two hours, when the most interesting Medical cases are discussed in turn before a gathering both of graduates and students.

Attention was specially drawn to three diseases which I think are apt to be overlooked—Chronic Pancreatitis, Multiple Diverticulitis and Spastic Colon.

Diverticulitis of the Colon was demonstrated to be a not uncommon disease. This is a condition as you all know in which the mucous membrane lining the bowel protrudes through the muscular coat. These protrusions may project from the peritoneal surface, or may be hidden in the fat. They are usually present in large number. They are found most commonly in the pelvic colon, less frequently to the left of the middle line and in the descending colon.

Diverticulitis is commonly found between the ages of 45 and 65, more often in men than in women. The openings of the Diverticula are very small. In the diagnosis the X-Ray is often very valuable. I saw plates which revealed perhaps twenty or more diverticula, appearing as opaque areas about the size of peas. The observations may be made by a barium enema which sometimes shows a narrowing of the lumen of the gut for perhaps two or three inches in the inflamed and spasmodic area; or a barium meal may be given. But diverticula may be present which are not shown by the X-Ray. The diagnosis may be very difficult till a late stage of the disease.

As to the symptoms, the patient who has become more and more constipated, is suddenly seized with a pain in the lower left quadrant. The pain is spasmodic in character and increases in severity every few hours. It is made worse by jolting or by exercise. The temperature rises to between 99° and 100°. There may be tenderness of the abdomen. An abscess may form.

Chronic Pancreatic disease is now regarded as one of the common diseases of digestion manifested by attacks of general weakness, nausea, vomiting and diarrhoea, with perhaps jaundice, and with bulky stools laden with undigested fat and undigested meat fibres, and absence of pain, as a rule. I will mention the history of two cases to show how easy it is to be mistaken about Chronic Pancreatitis.

E. F., aged 46, was admitted into Miriam ward, under Dr. Hurst, with jaundice and vomiting. She had no previous illness, but had experienced some fulness and flatulence after meals.

The present trouble began six weeks before admission when she had attacks of severe colicky pain, starting in the region of the liver and coming round into the epigastrium. The attacks lasted ten minutes and continued to occur for three days. There was no vomiting. Two weeks later she became yellow, but had no further attacks of pain though the jaundice increased. A fortnight before admission she began to vomit her food, and had difficulty in keeping anything down. She had lost about 28 pounds in weight.

In this case, in the provisional diagnosis, there was doubt between a Stone in the Common Duct with Chronic Pancreatitis, and Carcinoma of the Pancreas. At the operation, which was a Cholecyst-Gastrostomy, the gall bladder was found to be *distended* and full of stones. Though the head of the Pancreas was hard and irregular and suggested Scirrhus Carcinoma, the patient made an uneventful recovery, when the biliary obstruction was overcome. It is interesting in that it is an exception to Courvoisier's so-called law, that a distended gall bladder in the presence of jaundice means a growth and not calculi.

The second case is that of Mrs. S. B., who was admitted to Mary Ward, November 5th, 68 years of age, complaining of weakness and diarrhoea. She had been operated on twenty years ago for bladder trouble. Ten weeks ago she was feeling well. A fortnight later general weakness was felt; also the urine became dark brown. She had diarrhoea three days; the stools were pale. She looked yellow. Her doctor said she had jaundice. She went to bed. Soon solid food made her vomit. During the last three weeks she had been growing steadily weaker and more jaundiced.

The duodenal contents were examined, after administering Magnesia Sulph. The report of the Levulose Test was also considered.

At the combined Tuesday afternoon Clinic, Dr. Hurst said that this was a case of Enlargement of the Liver and slight Jaundice. No pain. Increase of fatty crystals. No occult blood. Probably a case of Chronic Pancreatitis, which might recover in three months.

The test for Pancreatic Deficiency made from the Duodenal contents usually show reaction slightly acid; rich in fatty crystals; no fat globules; no meat fibres; a large quantity of neutral fat unsplit. Fat may go up to 70 or 80 and not split. The starch granules are only dealt with by the amylopsin of the pancreas.

This patient was operated on about December 5th, when a tube was inserted into the gall bladder. She died three days later. At the autopsy, the pancreas showed *no disease*. There was a stone $\frac{1}{4}$ " in diameter in the cystic duct. Death was from Cholangitis and Jaundice.

The examination of the bile and duodenal contents is a matter of routine in all cases of suspected diseases of the Gall Bladder with Dr. Hurst at Guy's. This method was first introduced by Lyon of Philadelphia. This is performed with a Ryle's Duodenal tube just as for examination of the gastric contents by the fractional method.

Concentrated Magnesia Sulph is injected through the tube. The succeeding flow of bile is aspirated after five minutes in three portions and examined.

Dr. Hurst has a special treatment for Cholecystitis, consisting of very large doses of Hexamine, which can be tolerated by the urinary bladder because of the large doses of soda citrate, which he administers with it. Dr. Hurst believes it is now possible with early diagnosis to treat many cases successfully by medical treatment. If there are stones in the gall bladder you have cholestrin crystals and germs in the duodenal fluid.

The indications for operation in gall stone disease were given us as follows:—

1. Recurrent biliary colic.
2. Chronic Jaundice due to gall stones.
3. Gall stone symptoms with pain or loss of weight.
4. Gall stone dyspepsia which has failed to respond to medical treatment.

Dr. Ryle speaks of *Spastic Colon* as a not uncommon disorder, characterized by frequent and prolonged discomfort, or troublesome and even severe pain, which is unassociated with any demonstrable organic change in the abdominal viscera, which sometimes simulates important organic disease, and for which consequently operations and explorations are unnecessarily performed. The condition is unaccompanied by mucous excess in the stools or signs of ulceration. Under the X-Ray in extreme cases the affected length of colon appears as a thin thread or streak of barium, sometimes with a sharp line of demarcation from the better filled portions.

These patients are often thin and nervous. Migraine and Asthma are often associated with the condition of Spastic Colon. Thirty (30) per cent. of these patients suffer from constipation. In thirty-six (36) per cent. of these cases, the appendix had been removed.

The usual complaint is pain in the lower abdomen—a feeling of "stoppage" or "a ball" or "a lump"—a dull continuous ache, never rhythmical or griping. The discomfort of the pain varies from an hour to many hours. The pain may be on the right or left iliac fossa or over the transverse colon. The colon can often be felt as an unduly hard cord.

Dr. Ryle says—"the conditions simulated by the *Spastic Colon* are:

1. Appendicitis.
2. Duodenal Ulcer.
3. Diverticulitis.
4. Colonic Carcinoma.
5. Renal Colic.
6. Intestinal Obstruction.
7. Ovarian or Tubal Disease.
8. Neurasthenia and Hypochondriasis.
9. Fecal Tumors.
10. Colitis.

Dr. Ryle concludes that Spastic Colon is a common disorder, more frequent than gastric ulcer. He considers that it is closely allied to asthma and is a visceral neurosis.

He also says—"The recognition of Spastic Colon as an occasional cause of severe abdominal pain and as a common cause of persistent or recurring pain in the right iliac fossa is, I believe, especially worthy of emphasis."

Turning now to *Gastric Diseases*, the Rehfuß fractional test meal of strained oatmeal gruel is constantly employed. The fractional test meal not only shows the amount of acidity of the stomach, but the motor efficiency, and often shows the presence of Gastritis, which, according to Dr. Hurst, is one of the common antecedents of cancer. Gastric lavage is only useful in the treatment of two definite conditions—Catarrhal Gastritis and conditions of Pyloric obstruction.

With regard to the choice of alkalis in ulcer, investigations have been made at Guy's Hospital to determine what alkalis are best for neutralization, while at the same time not acting as systemic alkalis. Bicarbonate of soda, for instance, produces almost instantaneous neutralization of the acid present, but the neutralization is followed by a great increase in secretion. The tribasic phosphates of calcium and magnesium have been selected as not causing alkalosis and not stimulating secretion.

The indications for operation are:

1. Stenosis.
2. Perforation.
3. Long history with increasing vomiting.
4. Posterior ulcer adherent to pancreas.
5. A duodenal ulcer which has completely failed to respond to medical treatment.

