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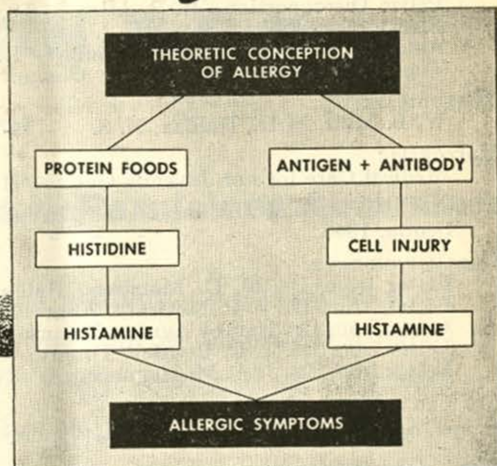

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Pelvic Disproportion

H. B. Atlee

Because we are the children of textbooks and our wisdom concerning the bony pelvis is built on the more horrendous illustrations in such, we continue to think of disproportion as something gross enough to hit one in the eye. That this is not the case is proved by the fact that the most of our Caesarian sections are done on women in whom either (1) disproportion was not suspected, or (2) where suspected it was felt to be slight enough to justify a trial of labor. Only occasionally these days does one meet with a case where from the beginning one is certain that a living baby will not be born per vaginam.

Such being the case it is essential that all the easy clues to disproportion be taken into account from the beginning, to the end that labor will be conducted in such a way that an eventual Caesarian section may not become outrageously dangerous, and a craniotomy offer the only real safety to the mother.

Since inlet disproportion is by far the commonest type—outlet disproportion being comparatively rare—I propose to deal only with the former in this discussion. And since the problem arises pre-eminently in a primipara, I shall deal only with inlet disproportion in a primipara.

I have stated that all the 'easy' clues should be taken into consideration. What I mean by 'easy' clues are signs that anyone doing obstetrics ought to be able to spot. I shall later mention some of the more difficult clues, but I am primarily interested here in simplifying the picture in the hope of cutting down the incidence that most dangerous of obstetrical operations, high forceps.

What are the 'easy' clues to pelvic disproportion?

1. The head is high or floating.
2. It is in an O.A. or O.T. position.
3. On vaginal examination with two fingers in the vagina you can feel the promontory of the sacrum. While ability to feel the promontory in the presence of clues 1 and 2 strongly suggests disproportion, inability to feel it does not mean than disproportion is not present. If your fingers are average length you may not be able to feel the promontory and still have disproportion.
4. If the diagnoal conjugate measures 9 cm. or less the patient should not be allowed to go into labor.

Everyone doing obstetrics ought to be able to determine whether or not these clues are present. If there is any doubt as to the position of the head—that is whether it is an O.A. or an O.P.—lateral and frontal x-ray pictures should be taken to ascertain it. This is most important since the head in the O.P. position tends to remain high before the onset of labor and during labor until rotation into the O.T. has occurred. It is held by some of our obstetrical leaders that position should be diagnosable by palpation alone, and recourse to the x-ray for aid is regarded somewhat contemptuously. I remember when the same attitude was adopted towards stone in the kidney. Granted that one should attempt first to make the diagnosis by palpation and the position of the fetal heart, granted that in most cases this will be enough, I feel very

strongly that if one is faced with a high or floating head at the onset of labor one should make certain of the position even if it requires the help of the x-ray. The German Army got to the Channel ports because it did not hesitate to make full use of the machine. In obstetrics, as in war, one should make every possible use of science—otherwise the evacuations from the pelvic canal will remain as tragic as that from Dunkirk.

Very well, one has picked up these clues. One has the first two certainly—and perhaps the third. What shall one do?

1. Regard this as a case of pelvic disproportion until it can be proved that it is not.
2. If the patient is not already in hospital, take her there.
3. Hold a consultation—two lives are at stake.

The value of a consultation at this point lies in the capacity of the consultant to bring to bear on this case the more difficult clues. Through their use he may be able to state definitely that the patient has absolute disproportion and should not be allowed to go into labor.

But supposing you are one of those complacent gentlemen who do not believe that two heads are better than one. Perhaps you dislike the whole tribe of obstetrical consultants. In that case I suggest the following rules.

1. If the patient is not in labor do not let her go over her due date, but don't under any circumstances induce labor by rupturing the membranes.
2. In allowing her to go into labor do so only on the understanding that this shall be a test of labor.

What is a test of labor? Different men define it differently, but to me it means that the patient has been having strong pains and that the cervix is fully or almost fully dilated. If at the end of such a test the head has advanced, and is continuing to advance, labor can be allowed to proceed in the reasonable hope of delivery per vaginam. If, on the contrary, there has been no advance, the head has not really entered the pelvis, then the most important decision must be made—shall you persist or shall you do a Caesarian section? Here again, consultation should be undertaken. This is a very crucial point, since at this stage Caesarian section may be relatively safe, while every hour that it is delayed it becomes less safe.