Dr. Hurst urges that in gastric ulcer, medical treatment should be continued till a week after every trace of pain and tenderness is gone, occult blood and direct radiological evidence have disappeared. If after eight weeks pain continues, or if occult blood continues for six weeks, operation is indicated. Ulcer should almost always disappear in six to eight weeks. The only operation of real use for

ulcer is partial resection of the stomach—a big operation. Speaking of Duodenal Ulcer in his book, Dr. Hurst says:—"As the years pass, the number of patients I see, who are suffering from Jejunal Ulcer and from other unpleasant sequels of gastro-enterostomy steadily increases. Much as we owe our surgical colleagues for the advances in our knowledge of the symptoms and diagnosis of Duodenal Ulcer, I am convinced that this should be regarded as a medical, and not a surgical disease." In five to ten per cent. of cases, gastric and duodenal ulcers go together.

Of duodenal ulcer, Dr. Ryle considers it is characteristic to have periods of freedom from symptoms, the attacks getting longer when they come. Also a tender spot at the umbilicus is characteristic. In duodenal ulcer, stomachs often empty quickly. If there is no stenosis there is no need of operation. Eighty (80) or ninety (90) per cent. get well under medical treatment.

Speaking of Cancer of the Stomach, Dr. Hurst believes that the common predisposing cause is chronic gastritis. The achlorhydria that is found in cancer is not the result of cancer, but of chronic gastritis. Always examine for occult blood. He has never seen a case of a growth in which occult blood is not found constantly. If there is no occult blood, don't worry.

With regard to the use of X-Ray, he says—"I now never like to diagnose either ulcer or cancer without direct X-Ray evidence to support me. It is a combination of screen work with films—the latter mainly as confirmation, that we find most useful."

I have mentioned especially two physicians of Guy's. I saw—only two surgeons—Mr. C. H. Fagge and Mr. R. P. Rowlands—and the Orthopedist, Mr. W. H. Trethowan. I spent my time in the medical department. The spirit of every department seemed to be one of scientific research.

I cannot close without expressing my gratitude to the Dean, Dr. T. B. Johnston, to Mr. Winston, the Secretary of the Medical School, and especially to Drs. Hurst and Ryle, from whom I received much kindness and consideration.

THE MENTAL DEFECTIVE.

It was President Hoover who said the greatest problem in this connection is, "that there are so many of us." In this connection the *A. M. A. Journal* has the following:—

"Behold ye simple moron,
He does not give a damn,
I'd hate to be a moron,
Ye Gods! Perhaps I am."

PREPARATION OF MEDICAL PAPERS

THE title also suggests Addresses, Case Reports, etc. It so often happens that a medical man presents some exceedingly valuable scientific material, but which in the manner of presentment, he kills its effectiveness.

We have often seen a medical man at a meeting of his local society get up, put one foot on a chair, a hand in his pocket and, varying these positions, irrespective of the audience give a good clinical contribution, original or in discussion. But this is not good enough. It is necessary there should be a finished presentation of the subject before the receiving audience will be inclined to acknowledge its worth.

This statement is true and is illustrated at nearly all Branch and Provincial Society Medical Meetings.

If you have anything to say to your Brother Practitioners that is *worth while*, please give them the courtesy of saying it in the most acceptable manner possible. The effectiveness of a paper or any part of its discussion depends greatly upon the manner of its presentation. Perhaps, then, the following Editorial from the December Journal of the University of Toronto will be appreciated.

"On reading medical literature one is struck by the great diversity of method used in the writing of papers. Some are written in the literary style of Osler; others are thrown together in a haphazard or incomplete way, with the result that excellent material is spoiled because the reader cannot follow the writer's argument. By following certain rules, and by practice, the craft of writing may be acquired.

"The first consideration is the choice of a subject, and this must be made with care. If the writer cannot report original work he should at least choose a subject on which work has been done recently and which has not been completely summarized already. Also, he must consider the type of journal in which the paper is to be published and choose a subject which will be of both interest and value to the readers of that journal, or, more logically, it may be done the other way—a subject chosen and then a suitable journal found.

"Having decided on the subject the next step is to gather the material. This must be complete, as nothing chagrins an author more than to find that an important source of information has been overlooked. The surest method is to use the Index Medicus, make notes of all pertinent articles and then read them, making a summary of each. This brings a large amount of material into readily accessible form.

"The presentation is quite as important as the material itself. An outline must be made and then followed. First comes the introduction; it should be brief, and it is better to avoid time-worn phrases. All the facts should then be listed in logical order and divided and subdivided under suitable headings. The manner of division varies

with different subjects, but, as a rule, that found in the standard textbooks is satisfactory. Having presented the facts, the conclusions to which they lead are set down. At times the reader is left to draw his own conclusions but that gives a lack of finish to the paper and does not impress the reader as does one in which the writer takes a definite stand.

"A summary, placed at the end, is a distinct asset to any scientific paper as it brings once more to the reader's attention the important points and he is able to quickly review the whole thing in his mind. Also if at any time he wishes to refresh his memory he may do so by simply reading the summary.

"No one paper can give a complete account of all the literature on any subject, but should mention the work which has been done and its result, and in that way stimulate a desire for further reading. If an accurate list of references is attached, this further reading is greatly simplified and the author will have the blessing of his readers. Equally as important is the courtesy to the authors who have supplied the material for the paper.

"After the paper has been written it is well to lay it aside for a considerable length of time and then look it over with a critical eye and ask oneself certain questions. Are the facts in logical order? Do the conclusions follow from the facts? Are there any unnecessary words or sentences? Is the list of references accurate? These and other questions should be considered in as disinterested a manner as possible, and then the paper rewritten.

"The above is a brief outline. For greater detail a handbook on the subject may be consulted, such as 'The Writing of Medical Papers' by Mellish."

THE BLOODLESS PHLEBOTOMIST.

Probably every practitioner in Nova Scotia has received a copy of "The Bloodless Phlebotomist" Vol. VII. No. IV, English edition, a copy of which is sent to every English-speaking physician in the world with a known address.

This issue of the "Phlebotomist" is being printed in nine languages—English, French, German, Spanish, Portuguese, Italian, Chinese, Japanese and Hungarian—with a total circulation of over 1,250,000 copies, reaching physicians in every country of the world (with the exception of Russia, Latvia, Bulgaria and Lithuania).

This edition contains a review of the book "The Conservative Treatment of Diabetes," by Professor Doctor Singer, of the University of Vienna, which has elicited favorable comments from medical journals of international reputation.

The severe reactions following the injection treatment of varicose veins, which is now being accepted as the method of choice, is also discussed in an original article by Dr. Tournay, of Paris, a collaborator of Professor Sicard. (Denver Chemical Company)

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ANNUAL FEES

SHORTLY after this issue of the BULLETIN reaches our readers the membership drafts will be presented to practically all members of the profession. It is necessary that 300 fees be paid to keep the Society solvent. Briefly stated our obligations are roughly as follows:—

Salary—General Secretary.....	\$1,200.00
Travelling Expenses.....	300.00
Office Rent.....	300.00
Stenographer.....	180.00
Deficit on BULLETIN.....	360.00
Sundry Office Expenses, Postage, Telegrams, etc.,	160.00
	<hr/>
	\$2,500.00

Should some of our members secure a little more advertising for the BULLETIN it might be made self sustaining, with a saving of over \$300.00. Perhaps some one will thus assist.

Membership in the Medical Society of Nova Scotia for 1930 promises to be very profitable with post graduate lectures, one or two for every Branch in May and October; the Annual Meeting July 1st to 3rd at The Pines Hotel, Digby; the British Medical Association and Canadian Medical Association meeting, August 25th, to 29th (a special excursion from Nova Scotia is being arranged); the entertainment of a large party of British Delegates as they make a tour through the Maritime Provinces. It is also expected that several of these delegates will lecture also at the usual Dalhousie Refresher Course in September.

Then besides this, you have the BULLETIN whose aid to good fellowship cannot be measured by a few dollars. Notice how it has grown to sixty pages and it cannot fulfil its obligation to the profession in a smaller issue. Every province, excepting Prince Edward Island, has found it necessary to issue a Bulletin, several of them reminding us of our early issues. Only the Province of Ontario had an established Journal earlier than Nova Scotia. We understand that a previous publication was taken over by the Ontario Association as its official publication. Again in Nova Scotia we have been "pathfinders" and let us continue to blaze the trail.

There is one feature about our Society work that must appeal to us all. When the call comes for one of our members to answer the last summons there is no delay of months or a year before the bereaved know they have the sincere sympathy of the medical profession. It seems to get stale if it is delayed for a number of months.

So, take it all in all, we are going steadily forward. Nobody can ever stand still, for then you slip backwards. There is a big work ahead of the Medical Profession in Nova Scotia this year especially, and every practising physician should make his membership in the Society effective.

OUR ADVERTISERS

IT is not the desire of the BULLETIN to find fault with Pharmaceutical and other organizations doing business in Nova Scotia who do not advertise in the BULLETIN. Of course, we desire to obtain as much advertising as is possible in this connection. We wish, however, to have the members of the Medical Society of Nova Scotia notice that our BULLETIN advertising pages have been occupied only by those concerns that might be regarded as among the best possible agents for the profession in this Province.

We were exceedingly glad, then, to add to our list the advertisement of the Mead, Johnston Company which appeared in our December number. We are in hopes that the advertising in the BULLETIN will soon pay for the cost of its publishing.

Of course if we had the co-operation of New Brunswick and Prince Edward Island there would be absolutely no question but what the official medical publication of the profession in the Maritime Provinces would pay its own expenses. It is not the fault of the Medical Society of Nova Scotia that this does not obtain to-day. We are very clearly on record as desiring a Maritime Union along this line. If the other provinces—New Brunswick and Prince Edward Island do not feel like joining with us that is entirely their own affair. Nova Scotia has absolutely no reason why it should take further initiative in connection with a Maritime Union of Medical Societies without losing any provincial autonomy.

Perhaps to some extent this has been centered around the Secretaryship of the Medical Society of Nova Scotia in the person of Dr. S. L. Walker. It must be very clearly understood by the medical men in the Maritime Provinces that the attitude of the Medical Society of Nova Scotia has absolutely nothing to do whatever with the person who shall be or who might be selected as Provincial or District Secretary of the Canadian Medical Association for this district, if the proposed zoning ever becomes effective.

This brings up one more point. If there is one thing more than another which has characterized our Medical Societies and Journals it has been a tendency *not to speak too positively*, or *not to find fault*. Every medical man in Nova Scotia has the right, if he belongs to the Society of expressing his opinions in the BULLETIN. We can only regret that its pages are not used to the extent that is desirable. It should be our actual Forum as it is open twelve months in the year as compared with two days at an Annual Meeting.

Write the BULLETIN of what you are thinking and talking and remember you wouldn't have this journal were it not for Our Advertisers.

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The Maritime Life was started by Maritime Capital to fill the gap caused by the fact that there was no life insurance company with headquarters in the Maritime Provinces.

It is staffed by Maritime men.

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THE MARITIME LIFE

Head Office

Halifax

British Medical Association

Winnipeg, August, 1930.

LEADERS IN BRITISH MEDICINE.

Sir E. Farquhar Buzzard, K.C.V.O.

IT will be a high honour to Winnipeg to welcome in August, 1930 the Regius Professor of Medicine at Oxford, the successor in that office to the late beloved Sir William Osler. Sir E. Farquhar will come as President of the Section on Neurology. He was born in 1871, the son of a distinguished physician, and was educated at Charterhouse, Magdalen College, Oxford, and St. Thomas' Hospital where he was Mead Medallist. Scholarship was not his only claim to distinction, for he was a member of the Oxford University Association 1892-94, the old Carthusian XI Winners of Amateur Cup 1894, 1897, and London Senior Cup 1895, 1896, 1897.

After graduation he turned his attention to diseases of the nervous system, and has gained a deservedly high reputation. He has been Physician to the Royal Free Hospital for Paralysed and Eplipetic, and has contributed extensively to medical literature. He is now Honorary Physician to the Radcliffe Infirmary, Oxford, and to the Artists' Benevolent Fund.

He is married and has two sons and three daughters. His recreations are golf, fishing and shooting.

Honours and distinctions have come to him in full measure. He was knighted (K.C.V.O.) in 1927, is Physician-Extraordinary to the King, Fellow of the Royal College of Physicians, Fellow of the Royal Society of Medicine, and Hon. Colonel A.M.C. (T.F.).

Professor Robert Muir.

The President of the Section on Pathology at the British Medical Association in Winnipeg, 1930, is one of the most distinguished English speaking pathologists. Since 1899 he had been Professor of Pathology, University of Glasgow, and with the late Professor J. Ritchie the author of a Manual of Bacteriology which has gone into eight editions.

Like so many men of distinction he is a son of the manse. Born in 1864, he was educated at Edinburgh University where he made a reputation for scholarship. In 1892 he was appointed senior assistant to the Professor of Pathology, Edinburgh University, and Pathologist to the Edinburgh Royal Infirmary. In 1898 he went to St. Andrews' as Professor of Pathology and in the following year to Glasgow.

His other publications are Studies on Immunity, Text-book of Pathology and scientific papers. His recreations are golf, fishing and curling. He is a Fellow of the Royal Society and a member of the Medical Research Council.

The Banting Research Foundation

Toronto, Canada.

AS a result of the discovery of insulin several members of the staff of the University came into contact with several young physicians who had research ideas but for whose work ordinary University Departments could not provide. This situation was presented to several laymen, such as Sir Wm. Mulock, Chief Justice of Ontario and they were inspired to help to raise a fund to meet such cases. The Banting Research Foundation was a result of these efforts. The capital sum raised, something over \$600,000, is held in trust, the interest only being expended. Firstly, the Foundation supports research by the staff working under Dr. Banting in the chair of Medical Research in Toronto. From time to time physicians who have had ideas in regard to such problems as cancer, pernicious anaemia, arthritis, have talked these problems over with Dr. Banting and owing to the resources placed at his disposal, have found a place to and support in undertaking researches, recently. The Trustees consider applications from physicians anywhere in Canada, who require assistance in carrying out original research on medical problems. The applications are considered by the Board of Trustees supported by a large advisory committee consisting of Professors in the University of Toronto and in other Universities. The Dalhousie representative is Professor Young of the Department of Biochemistry. If the problem appears clear cut and within the confidence of the proposer, money is granted if it is required and cannot be supplied locally. There is, of course, a limit to the amount available. Of the list referred to in the clipping,* several are physicians in practice; all but one of these has however a University connection. One is in a town where there is no University. In view of the fact, that most of the forward steps in Medicine to-day are made in teaching hospitals or in scientific (medical) laboratories, one of the greatest contributions the Foundation can make to the development of Medicine in Canada, is to put young graduates at work on medical problems, lead them into the field of research, or at least smooth their way, so that they will acquire in their youth the thoughtful attitude which will mean so much to them if they are going to do research in practice as Sir James MacKenzie did. No startling discoveries have been made as yet, but many of the workers have made valuable contributions to science.

(Sgd.) V. E. HENDERSON, M.D.,
Hon. Secretary to the Foundation.

*This refers to a newspaper clipping press despatch which was passed by the BULLETIN to Dr. Routley for confirmation. The BULLETIN gladly acknowledges this courtesy.

Correspondence

Pittsfield, Mass.,
Jan. 4, 1930.

Secretary of the Medical Society,
Halifax, Nova Scotia.

Dear Doctor:

I wish you would please put me down on your list of subscribers for your magazine. A year or so ago I received the magazine for a length of time and enjoyed the medical articles, but most of all I enjoyed the references to medical men, some of whom I have known in years gone by.

I will be glad if you will have them send me a bill for a year and I will send the remittance by return mail.

With kind regards,

Yours sincerely,

(Signed) GEORGE H. THOMPSON, M. D.

The Antiphlogistine people have sent the BULLETIN the following Christmas Greeting which we gladly acknowledge.

"We who gather around the Home Fireside of the Antiphlogistine Family at this holiday season, sharing the joys and disappointments of our daily work, pause to extend the open hand of Fellowship and Good-will to those in foreign lands and at home who have co-operated with us. In this spirit we wish you a Very Merry Christmas and a Happy, Constructive 1930.

(Signed) THE DENVER CHEMICAL MFG. COMPANY

FRANK J. STEIN, M. D.
Medical Director."