In the meantime, however, certain strict rules should have been obeyed.

1. Keep the patient in bed on her side and don't let her bear down. This will delay rupture of the membranes, and the longer you can delay that the better.
2. Do only rectal examinations.
3. Don't let the patient become exhausted for need of sedatives and nourishment.
4. Keep her reassured—which generally means keeping the relatives out of the room.

The above rules have as their object the doing of nothing that will militate against the success of a possible Caesarian section—in short, you guard against infecting the genital tract, and keep the patient's strength up.

Well, you have carried out the test of labor—the cervix is about fully dilated and the head has not come into the pelvis properly. You feel you must now decide whether to let labor continue or do a Caesarian section. I have

suggested the calling of a consultant before this grave decision is made. At both maternity hospitals in Halifax we have made rules that neither Caesarian section nor high forceps be undertaken without a consultation. At the Grace we insist on this even within our closed staff—and have never had cause to regret it. Once again it must be insisted that two lives are at stake—and that *a difficult high forceps may be a most serious undertaking to both mother and child.*

Let me illustrate how serious an undertaking it may be with the following case. A young primipara was admitted to the Grace Maternity Hospital with the following history. When she had been in labor for 12 hours with strong pains the head was still high and floating and in an O.A. position. The cervix was two-thirds dilated. Forceps were applied, but delivery could not be effected. The patient was now given morphia. The following morning, with dilatation about complete the head was still high and had made no progress into the inlet. Forceps were again applied—and failed. She was then brought to the Grace Hospital with a temperature of 101 and a pulse close to 100. There was some edema of the vulva.

We were faced with the following situation.

1. The head was still high and mobile. It bulged so far over the symphysis that delivery per vaginam was unlikely. The fetal pulse was very rapid and meconium was being passed.
2. The genital tract was undoubtedly infected and the cervix quite badly damaged as a result of the forceps applications.
3. The patient's general condition was deteriorating.

A consultation of the entire closed staff was held. We felt that a Caesarian section here would be a most dangerous operation, carrying the practical certainty of a serious puerperal infection. It was decided that the patient should be delivered per vaginam, and to that end forceps were applied again. A reasonable pull showed that the barrier was absolute and that to persist would certainly mean a dead child and grave damage to the mother's genital tract. Very regretfully a destructive operation was performed. Even at that, the mother's condition became so grave that a blood transfusion had to be given. This tragedy could unquestionably have been averted had the 'easy' clues present at the onset been spotted and the patient brought immediately to hospital. It could still have been averted had forceps not been applied either at the end of 12 or again at 24 hours after the onset of labor, and the patient then brought into hospital for consultation.

Supposing this case had been treated from the beginning as a potential disproportion, and given a full test of labor. The head is still high, and there has been little if any progress. I believe it would be a safer policy to do a Caesarian section without further delay than to attempt high forceps, or to allow labor to proceed until both mother and child show signs of exhaustion.

But what further investigation might be carried out? We come now to the 'difficult' clues, and I call them 'difficult' because they require a considerable experience to evaluate them fully.

1. Bulging of the head over the symphysis. This sounds like an easy clue, but it is not always so. If, after a test of labor, there is still considerable bulging, the head is not likely to come through. If the bulging is only slight further moulding may allow it to pass.
2. A bimanual vaginal examination after the Munro-Kerr technique will enable one to estimate whether the head is firmly held, or whether

it is pushable into the inlet. It also gives one further information on clue 1. With two fingers against the head in the vagina, and someone pushing down on the fundus, the free hand grasps the head through the abdominal wall and attempts to push it into the pelvis. If it comes hard up against the inlet immediately and sticks there—and there is considerable overlapping above the symphysis—delivery is unlikely per vaginam. If it can be pushed on a little distance and there is not much overlapping, labor can be allowed to continue.

3. An X-ray examination. It is unfortunate that, even in the best hands, X-ray examination is not a sure determinant of the presence or absence of disproportion. Even such complicated methods of measuration as the Ball technique can err considerably. It is therefore only occasionally that the X-ray is of definite value. But it will reveal the presence of a flat or android pelvis, both of which types tend to produce difficulty in labor, and if with the clues above adverse such a type of pelvis is discovered, one would be swayed towards a Caesarian section.

But the above three clues are, as I have said, "difficult". Even when evaluated by experts there is a considerable margin of error. I believe, therefore, that it would be safer to leave them to the expert and stick to the "easy" ones. *So, I repeat again, in the absence of an expert it is better to do a Caesarian section when, after a trial of labor, the head is still high, than to endanger the safety of such an operation by first trying high forceps. It is better to be guided entirely by the 'easy' clues than to attempt the 'difficult' ones in the evaluation of which one has not confidence in one's ability. Some unnecessary Caesarian sections will be done but fewer badly damaged mothers will result, and fewer dead babies be born.*

Early Rupture of the Membranes:

It is an unfortunate fact that the membranes tend to rupture early in just this type of case. It is unfortunate for the reason that the longer a Caesarian section is delayed after rupture of the membranes the more dangerous an operation it becomes. I might have placed early rupture of the membranes among the 'easy' clues to disproportion because of the frequency with which it either ushers in or early follows the onset of labor in pelvic disproportion. I have kept it for this place because of the special attention it merits.