To show that our Advertisers appreciate the service of the BULLETIN we give the following letter:

"I read with interest your article—'Doctors Wanted'—in the December issue of the Nova Scotia Medical BULLETIN. The January issue of 'Dr. Collectem' is already in the mails, but I intend to run in the February issue a little item* regarding openings for doctors in Nova Scotia, and referring any young doctors who may be interested to you. That may put you in touch with some very desirable young physicians.

Merry Christmas, Doctor!

Cordially yours,

THE MEDICAL AUDIT ASSOCIATION."

*We have already had one inquiry from this source. S. L. W.

Hospital Notes

MISS Barbara McNeil R.N., for a number of years Superintendent of the Glace Bay General Hospital retired from that position December 31st, 1929. On December 19th the Medical Staff interviewed Miss McRae and the *Sydney Post* report is as follows:—

On behalf of the doctors present, Dr. Dan McNeil addressed Miss McRae and referred in a very complimentary manner to the very efficient manner in which she had managed the hospital during the years she was in charge. He also referred to the cordial relations that had always existed between the members of the medical staff and the retiring superintendent and the splendid co-operation that had characterized her term of office. Dr. McNeil then presented Miss McRae, on behalf of the medical staff with a beautiful purse of antelope leather containing one hundred dollars in gold.

Miss McRae was visibly affected with the lovely gift and the flattering words that accompanied it, but she sincerely thanked the Doctors and stated that one of the memories she would long cherish was the fine assistance and sympathy she had at all times received from the medical staff of the General Hospital.

Lunenburg is now realizing the very great advantage of having a Health Nurse available for service in that town. The V. O. N. started this service about two years ago and the recent report at the Annual Meeting is proof of this statement. The report showed several things that are worthy of notice. It is noted that very considerable work was done. Thank goodness the medical profession has reached the stage where it recognizes the good and ignores, as far as possible, the failures of many organizations, because the intentions and general results are much in the interests of community welfare.

The report showed that 1690 visits in the following classifications had been made: Medical and surgical, 777; communicable, 69; pre-natal, 102; maternity, 290; child welfare, 276; school, 36; home-school, 122; miscellaneous, 43. The visits to the schools, when 1614 children were inspected for minor defects, resulted in 250 corrections of defects, the nurse having the sympathy and co-operation of teachers and parents in this phase of her work. Apart from the daily visiting, the nurse has conducted very successfully classes in mother-craft, home nursing, and baby conferences, in which valuable information, relative to the care of children in the home, has been imparted.

The fourth annual meeting of the Western Kings Memorial Hospital Association, held on the sixth of December, was characterized by excellent reports and addresses indicating the pride and interest

taken by the people of Berwick and vicinity in the hospital. There has been substantial growth in its work, and the financial situation is very satisfactory. District nursing is being done by members of the nursing staff of this hospital.

As part of a drastic endeavour to effect economies, the managing board of the Highland View Hospital, Amherst, have dispensed with the services of two graduate and five pupil nurses. According to newspaper reports the deposed nurses feel that their summary dismissal without notice is unwarranted, and they may take legal action against the hospital board.

The Digby Hospital Board have decided to proceed with the erection of a new hospital building, and to have the work done under the supervision of the Board rather than by contract.

A MESSAGE FROM FILENE'S.

Boston, may only mean to the Nova Scotia Doctor, the place where his wife is most likely to spend considerable of his money whenever she gets the chance. Yet, the President of the above firm last year delivered an address before the American Hospital Association which, in a condensed form has been published recently in the *A. M. A. Journal*. He notes the rapid progress made by medical science, but he believes that the organization by which it is applied is away behind the times.

Then he says medical costs cause unrest:—

“As one of the great medical service buying public, I submit that we customers have cause for dissatisfaction. If we happen to be rich we must pay not only for our own treatment but for that of our poor relations—and of the poor with whom we claim no relationship at all. If we are poor we must go to a clinic and become objects of charity. If we are neither rich nor poor, one serious illness in the family may put us so seriously in debt as greatly to hamper or destroy our progress and happiness.

“I do not think I exaggerate when I say that the high cost of sickness, at least among the middle classes, is as potent a cause of social unrest as poverty among the poor,—for in the long run they produce the same result. I know of person after person,—some of them members of our store staff,—whose lives have been twisted and warped by the financial burdens of illness. One sometimes doubts whether, in some instances, the cure did not cause as much or more suffering—of a different sort, no doubt, but suffering just the same—as did the disease itself.”

Then he brings out, what we all realize, that this is poor business for the physician who is entitled to a good livelihood. He makes a rather unusual suggestion, that might be considered as an alternate to that bogey of 'State Medicine,' when he suggests Medical Guilds:—

"Why should we not have what might be called 'Medical Guilds'? Suppose a group of fifteen or twenty physicians should get together and pool their resources in the creation of an efficient organization,—owned and operated by them,—for dispensing medical service on the basis of a periodic examination for a fixed annual fee. Might not such groups, widely organized throughout the country, go further than any agency has yet gone in the solution of our problem?"

Consider what these medical guilds might do. Among the members of a guild one or two would be skilled general diagnosticians, the others would be specialists in the various branches of medical science—a nose and throat specialist, a gynecologist, a pediatrician, one or two dentists, a neurologist or two, and so on. All of them would have their offices in the same building. They would all share in the operating overhead and in the expense of those facilities and apparatus which might be used jointly by them. They would employ an expert in scientific business management to carry on their business operations, such as upkeep and management of the plant and accounting.

They would offer their services not as individuals but as an organization. They would sell to the public not ten or fifteen separate and disconnected special branches of medical care, but a well rounded, complete and self-contained medical service. The guild's patients would not be put to the exasperating nuisance of going from one end of the city to another, from one physician with his own set of questions and records, to another, in search of specialized advice on one or more angles of their particular disabilities. The guild's general diagnostician would refer each patient to the guild specialist best equipped to give the special treatment indicated—in the same building and using a single set of records."

We have in mind in this Province of Nova Scotia several centres where a scheme of this kind might be practicable. In any case it is worth considering.

S. L. W.

In a paper contributed to the December number of *Health Rays*—an excellent monthly magazine published by the patients of the Nova Scotia Sanatorium—Dr. A. F. Miller pleads for more generous co-operation of the municipal authorities with the provincial government in making proper treatment more readily available to needy persons suffering from tuberculosis. While the tuberculosis death rate of Nova Scotia has been materially reduced within recent years, it is still distressingly high, and Dr. Miller continues tirelessly in the endeavour to bring about further betterment.

Branch Societies

Semi-Annual Meeting, Valley Medical Society. Kentville, Oct. 21, 1929.

THE Valley Medical Society met at its regular semi-annual meeting in the Recreation Hall, N.S. Sanatorium, Kentville, N.S., at 3 P.M. Monday, Oct. 21, with the President Dr. A. B. Campbell in the chair. The minutes of the last meeting were read and approved. A letter from Dr. White of Bridgetown was read, concerning the advisability of meeting regularly at some central point in the Valley, Dr. Burns moved that we continue to hold our place of meeting in the various towns in rotation as formerly, this was seconded by Dr. Cochrane, and after discussion passed. The question of increased accommodation for tuberculosis cases was brought forward by the secty. It was moved by Dr. Elliott and seconded by Dr. Cochrane that this Society put itself on record as favoring increased bed accommodation at a central Institution, after freely discussing the matter, it was passed.

It was moved by Dr. Morse, seconded by Dr. Sponagle that the Secretary of the Valley Med. Society convey by letter to Dr. Murdoch Chisholm, of Halifax, the very hearty congratulations of our society on the fiftieth anniversary of his medical practice, unanimously passed. The following new names were handed in for membership, Dr. Evelyn Rogers, Dr. Charles Beckwith, and Dr. E. A. Kirkpatrick. All were nominated and elected. Word was received, at the last moment that Dr. Johnson of Halifax, who was on the programme, would be unable to be present, and Dr. Corbett of the N. S. Sanatorium kindly consented to fill the gap.

Dr. Goodall, of Montreal, opened the programme with an address "The Toxemias of Pregnancy," this was given in a clear and comprehensive manner and was listened to with great attention, a very generous and helpful discussion followed.

Dr. Corbett then gave a paper on Gastro-intestinal tuberculosis which was freely illustrated by X-Ray films, Dr. Corbett brought out many points of interest to the general practitioner, and his paper was greatly enjoyed by all, and a hearty vote of thanks tendered him, especially for favoring us on so short a notice.

The last address of the afternoon was given by Dr. Walker of Halifax, his subject being "and the C. M. A.". He spoke straight from the shoulder and gave some splendid advice and information, stressing the point that every physician should get behind his own local organization and also the C. M. A. and not to forget the great good the C. M. A. was now doing and would continue to do as the years go by.

At 6.30 p. m. the members were guests of the N. S. Sanatorium at dinner and a hearty vote of thanks was conveyed to Dr. Miller and staff for their kindness in this respect.

After dinner the members again assembled at the Recreation Hall and heard Dr. Goodall speak in a clear cut and most impressive way on "Uterine Cervical Infections." This address was freely discussed by many of the members, Dr. Goodall answering many and varied questions put to him regarding the problems so frequently met with by the general practitioner. The secretary will not insert in these minutes the details brought out by the speaker, as no doubt, the above mentioned papers will be published in our journals, but the general opinion was that we had listened to one of the most up-to-date and instructive addresses it has been the pleasure of our society to hear. After a cordial vote of thanks, in which the mover voiced the hope that we would have the pleasure of having Dr. Goodall with us again, the meeting adjourned.

C. E. A. DEWITT, M. D.

Secty. Treas.,
Valley Medical Society.

General Militia Orders.—The following will be of interest to many of our readers:—

"578—Detailed for Duty.

The Royal Canadian Army Medical Corps:—Lieutenant-Colonel and brevet Colonel J. T. Clarke, C.B.E., vacates the appointment of District Medical Officer, Military District No. 4 Montreal, P. Q., and is detailed for duty as Acting Director General of Medical Services at National Defence Headquarters, Ottawa, Ont., during the absence of Lieutenant-Colonel and brevet Colonel H. M. Jacques, D.S.O., with effect from the first January, 1930.

Captain H. M. Cameron, No. 4 Detachment, is detailed for duty as Acting District Medical Officer, Military District No. 4 from the first January to the 30th April, 1930.

579. Transfers.

The following transfer is authorized:—

The Royal Canadian Army Medical Corps—Lieutenant W. L. Coke, from No. 3 Detachment, Kingston, Ont., to No. 4 Detachment, St. Jean, P. Q., with effect from the 15th December, 1929."

Again we notice keen competition among medical men for medical officers to municipal institution, Dr. W. H. Rice of Sydney being recently appointed by the Cape Breton County Council as Physician to the Cape Breton Hospital by a vote of 13 to 11 for Dr. W. J. Egan. But then Dr. Egan was appointed jail physician while Dr. A. C. Gouthro was appointed Health Officer for the County:

Our Exchanges

Canadian Social Hygiene Council Annual Report.

THE 10th Annual Report of the Canadian Social Hygiene Council has just been received at the BULLETIN office of the Medical Society of Nova Scotia. This Report is of a meeting that was held beginning June 21st, 1929 and, as far as we can see concluding the same day. Of course, a short annual session like this should hardly be expected to take six to seven months to report their proceedings. The Medical Society of Nova Scotia holds an Annual Meeting, say the last three days in June or the first three in July, if the full report is not available in August or September, both the Society and its general Secretary would have considered they had fallen down on their job. At the same time we recognize how many things may conspire to make this delay.

An Exchange reference or acknowledgement is not worth anything if the writer is not permitted to give expression to an honest opinion. So let us add a further little matter for consideration. How many of these Canadian National Organizations primarily concerned with the prevention of Disease and the Promotion of Health, do we require in Canada. I do not mean Head Offices in Ottawa, Montreal, Winnipeg, Toronto or Halifax. But, I do include the Social Hygiene Council, the Tuberculosis Council, the V. O. N., the Canadian Red Cross, the Anaesthetists and Psychiatrics, etc. In Canada let us simplify our machinery as much as possible.

Now, personally, I do not get as much from an Annual Report of any Society as is actually contained in its report. That is my disability for my candid opinion is that the 1929 Annual Report of the Canadian Social Hygiene Council is the best of theirs I have ever read, and I have read them all. Nevertheless I am looking forward to the time when most of the Health Activities we have mentioned will be more directly under the general supervision of the Canadian Medical Association.

An investment by the Council of \$1000.00 in Nova Scotia has very little to show for it, but the plan suggested is practical and we predict its adoption in the early future. We consider Dr. Gordon Bates of Toronto is doing a wonderful work for Canada in directing the activities of this Society.

S. L. W.

Year Book Medical Publication.

From time to time in these pages mention has been made of the desirability and necessity of keeping up-to-date. Keeping in touch with all of the latest ideas and methods is a real problem for the average practitioner. He cannot spare the time to visit medical centers.

Likewise it is impossible for him to read *all* of the medical journals of his and other countries. It is interesting, therefore, to learn that this problem has been recognized by others and to find that very able assistance is available to the busy practitioner.

If one could read all of the contemporary medical journals he could maintain a practical knowledge of all that is important in medical progress. Such a procedure is, of course, impossible but the advantages of such a method are available to physicians and specialists. A digest of all the significant literature of the year—stripped of non-essentials—is contained in readily accessible form in eight books. These books—the Practical Medicine Year Books—have been published every year for more than a quarter of a century by the Year Book Publishers of Chicago, Illinois, U. S. A. Their value to the profession is attested to by the fact that more physicians subscribe to them than to any other works of their kind. Of some volumes, we are told, it is literally true that *most* specialists in the fields covered by these books buy them every year.

The eight volumes of the Practical Medicine Year Book Series include the following—General Medicine; General Surgery; Eye, Ear, Nose and Throat; Paediatrics; Obstetrics and Gynecology; General Therapeutics; Dermatology and Urology; and Nervous and Mental Diseases. Each of these volumes is edited by one or more men who are recognized as authorities in their respective fields. Leading journals of five countries are appraised, analyzed and summarized to supply the material which is submitted to these editors. These eminent men, according to the publishers, go over all of this material thoroughly, eliminating all non-essentials and presenting the salient points concisely and interestingly. Comments by these same authorities, drawn from their own rich experience, add to the value of the books.

As the Year Book of General Medicine has, perhaps, the widest application, we will indicate the names of the contributing editors and the subjects which they cover. This volume of over 800 pages is divided into five sections. The first section—Infectious Diseases—is edited by George H. Weaver, M.D., Clinical Professor of Pathology, Rush Medical College of the University of Chicago. Part two—Diseases of the Chest—is covered by Lawrason Brown, M.D., Trudeau Sanatorium, Saranac Lake, N. Y. Section three—Diseases of the Blood, Blood Making Organs and Kidneys—is presented by George R. Minot, M.D., Professor of Medicine at Harvard, and W. B. Castle, M.D., Associate Professor at Harvard. Section four—Diseases of the Heart and Blood vessels—is the work of Wm. D. Stroud, M.D., Associate in Medicine, University of Pennsylvania. And the last section—Gastro-Intestinal Diseases—was edited by Ralph C. Brown, M.D., Clinical Professor of Medicine, Rush Medical College of the University of Chicago. The other books of the series are equally as well organized and are as authoritatively edited.

Two or three volumes of the 1929 Practical Medicine Year Book Series (just off the press) have been placed in the BULLETIN Library

and we can truthfully say that these books should prove extremely helpful to general practitioners and specialists. The publishers tell us that any of these books will be sent on ten days approval and may be returned at their expense. Prices range from \$2.25 to \$3.00, postpaid.

Just after we sent our copy for our January issue to the Printer, the Bulletin for December, 1929 of the *New York Academy of Medicine* came to hand. Most of its contents refer to the Second Annual Fortnight of the Academy. We quote:—

“The enterprise began some seven years ago and consisted in the co-operation of the Medical Society of the County of Kings and the Long Island Medical School in courses of late afternoon lectures on subjects of direct clinical interest to the practitioner and in offering in conjunction with several hospitals of the Borough short courses in a matter of more or less practical medical and surgical subjects. It has been successful and is still going on. The lectures are regularly crowded and the extension lectures have had a varied popularity. In general, a registration equivalent to about one-fifth of the medical population has taken one or more of the courses offered. This is not the time nor the place to discuss in any detail the reasons for the degree of its success nor the obstacles to its greater glory. Two striking facts, however, seem to make themselves clear.

First, a certain separation which exists between the school and the profession who seem in a measure to have lost touch with one another; and, secondly, a gradual but very definite and progressive decay in the older methods of training by apprenticeship, with loss of some of its virtues.”