When it complicates the situation one's hand is forced in the direction of Caesarian section much earlier than otherwise would be the case. It is not safe to allow the test of labor to proceed longer than 12 hours in the presence of good pains when it has occurred. The danger, of course, is infection—and this is more likely to occur when the patient is kept at home, and when frequent vaginal examinations are done. In hospital, where only rectal examinations are made, and the vulva can be kept relatively clean, one may take chances, but the 12 hour rule still remains the safest one.

Pelvic Disproportion With Posterior Positions:

An O.P. position of the head unquestionably complicates the diagnosis of pelvic disproportion—and unhappily O.P. positions are common with disproportion. The following factors befog the issue:

1. The O.P. head does not fit the inlet well and will not come into it properly until it has rotated into the transverse. As a result the head will tend to remain high until rotation has occurred.

2. The head may persist in the O.P. position, so that even at the end of the test of labor it may have made little or no progress.
3. Though this head may come through when rotation has occurred, its persistence as an O.P. in cases where the pelvis is a fairly close fit, actually constitute disproportion, and delivery will be impossible until it has been rotated.
4. The forehead may bulge over the symphysis, suggesting disproportion.

An O.P. position of the head is likely to cause difficulty in diagnosis only in those cases where the head is a relatively close fit to the pelvis. Where the pelvis is relatively ample the head will not be high at the onset of labor, and certainly after a test of labor it will be fairly well down the canal.

We can therefore, from this standpoint, divide our O.P.'s into three groups.

1. Those with ample pelves where there is no question of disproportion.
2. Those where the fit of pelvis to head is relatively close and the situation may simulate disproportion.
3. Those where with an O.P. there actually is disproportion.

We are interested here only with the last two groups, and we are interested in group 2. only when the head is arrested at the inlet. How does one determine whether or not there is real disproportion when faced with a high posterior? I find this one of the most difficult of all diagnoses to make, and from what I have read in the literature and observed in maternity hospitals, others find it no different.

The important thing, of course, is to be sure that it is an O.P.—and here the X-ray picture (lateral) is invaluable if there is any doubt. The woman is given a test of labor. The head is still high—and still posterior—the cervix is fully dilated. What shall one do in this dilemma?

If I cannot feel the promontory, and if by the Munro-Kerr manoeuvre I am able to push the head along slightly, I allow the test of labor to proceed. If I can feel the promontory, and if the head is absolutely fixed, I decide on a Caesarian section. If I have allowed labor to proceed I take the following precautions.

1. I give the patient rest through sedatives.
2. Keep up her nourishment—if not by mouth with 10% glucose intravenously.
3. Watch the progress with the occasional rectal. If the head shows signs of advancing I sit tight until the cervix has been fully dilated for at least two hours and sometimes longer. If the head has ceased to advance I would not wait more than two hours.

But finally, I reach a place where I realize that something has to be done. There has been no advance for some time and the cervix is fully dilated. If the membranes have not ruptured I now rupture them and get the patient to bear down for a while. If, after half an hour of this, there is no advance I realize that labor will not complete itself unaided.

But the head is still fairly high: I am still in doubt of delivery per vaginam. The time has arrived to give the patient an examination under anesthetic. Before doing this it is good policy to have everything ready for the two alternatives—forceps or Caesarian section. Under the anesthetic I attempt the Munro-Kerr monoeuvre again. I note the amount of bulging over the

symphysis. If these are against me I go on to Caesarian section. If they favor me I decide to deliver by forceps.

A word about the type of forceps delivery. This head is relatively high. It's most advanced part is well above the ischial spines. To put forceps on in a pelvic application and pull the baby out face to pubis is an absolutely unjustifiable and dangerous operation—both to mother and baby. *For as long as this head remains O.P. it is too big to come through this pelvis, and to so drag it by main force is to invite great damage to the maternal structures and intracranial hemorrhage in the baby.*

There may be something to be said for a face to pubis delivery where delay has occurred on the pelvic floor, but where it has occurred above that point the only safe vaginal method of delivery to both mother and child is by means of some forceps method that turns the head from O.P. to O.A.—the key-in-lock or Melhado.

It will be noted that I have given very little attention to pelvic measurements apart from the diagonal conjugate. In so far as inlet disproportion is concerned, I am convinced that the diagonal conjugate is the only valuable measurement, and it is only of definite value when it is less than 8.5 or 9 cm. When it is that small I feel that the baby should have the benefit of a Caesarian section. But when it is larger than that it tells me nothing. You may have disproportion with a promontory you cannot feel: you may not have disproportion with a promontory you can feel. Such measurements as the external conjugate, the interspinous and intercristal carry such a variability as to the size of the inlet that I long ago gave them up. I ran into too many cases where there was pelvic disproportion in the presence of normal or better than normal external measurements.

And why should such measurements be of value when the fetal head is so variable in its size? What I want to know is will this baby go through this pelvis and you may measure the pelvis with the skill of angels and not be able to answer that question. What value is the diameter of the bottle-neck is you have no idea of the size of the cork? I believe it is safer to do no other measurements than the internal conjugate, and to relie on the clues that I have indicated above, than, finding measurements normal, to take no thought of disproportion. So often have I heard men say when a Caesarian section had to be done on one of their cases: "But her measurements were normal!"

Nor, having tried them, have I any faith in methods of estimating the size of the baby. There are too many variables—the thickness of the abdominal walls, the thickness of the uterus, the fact that in babies, as in adults, the size of the head is not always proportionate to the length of the baby. To base a prognosis of labor on such variables is to ask for trouble.

I would like to make a plea for the baby. We still have a tragically high intra—and neo-natal death rate. We should no longer be satisfied with the conduct of an obstetrical case that does not produce a live undamaged baby. When the average woman had more babies than she does to-day we could afford to be careless with infant mortality rates, but in these days when the average woman only gets pregnant two or three times in her life, such carelessness spells race suicide. I am not advocating that we should risk the mother's life for the baby's, but I am certain that the doing of an occasional unnecessary Caesarian section under the conditions laid down above is better even for the mother than the risk and damage of injudicious high forceps.

But when I say Caesarian section I do not mean the classical operation. No self-respecting obstetrician should any longer do the classical Caesarian, which should be relegated to that same limbo to which we have sent the snipping of tonsils with a tonsillotome. When I refer to Caesarian section I mean the low-flap operation, which not only carries a much lower mortality rate, but leaves a safer wound in the uterus.

But to return to my primary thesis: I believe the average practitioner of obstetrics would do best to simplify the criteria on which he will decide that he is dealing with disproportion. He will make this decision when, with the head high or floating at the onset of labor in a primipara, he is either able or unable to feel the promontory. If he allows such a case to go into labor he will regard the labor only as a test. In the course of this test he will do nothing to militate against a possible Caesarian section. He will handle such a case in hospital. He will hold a consultation not later than at the end of a test of labor which has failed. He will never under any circumstances apply high forceps, or do a classical Caesarian section. I am convinced that a strict adherence to the above rules would greatly improve our live birth rate, and cut damage to the birth canal to a minimum.

*Electro-Encephalography

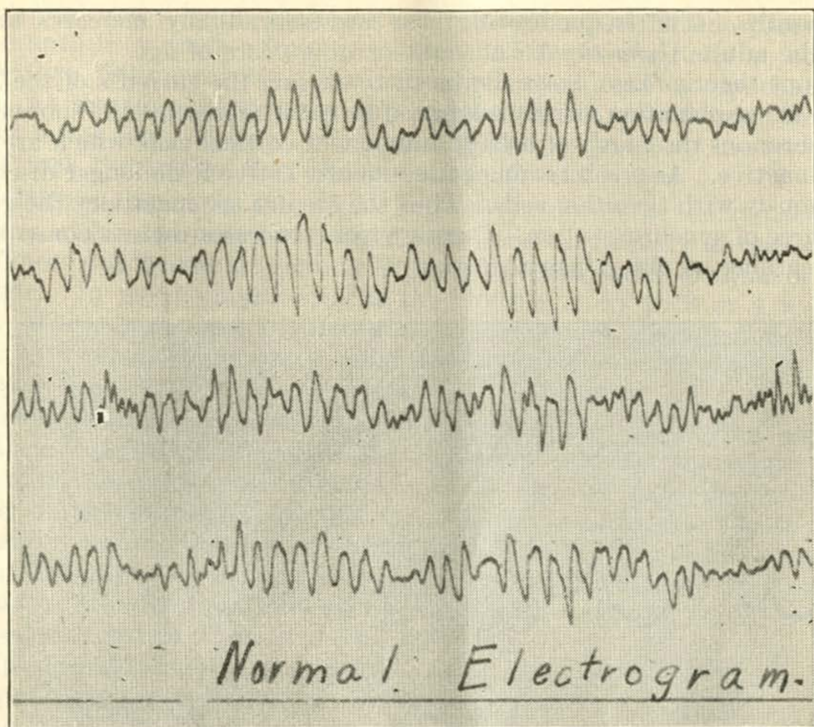
W. J. J. DYER, M.D., Halifax, N. S.