Dr. Harlow Brooks gave the opening address at this annual function. He very clearly points out that Post-Graduate Study in Great Britain and the Continent is much more effective because better systematized than in America. We are glad to note that such centres as New York, Baltimore, Philadelphia, Rochester, Toronto, Montreal, not forgetting the splendid work of the Canadian Medical Association, are beginning an effort to meet this need. Short courses or long are required for 85% of our profession. Hitherto these have not been available on this continent in any definite manner.

International Clinics.

One of the most valuable Exchanges our BULLETIN enjoys is the International Clinics published by the J. B. Lippincott Company of Philadelphia, London and Montreal. As a publishing firm the Lippincott Company issues practically the latest word along medical scientific lines. Perhaps the publication of the Clinics, which has been coming to the writer for a quarter of a century, giving the last word in medicine, surgery, obstetrics, neurology, paediatrics and the

specialties, has been a factor in having the firm publish chiefly recent works rather than new editions of older books.

As some of our readers know, for we have seen the Clinics in many offices, Henry W. Cattell, M.D., Burlington, New Jersey, is Editor of the Clinics, associated with him being many men prominent in this continent and in Europe. The articles published are in many cases stenographically reported actual clinics by the ablest clinicians.

An interesting editorial that may be of special value to Dr. K. A. MacKenzie, who is giving the subject special study, is one "The Cost of Medical Care." It is expected that something very definite along this line will be reported by a special Committee of the American Medical Association in 1932 and it behooves the Medical Society of Nova Scotia to formulate some policy which will secure a better or more adaptable medical service for a largely rural district like these Maritime Provinces.

Just preceding the general index subjects considered in the four volumes of 1929 the concluding Editorial note indicates the policy of the Clinics for 1930 thus:—

"The long established editorial policy of only publishing requested contributions in the pages of the *International Clinics* will be continued during 1930, and it is to be hoped that Professor Lewellyn F. Barker, of Baltimore, will be able to open the first volume of the fortieth series with one or more of his excellent clinical lectures. As far as can be ascertained, the new departments of Medical Questionnaires and Medical Trend have been received with manifest approval, and it is hoped that subscribers will write the Editor frankly as to the kind of material that they would like to see commented upon and written about. From one-third to one-half of each issue is devoted to the Department of Diagnosis and Treatment of the various diseases covered by the Bertillon Classification, both from the standpoint of mortality and morbidity, and the especial subject for consideration in the next issue will be typhoid fever which is again bobbing up its ugly head as the politicians become lax. In each volume, as has been done in the last several numbers, an institution, hospital, a medical school, or a city will be personally visited and a symposium arranged for or the work going on there described. It is intended to make the reading matter conform to present-day conditions of practice as it exists, and the cost of medical care and the methods of securing an adequate income derived from the professional practice of the physician, will be given most careful consideration."

It is our experience that this publication is one of great value to every physician.

S. L. W.

Our January number of the *Medical Journal* of the University of Toronto has been received and it has a number of articles of very considerable worth. Perhaps we will be able in future issues to make some definite references to one or more of these articles.

Reminiscences

FARISH.

THE earliest record obtainable of the Farish's in medicine dates from Skeery Greggs Farish, who was born in Brooklyn, N. Y., whilst the British flag was still flying, in the year 1781.

The records say "The British flag was flying over the house and a sentry guarding the door."

His father and mother both died when he was a young man, and he took up the study of medicine with a Dr. Perry, a great friend of his father's, and even when so young aged 17, he attended Dr. Perry through a long illness.

Dr. Perry eventually died and Colonel Hamilton, the British Consul at Norfolk, Va., obtained an appointment for him on board of his Majesty's ship *Asia*, as Surgeon or Assistant Surgeon and subsequently on the *Cleopatra*. He must have been a very young man at that time, the records not designating his age, and evidently all the medical and surgical knowledge he had stored up was obtained from his study and observation whilst with Dr. Perry.

After peace was declared he was returned to England, discharged and left alone in London with 15 guineas in his pocket and nothing in sight whereby he might earn a shilling.

He got a position as Surgeon's Assistant, when one day he had a letter from Dr. Bond, then practising in Yarmouth.

Hearing of the young man, he asked him if he would come out and take the position of his assistant, an opening which he was only too glad to avail himself of.

After 5 years as assistant, he joined Dr. Bond on equal terms and eventually married his eldest daughter.

He practised in Yarmouth from 1802 to 1856, when he died at the age of 75.

Besides attending to the arduous duties of his profession, he held several offices, viz., Collector of Excise, Postmaster, Registrar of Deeds, and the high and honorable position of Chief Magistrate and as the records say, "presiding over the Bench at their meetings with firmness and decision."

Regarding one of his offices, viz., that of Postmaster, it is said that the Post Office was his Surgery office and he placed all letters in the window so that no one would need to enter the Post Office to enquire for their respective mail.

There were three sons born to Skerry Greggs and Sarah Farish viz., Greggs Joseph Farish, James Collins Farish, Skerry Greggs Farish and also 12 daughters.

Greggs Joseph Farish, the eldest son, was born in 1809 and died in 1881. He practised in Yarmouth for 46 years and becoming tired of the medical profession, accepted a position of Inspector of Schools for the County of Yarmouth and possibly of Shelburne.

He was an M. D. of University of Penn. and also an M. R. C. S. of London and a Gold Medalist of his class.

James Collins Farish, familiarly known amongst the County fold even to-day as Dr. Jimmy, was born in 1811 and died in 1889.

He practised in Yarmouth for 50 odd years and at his death was succeeded by G. W. T. Farish, a son of Henry G., of Liverpool, who is still carrying on.

Those who remember Dr. Jimmy often speak, even to-day, of his style in the saddle, with flowing frock coat and as straight as a rush.

Henry Greggs Farish, the third son, was born in 1825 and died in 1914, being then at the ripe old age of 89.

After he graduated from the University of Penn. he was sent to London and spent some time at the London Hospital, where also both of his brothers had been. He received the degree of M. R. C. S. London and returned to Yarmouth.

His father evidently thought that there were sufficient Farish's in the practice of medicine in Yarmouth at that time, and so despatched him to Liverpool.

He remained there throughout his lifetime and practised 60 years.

Some years before he died he wrote a very interesting paper to be read at a meeting of the Medical Society of Nova Scotia at Yarmouth, where his son was President on his 60 years of practice in Queens County.

He was survived by three sons—two of whom G. W. T. Farish and J. C. Farish took up the medical profession. The former still holds sway at Yarmouth and the latter has for the past 15 years been located at Vancouver, B. C., as a Specialist in Eye, Ear, Nose and Throat. At the present time the name of Farish has been continuous in Yarmouth since 1802. 127 years is a record hard to beat.

G. W. T. F.

It's a Trick. Excerpt from the Fantus "Technic of Medication", page 118. "Just before use, cachets are dipped in a tablespoonful of water; and, when the entire surface has been thoroughly moistened and softened, which takes only a few moments, the spoon is placed far back on the tongue, and the whole swallowed at one gulp."

Farmer: "Doc, I am working like an ox, eat like a wolf, am tired like a dog, and sleep like a bear."

Doctor: "In such a case you would better consult a veterinarian."

OBITUARY

MURDOCH CHISHOLM, M.D., C.M., McGill 1879, L.R.C.P.,
London 1886, LL.D., Halifax, N. S.

BORN at Loch Lomond, C. B., in 1848, Dr. Murdoch Chisholm of Halifax, full of years and honors, passed away December 29th, 1929, at the Victoria General Hospital following an operation from which he failed to rally.

From Cape Breton came many men who had to work their way through college and a surprising number became eminent in their chosen professions. Perhaps that struggle for a number of years and the necessity for hard work and rigid economy helped materially to develop those attributes that make for the sterling character of so many men in Nova Scotia of a generation that seems to be passing.

So much has been written recently about Doctor Chisholm as to his Jubilee, his honors by the Halifax Medical Society and the Canadian Medical Association that it almost seems like repetition to give any extended obituary at this time. It will always be a matter of congratulation that these honors came to him while he still was able to thoroughly appreciate them. Too often we delay in these things until it is too late. If we have kind things to say or do, let it be now while those we would honor are with us.