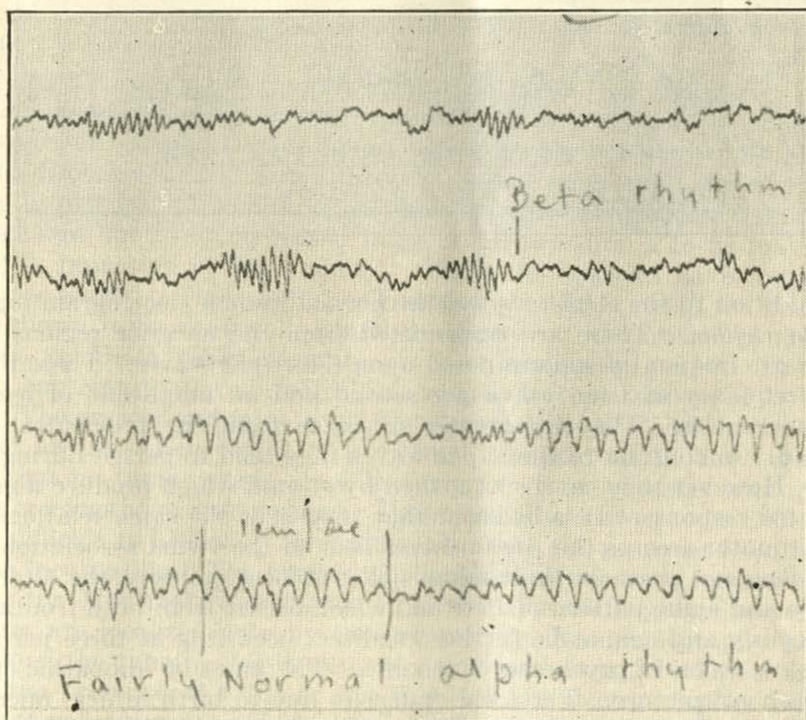
AS long ago as 1875 Caton describes some experiments in which he recorded electric currents directly from the exposed cortex of animals by means of a crude galvanometer. In the following fifty years articles occasionally appeared which were concerned with the electrical phenomena of the brain elicited in response to the stimulation of the afferent nerves. In 1929 Berger first demonstrated the possibility of recording brain waves in man through the unopened skull, but it has only been in the last five years since the work was standardized by Jasper, now head of this department at the Montreal Neurological Institute, that its tremendous practical importance has been realized in neurological and neurosurgical investigation. It must be remembered that like the electrocardiograph, it is purely a laboratory test.

I shall avoid going into detail regarding the mechanism and stress the great clinical importance of this test. In brief the electrical activity emitted by the cerebral cortex is transmitted to electrodes placed at definite sites on the scalp, 6 cms. apart, which carry the impulse to a set of amplifiers somewhat similar to a group of radios. The amplifiers increase the magnitude of these impulses which are of minute strength, 20-150 microvolts, by about a million times, conveying them to an ink-writing system which produces the permanent record. The tracing is called the electro-encephalograph or electrogram. It is possible with the set-up at the Montreal Neurological Institute to record from four different cortical areas simultaneously. This test can also be performed in the operating room following trepanation when the electrodes are placed directly on the cortex. When the ordinary test is being done the patient is placed in the reclining position in a darkened sound-proof room with a nurse in attendance. The technician works in an adjoining room connected by a speech system whereby directions can be given to the nurse by means of ear-phones.

The most characteristic feature of the normal human electrogram is a uniform rhythm of waves known as the *Alpha rhythm.* The *Alpha rhythm* exhibits a frequency of from eight to thirteen per second averaging approximately ten per second. Although the frequency varies from individual to individual it is remarkably uniform and constant for a given individual over a period of years. It has been claimed that the electrogram is as characteristic for each individual as his finger-prints. The focus from which the *Alpha rhythm* arises is usually in the visual areas of the occipital lobes. The size of the focus varies but it is rarely located outside the limits of the occipital lobes. The foci in the two cerebral hemispheres are nearly always symmetrical, their rhythms being in phase with one another. This relationship persists during spontaneous and induced alterations of the discharges. This *Alpha rhythm* can be readily inhibited by visual activity on the part of the subject. It is for this reason that electrograms are usually taken while the subjects eyes are closed. At birth this *Alpha rhythm* is not present. A very slow rhythm of a frequency of from four to five per second makes its appearance at the age of from three

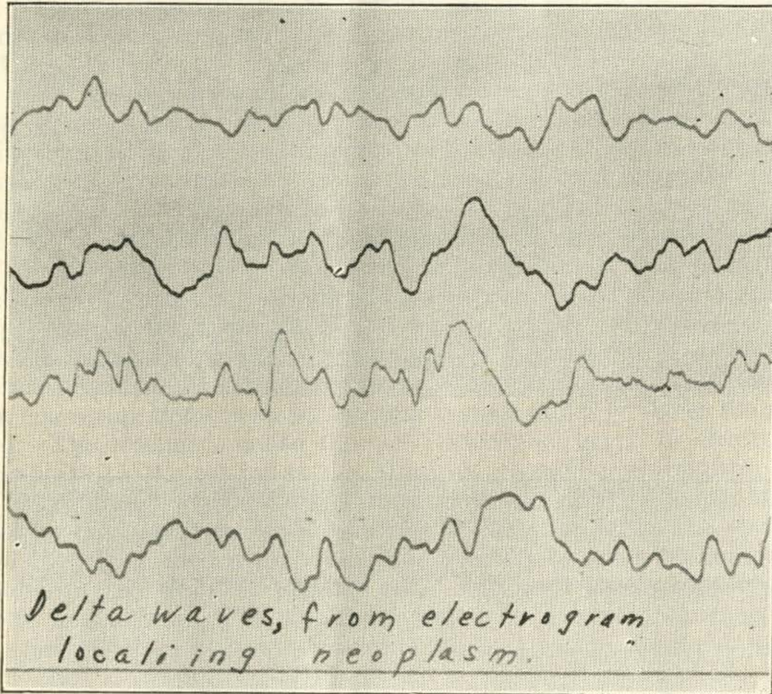
*Read before the Halifax Medical Society, February 7th, 1940.


Normal Electrogram.


Beta rhythm
Fairly Normal alpha rhythm

to six months. The frequency of these waves gradually increases until it reaches the adult *Alpha rhythm* at eight or nine years of age.

Various theories have been advanced to explain the currents of the *Alpha rhythm.* The explanation usually advanced is that it represents the spontaneous and synchronous discharge of a large number of cortical cells which are functionally inactive. As a cell becomes functionally active it no longer discharges synchronously with the other cells. Thus the greater the inactivity the greater is the degree of synchronization. During visual processes there is consequently a disappearance of the *Alpha rhythm.*


Delta waves, from electrogram localizing neoplasm.

In addition to the *Alpha rhythm* the normal human electrogram may also show *Beta rhythm.* These are transmitted from the anterior regions of the brain and are frequently superimposed upon the *Alpha* waves. These have an average frequency of twenty-five per second and an amplitude of less than twenty microvolts. They apparently originate from the pre-central region of the head. In contrast to the *Alpha* waves they tend to persist during visual activity. However they can be abolished by stimuli which produce a generalized startled response. It is believed that they bear the same relationship to the sensorimotor area as the *Alpha* waves bear to the visual association areas.

The abnormal waves are the random spikes of focal epilepsy, the alternating slow wave and spike pattern of Petitmal which occurs from both frontal areas simultaneously and cannot be further localized, occurring at three per second and the slow waves of psychomotor seizures. The cases of idiopathic epilspsy give a clear cut picture. The focal epilepsies due to birth injury, microgyria or trauma can be accurately localized. The Petitmal type give a definite record.

In grand mal seizures the electrical rhythm and amplitude progressively increase until they reach a frequency of over 25 per second, and an amplitude of more than 100 microvolts. The individual waves take on the character of spikes. At the time convulsions appear these spikes may fuse to form slow waves at a frequency of 5 per second and of high voltage. At the termination of the attack the tracing may become almost free of waves.

In Petitmal seizures the *Alpha rhythm* disappears to be replaced by a slow wave with a frequency of 3 per minute, and a markedly increased amplitude. These slow waves alternate with short waves or spikes of equal or greater amplitude. In psychomotor attacks the rhythm slows to 3 or 4 waves per second. These waves are of high amplitude and are characteristically flat-topped, with superimposed more rapid *Alpha waves* indenting their crests. At the height of a seizure these indentations may disappear.

According to Gibbs, Gibbs, and Lennox of Harvard the rhythm regulating mechanism is at fault in the epilepsies. These investigators have been able to predict in advance the onset of a Grandmal seizure by inspection of the *Egg.* A rather important finding is that sub-clinical seizures may be frequently identified in epileptic patients. At the present time this group of workers is performing this test on all members of families in which there is an epileptic. This study will undoubtedly reveal a great deal of unknown factors regarding the hereditary characteristics of epilepsy.

Gulla, Graham and Walter have described abnormalities in the electrogram in epileptic patients between seizures. In many cases, they have been able to localize a focus giving rise to slow delta waves, located most often in the superior frontal gyrus in cases of Grand-mal, but usually in the post central portions of the brain in cases of Petit-mal. They believe that these local delta waves increase in amplitude and spread over the entire cortex during a seizure to constitute the seizure waves.