Indeed the tribute of Dr. G. H. Murphy is most appropriate right here when he said:

"And so we pass. What a great pleasure it must be for those who planned for this notable jubilee to note how it pleased and cheered him, and was not left until too late.

"For one who has Highland blood, as his was, it would almost seem that the last word should be the mournful lament of MacCrimmon, 'Cha till sin tuille,' (I shall not return). But for those who remember his indomitable courage and cheerfulness, we would rather hear him say, 'say not good night, but in a better world bid me good morning'."

Nor can we do better than quote the tribute paid to his memory by Dr. John Stewart, himself loved and revered.

"Few obituary notices in the morning papers will cause more sorrow and emotion than the unexpected news of the passing of Dr. Murdock Chisholm. Some of us did not even know he was seriously ill.

"Barely more than two months have passed since the Halifax Medical Society inaugurated its winter session by a complimentary dinner to Dr. Chisholm to celebrate the jubilee of his graduation. It is just fifty years since this young man, a native of Loch Lomond, one of the most beautiful districts in Cape Breton, completed his medical studies at McGill University and graduated M.D., C.M. in 1879. He had begun his studies in Halifax but completed them in Montreal. After practicing a few years in Newfoundland, he proceeded to London, where he obtained the diploma of the Royal College of Physicians. Soon after he settled at Halifax, where he soon became

one of the leading doctors. The venerable Hon. Dr. Parker, the Nestor of the medical profession in Nova Scotia, had lately retired, and with the exception of the late Dr. D. A. Campbell, Dr. Chisholm was soon regarded as the leading physician in the city specially skilled in affections of the heart and lungs.

"He was a man of wide reading and very varied information and always took an interest in public questions. No greater proof of his extraordinary versatility could be furnished than the fact that when, owing to the ill health and retirement of the late Dr. J. F. Black, a vacancy was caused in the surgical staff of the hospital, Dr. Chisholm was able to step into the breach and soon gained a high position as a surgeon, as well as physician. His power of diagnosis and his operative skill were remarkable, and he achieved success in many of the most serious operations of surgery. He displayed not only distinction as an operator, but he shone as clinical instructor and ample testimony to this was given by several speakers at the jubilee dinner by many of his former students."

Dr. Chisholm is survived by his wife, formerly Miss Clayton of Halifax, three sons, two resident in Halifax and Dr. A. R. Chisholm of Vancouver, and two daughters Miss Mary at home and Mrs. Clifford L. Baker of Kentville. To these bereaved ones every member of the Medical Profession in Nova Scotia, and many others elsewhere will extend deepest sympathy.

Dr. T. A. Lebbetter of Yarmouth writes the Bulletin as follows—

DR. MURDOCK CHISHOLM.

Surgeon and Gentleman.

He was a quiet, comely man of many parts. He was courteous and never unkind. He dwelt among men, and walked in shadowy places with a firm step. Human, but never hasty: the common things of the earth he loved because he was a man of the people. A son of the soil that never lost the common touch. Simple in his tastes, steadfast in his friendship. A lover of good books and homely deeds. Though he walked on Olympus he never lost his foothold on the path that led up the mountain, or failed to remember those who laboured below.

In the hey-day of youth he toiled without the thought of glory or of gain: In the glow of middle life he always had a helping hand for Brothers sorely pressed: In the fullness of old age he was never vindictive nor cynical. A dreamer with more than a day-dream vision. A toiler in the night who loved his fellow men.

And as he lived, so he died. Honors he received timely and bore these with modesty and great charm. And as he died—those whom he loved remembered the great teacher, the staunch friend, the stalwart citizen, the simply, kindly man who loved his fellow man.

He was an honor to a most honorable profession. His name and his fame will not soon be forgotten, and students still to come will hear of his work and his worth with pride. And the work he did will live long after his name is forgotten. What more is there to say?

S. L. W.

**SIFFROI HENRY THIBAUT, M.D., C.M., Dalhousie, 1911,
Little Brook, Digby County, Nova Scotia.**

Following a lingering illness of more than a year Dr. S. H. Thibault passed away at his home in Little Brook, Digby County, N. S. December 27th, 1929. He was but 47 years and 6 months old.

Vitamin A Therapy

Ayerst

Capsule No. 290

ALPHAMIN

each containing 5,000 vitamin A units now available where comparatively large dosage of vitamin A is desirable as a

Stimulant to Cellular Activity and Metabolism

Mellanby and Green (British Medical Journal, June 1st, 1929) describe five cases of puerperal septicaemia, treated with Vitamin A in a concentrated form, making the following observation,—“All made complete recoveries, thus indicating that Vitamin A, when given therapeutically, can raise the resistance of the human body against septic and infective micro-organisms.”

Van Leersum (Journal of Biological Chemistry, January, 1928) found a general keratinization of the mucous membrane throughout the body of experimental animals suffering from Vitamin A deficiency. This condition was evidenced by kidney and bladder calculi in most cases and by renal abscesses in some.

Alphamin capsules are indicated in the prevention and treatment of puerperal septicaemia, in acute rheumatoid arthritis, as a prophylactic for colds, infection of nasal mucosa and accessory sinuses, and in other conditions where the general resistance may be low.

Available in dispensing packages each containing 100 capsules.

Further information on request

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Limited

Pharmaceutical Chemists

MONTREAL - 781 WILLIAM STREET - CANADA

He was a graduate in Arts of St. Ann's College, Church Point and of Dalhousie Medical College in 1911. He had been in practice in his native district for some nineteen years. His wife formerly Mary Lombard of Deep Brook and seven young children survive him. A very large funeral was held from his residence to the Parish Church in which many priests took part. To Mrs. Thibault and family the BULLETIN desires to extend sincere sympathy.

We regret to learn that Dr. D. F. McInnis of Shubenacadie was called to Middle River, C. B., in December last owing to the death of his father. The doctor has our sincere sympathy.

There passed away recently a most estimable lady aged 82 years in the person of the widow of the late Dr. John Forrest, so long associated with Dalhousie University. By a former generation of Dalhousie students she was greatly loved and revered. Dr. W. D. Forrest of Halifax has our sincere sympathy in this passing of his beloved mother

The death occurred recently of Captain W. F. Gilchrist at his home in Medicine Hat. He was a native of Moser River, Halifax County and was 82 years of age. He retired from the sea some twenty years ago. He is survived by his widow, four sons and two daughters, the latter being Mrs. Hugh Dickson, M.D., of Truro and Miss Marion, R.N., of Medicine Hat.

The effect of Alcohol on the Mucous Membrane of the Stomach.

Professor Guillaïn, of the University of Paris, says, truly, that more people kill themselves with cocktails than with pistols, shotguns, knives, gas and poison.

That France and Britain should have copied our worst form of alcoholic poison, says little for their intelligence, but in both countries, only the worthless froth of the population drinks the mucous-membrane and kidney destroyers.

Dip your handkerchief in a cocktail, apply it to your eyeball, and you will know what a cocktail does to the lining of your insides.

If French and British cocktails shorten life, made with real spirits, ask yourself what bootleg liquor must do to the American interior. All of which only reminds us of an incident we cannot print in the BULLETIN, but will pass to any inquiring reader.

THE man or woman who plunges into thoughtless spending, making no provision for the future, faces financial shipwreck on the relentless reefs of debt.

Men in debt no longer control their time or their careers. Others control them. Freedom from debt lies in a definite savings plan.

Ask for our folder "A New Horizon." It will show you an easy way of saving \$1,000

The Royal Bank of Canada

S902

VITA GLASS

TRADE MARK

BRINGS WHOLE SUNLIGHT INDOORS

It is generally agreed that the stimulative power of sunlight during the summer months is responsible for the comparative immunity of the general population to epidemic ailments during the early part of winter. After a "bad" summer the incidence of infectious disease rises sooner and maintains a high level until the Spring.

This in itself is a clear indication of the need for more sunlight in the lives of the people as a whole, but while the majority live and work behind ordinary glass windows which do not admit the essential ultra-violet rays, there can be little hope of any great improvement in the standard of public health.

Write for authoritative data and the story of VITA Glass.

PILKINGTON BROTHERS (CANADA) LIMITED

264 Upper Water St., HALIFAX, N. S.

Local and Personals

WE note that a more or less of a Christmas festival in Mulgrave a debate, was conducted by the boys and girls. The topic was,—“Resolved that the old fashioned girl was better in social and business life, in sports and in the house, than the modern girl.” At this function, Dr. J. S. Brean introduced the various speakers, and, of course, the negative side won the debate.