The great majority of tumors which affect the cortex directly by infiltration or indirectly by other means produce in it a condition in which delta discharges occur. Tumors several cms. below the surface commonly give rise to a delta discharge in the cortex directly above, which may also show some flattening or oedema. When the local signs of tumor are masked by a general delta discharge due to an increased intracranial pressure, a focus may be revealed by a reduction of the pressure. These delta waves have frequencies of 1 to 6 per second. They do not originate in the tumor itself, for this tissue has been shown to be electrically inactive. However, localization of the focus from which the Delta waves originate serves to localize the tumor. The Delta waves, in contrast to the normal alpha waves, are not influenced by visual activity. The greater and more acute the abnormality produced in the cortex, the slower are the Delta waves. A normal electrogrom is not conclusive evidence that no tumor exists, since in three per cent of cases with proved tumor the tracings have been normal. Pathologically, Astrocytoma Diffusum is the most difficult to localize. Regarding situation, the posterior fossa is most difficult in localization. The average for localization of brain tumors by this method at the Montreal Neurological Institute is around eighty five per cent. Many cases are localized only by this manner i.e. Encephalography has not demonstrated the tumor. Jasper reports seven cases in which clinical findings indicated the presence of a tumor but in which the electro-graphic diagnosis of no-tumor was proved to be correct.

The elecotrogram is of great value in following the course of head injuries. The progression of the waves towards normal corresponds with the clinical improvement. There is a definite picture following trauma and this is valuable in situations where hysteria, malingering and actual abnormality are to be differentiated. The first two give a normal picture. It is important to realize the fact that the more acute the cerebral lesion the clearer is the electrographic picture. This is quite in contrast to the X-ray where the reverse is true. The cerebral vascular accidents can be localized by this method and it is the opinion of Dr. Penfield that these cases should be operated upon very early to evacuate the clot and to prevent later motor spasms.

The electrogram has been considered to record mainly abnormal *cortical* potentials, but the cortical effect produced by deep lying lesions now is being recognized. Another recent valuable observation is the differentiation between situations of actual increased intracranial pressure and those in which such does not exist. Particularly so in the case of optic neuritis with marked papilloedema which obviously is not the result of increased pressure. These give almost normal waves or high frequency, low amplitude pictures, whereas the true cases of increased intracranial pressure show various slow waves.

With regard to the psychoses Jasper, Fitzpatrick and Solomon, working at Providence, R. I., on investigating the schizophrenics found that 23% of these patients showed electrographic evidence of epileptiform activity. Twelve of these patients showed epilepsy and six had definite clinical convulsions. They considered that 15% of their group of patients diagnosed as schizophrenic might well be suffering from mental disorders due to head injury, mental deficiency or other organic defect of the brain. They therefore class schizophrenia as a type of cerebral dysrhythmia.

In regard to behaviour problem children, Jasper, Sullivan and Bradley report that the majority of the children, 71 in number examined by them, exhibited abnormalities in their electrogram. Most of these abnormalities were of the type found in epilepsy, although this disease had previously been suspected in only two instances. The behavioral difficulties of these children consisted in emotional outbursts and various other attitudes often associated with the epileptiform personality. The nature of the fundamental pathology of the brains of these children is not as yet known, but the findings have been found important in evaluating prognosis and treatment.

In conclusion I wish to again stress the point that the electrogram is purely a laboratory test and although it has advanced and changed considerably our knowledge of the physiology of the brain and has increased our diagnostic ability to a great extent many problems are yet unsolved. We can look forward to this test as becoming an increasingly important factor in solving many of the problems referable to our asylums and neurological institutes.

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Anuria in Congenital Solitary Kidney

R. B. EATON, F.R.C.S. (Edin.), Amherst, N. S.

ALTHOUGH congenital absence of one kidney cannot be classified as extremely rare, the added complication of anuria for 5 days followed by operative recovery should make this case worth recording.

Case Report

Male, age 38 years, admitted to hospital with a history of anuria for 3 days.

There was no previous history of any significance except operations for bilateral cataracts during childhood. Two weeks previously he took suddenly ill with an attack of pain in the right loin. The pain was first sharp and radiated to the abdomen, latter settling down to a dull aching type. At the onset he felt nauseated but did not vomit. He had no urinary complaints, no headaches and his bowels were regular. With a day's rest in bed this attack subsided and he resumed his usual work. Three days before admission to hospital the pain returned, this time more severe in character necessitating bed rest and the application of heat for relief. He vomited bile stained fluid at the onset. His doctor found a catheter passed easily into the bladder but no urine escaped. Following two days of conservative treatment at home, consisting of hot packs to the abdomen and bladder irrigations, he was referred to hospital.

ON EXAMINATION: He was stoutly built and well nourished. Weight 170 lbs., temperature 98.4; pulse 68; tongue moist and clean; no odor on his breath; heart and lungs clear; B.P. 130/84; abdomen generally distended and tense. There was tenderness in the upper right quadrant. The percussion note was tympanitic. No masses were palpable. The external genitals were normal in appearance. On catheterization no urine was obtained. W.B.C.—8,000. The blood urea was not estimated. Flat X-ray of the abdomen revealed no evidence of renal or ureteric calculi. Kidney shadows were not visible owing to gaseous distension of the intestions. In spite of these findings a diagnosis of calculus anuria was made.