Miss Margaret MacLean, R.N., of New York spent her Christmas vacation with her parents, Doctor and Mrs. J. W. MacLean of North Sydney.

Dr. W. A. McLeod of Hopewell was recently elected President of the East Pictou Liberal-Conservative Association.

Dr. and Mrs. W. H. Robbins of New Glasgow spent their Christmas in Moncton with Mrs. Robbin's sister, Mrs. Hayward. Mrs. Robbins visited also in Wolfville before returning home, but the Doctor at once went back to his practice.

The General Secretary is pleased to acknowledge Christmas greetings to the Medical Society of Nova Scotia from the Medical Society of Dalhousie. This is the card and shows excellent taste. The personal signature must be one of the family of Dr. B. S. Bishop of Kentville, all of whom we believe, are studying medicine:—

CHRISTMAS GREETINGS
AND BEST WISHES
FOR THE NEW YEAR
HALIFAX, 1929

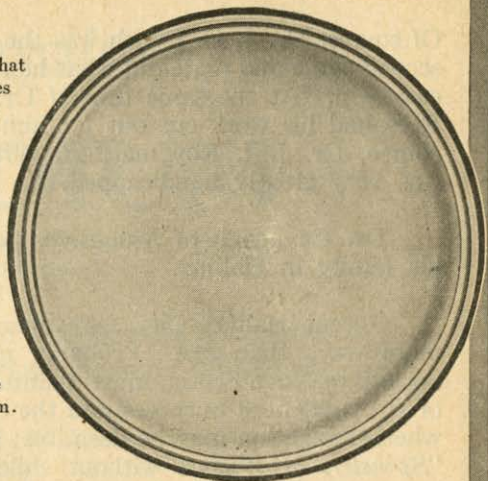
R. F. BISHOP,
Med- '33.

The BULLETIN very gratefully acknowledges Christmas greetings from the Vi-Tone Company of Hamilton, Ontario.

Curling. We have intimated that in the BULLETIN we will continue to refer to personal items regarding Curling. One reason for this is the apparent fad of the medical profession generally for golf. Many of our readers will realize that this item applies to them. We looked over the list of Sydney curlers, scheduled to take part in the usual President versus Vice-President—match and we noted:—

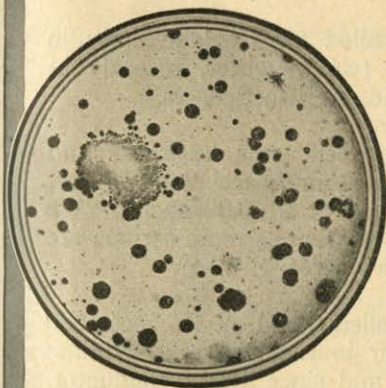
Dr. D. A. McLeod was lead in the rink skipped by Mr. R. J. McLean. If he put both stones between the middle and outside rings we believe he will be the most valuable member of the rink.

Every day that Dextri-Maltose is manufactured, control samples for bacteriological analyses are secured from certain points in the process which experience has shown give an accurate picture of the bacteriological condition of the product in the different steps of its manufacture. As a result of experiment and experience, it has been demonstrated that by exercising certain strict sanitary control measures and precautions, the bacteria count can be reduced to the point where the finished product approaches practical sterility. The Petri-dish at right shows a plate count of only 40 bacteria per gram, obtained from a package of Dextri-Maltose selected at random.



THE REALITY OF THE UNSEEN

The things unseen determine the cleanliness, uniformity and safety of Dextri-Maltose. From years of study and experience, we know how to produce the bacteriologically clean product indicated above.



On the other hand, the Petri-dish at the left visualizes the potential danger that may accompany lack of experience. At 37° C. this sample (bought in the open market) showed a bacteria count of 420,000 per gram (compared with 40 per gram in Dextri-Maltose, as mentioned above). Every physician is deeply concerned about the pasteurization, certification, etc., of the cow's milk his babies are fed on, but even sterile milk would give the infant *over seventeen million* bacteria per daily feeding when "modified" with a carbohydrate such as is represented by the Petri-dish at the left.

Of course, Dr. J. G. Lynch was the skip in one rink and, if his lead, second-stone and mate did what he told them to do, he would have an easy win. At the same time if Dr. D. A., did his duty Dr. H. R. Ross had his work cut out for him to skip his rink to victory. Of course, Dr. J. J. Roy mating against a rink skipped by a Minister was very greatly handicapped.

Dr. Cavanagh of Mulgrave spent the Christmas holidays with his family in Halifax.

Recent Halifax City Assessment forms are wonderful things in more ways than one. Probably many societies, like the Medical Society of Nova Scotia, must maintain an office for either (a) business or (b) residential purposes and the question may well be raised as to whether taxation may be desirable; but, when this notice states that, "*Spinsters or Widows* without children under fifteen years of age" are entitled to a certain rebate, it would appear to be not quite in good form.

Are there divorces in Heaven? Oh, no, You can't get divorces without lawyers!

Small Boy to Father. "You say you've been making New Year's Resolutions for years and years and years. Well, I jest thought I wouldn't start in at all."

A convenient desk calendar has been received from the Homewood Sanitarium for which the BULLETIN expresses thanks.

We have also received a similar calendar from the Nova Scotia Nursery. We believe our advertisers appreciate our service when they send these kindly recognitions.

Mrs. Philip Weatherbe of Halifax sailed for England early in January. She was accompanied by her two daughter, recently at Edgehill, Windsor, N. S., who will attend English Schools.

"Well some radios are like rows between some husbands and wives,—Words over nothing." "Yes, I believe in 'Peace' at any price, only my lectures on the subject are priced at \$100.00 each." "We always did have scraps with our wives, but what is more serious are the occasions when she is right and we can't agree with her."

A great many medical men have travelled the D. A. R. since 1880 and most of them met in the course of their journeyings one, William Herbert, a brakesman, baggage master and since 1893, conductor. On the last day of 1929 he completed 48 years of service and we trust

in cystitis and pyelitis

TRADE **PYRIDIDIUM** MARK

Phenyl-azo-alpha-alpha-diamino-pyridine hydrochloride
(Manufactured by The Pyridium Corp.)

*For oral administration in the specific treatment
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I. S. FREEMAN, MISS AUDREY MOREN

Registered Druggists

he has pension and income enough to live comfortably the remaining years of his life which we hope will be as many as he can enjoy.

Finance is Right. A Provincial newspaper says: "A Kansas man confesses to having killed the brother of his *finance*, because he insisted upon repayment of \$40.00 the killer had borrowed from him."

Besides having a considerable medical and surgical practice Dr. O. B. Keddy also finds time to be Mayor of the Town of Windsor. If he has any more leisure after this we think he spends it in the Curling Rink where he generally skips a very successful game. Query!—Where are the other Windsor Doctors in these local matches?

Let us Speak Out. Is it not time that an advertisement such as appeared recently in the *Liverpool Advance*, should be a thing of the past. The call is for *tenders* for attendance at the County Home and reads thus.

TENDERS.

For Medical Services at the County Home.

Tenders will be received by the undersigned up to and including Tuesday, January 7th, 1930 for providing medical attention and medicines, and tooth extraction for the inmates at the County Home, Middlefield, for the year ending December 31st, 1930.

The lowest or any tender not necessarily accepted.

E. D. FORD.

Isn't it rotten? Let us get this upon a proper and ethical basis *at once*.

The successful fairly young candidate for political honors in Nova Scotia a year or two ago suggested to two of his oldest constituents, who had never visited Halifax or travelled much by automobile, that they would be his guests for a day or two and come to Halifax in his car the next day. One objected on account of prostatic trouble which would require frequent stops. However, finally both old men accepted the invitation. Strange to say on the trip, coming and going the car only stopped four times, and only the young politician got out.

No less than three doctors were applicants for the position of jail physician for Colchester County. That one was elected over the others was to be expected, but was it worth while?

Dr. Dan MacDonald and Mrs. MacDonald of North Sydney recently returned from a three weeks' visit to Toronto.

He—"Every time I kiss you it makes me a better man."

She—"Well, you needn't try to get to Heaven in one night."