TREATMENT: This consisted of continuous intravenous drip of 5% glucose and saline alternating with 4.4% sodium sulphate solution, hot packs to the right loin and warm boracic bladder irrigations. After 2 days of treatment no urine had passed, and for the first time his general condition showed evidence of uraemia. His temperature was 98.8, pulse 90, and B.P. 140/90. He complained of increasing pain in the right loin and abdomen. He vomited several times. Abdominal distension was increasing and there was puffiness of the face and oedema of the lumbo-sacral region.

On cystoscopic examination the bladder mucosa appeared normal. There was moderate hypertrophy of the right interureteric ridge and a normal looking right ureteric orifice. On the left side there was complete absence of the interureteric ridge and the ureteric orifice. The right ureter was catheterized presumably to the renal pelvis without any apparent obstruction but no urine escaped.

As no relief was accomplished from this procedure, operation was decided on. The ureteric catheter was left in situ.

OPERATION: Nephrostomy under spinal anaesthesia (16 mg. pontocain). The kidney was exposed by a right oblique lumber incision. The perinephric tissues were very oedematous. On opening Gerota's space and stripping away the oedematous fatty tissue, the kidney was found normal in position and shape but markedly hypertrophied and congested. The renal pelvis did not feel abnormal and no calculi were palpable. No attempt was made to deliver the kidney. On needling its lower pole clear straw colored urine was obtained. At this point a small incision was made followed by quick insertion of a de Pezzer catheter. Haemorrhage was controlled by a gauze pack. After closing the incision the catheter was connected to a tube for drainage into a bottle at the bedside. An immediate post-operative intravenous 5% glucose and saline was administered.

PROGRESS: In the first 24 hours, 64 ounces of blood stained urine drained from the de pezzer catheter. Urine continued to drain freely though less blood stained. On the 6th day he began to pass small quantities of urine per urethram. On the 10th day the de pezzer catheter was removed. Increasing amounts of urine were being passed per urethram. The sinus closed on the 25th day. He was voiding normally except for moderate frequency. On the day of his discharge, 32 days after operation, intravenous pyelogram revealed a large right kidney pelvis and calyces (see X-ray plate). Dye concentration was only slightly delayed. Urinalysis was normal except for a faint trace of albumen. Three months later he appeared in perfect health, voiding normally and doing light work.

COMMENTARY: Congenital absence of one kidney is due to failure of development of the ureteric bud from the Wolffian duct. If vestigal remnants are present on that side it is probably due to early degeneration of the ureteric bud. With complete absence of one kidney there is usually absence of the ureter and ureteric orifice on that side, as occurred in this case.

The frequency of solitary kidney as computed by Ballowitz was 1-2400. Brassch and Merrick reported a series of 27 proved cases of renal agenesis at the Mayo clinic from 1909 to 1937. They also added 42 cases diagnosed by X-ray and cystoscopic examination. Of this total series of 69 cases, the sex incidence was equal; the average age was 38 years; the right kidney was absent in 32 and the left in 37. The commonest symptom was pain on the side of the remaining kidney.

It is a well recognized fact that congenital solitary kidney is prone to secondary complications. In order of frequency they are—1. pyelonephritis, 2. anomaly of the kidney present, e.g. ectopic failure of the kidney to rotate, 3. hydronephrosis, 4. tuberculosis, 5. renal calculi and 6. glomerulonephritis.

On cystoscopic examination there is usually hypertrophy of the interureteric ridge and ureteral orifice on the side of the kidney, with absence of the ridge and orifice on the opposite side. Usually urinary expulsions are more energetic from the remaining orifice.

On X-ray examination the size of the renal outline is larger, the size of the renal pelvis and calyces are larger, though normal in shape, and the psoas muscle shadow is usually less defined on the side opposite the kidney.

Probably the most interesting feature in these cases is the fact that they may live a healthy existence and show no symptoms referable to their kidney

anomaly unless suddenly complicated. This case developed anuria of sudden onset with a very short history of any kidney mischief. The history pointed to renal or ureteric calculi as a possible cause of the anuria but this was not found so on investigation. The actual cause of the anuria still remains obscure.

In a review of the literature I can only find six references to anuria in a congenital solitary kidney. Heymann reports a case with 5 days history of anuria relieved by ureteric catheterization but the cause of anuria was undetermined. P. Barge describes a fatal case of anuria in a patient with congenital solitary kidney and the pelvic remnant of the remaining ureter opening into a seminal vesicle. Welch and Banner also reported a fatal case.

To sum up, the most important causes of surgical anuria are post-renal. The obstruction may be due to calculi, new growths or inflammatory swelling of the mucous membrane of the pelvis or ureter. The cause of anuria in this case was undetermined, but was probably an inflammatory swelling of the mucous membrane of the pelvis and ureter.

I wish to thank Dr. Edward Barnhill for referring this case and Dr. A. E. MacKintosh for his kind assistance.

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The Divisional Medical Advisory Committee

IT will be recalled that at the semi annual meeting of the Executive Committee of the Medical Society of Nova Scotia on October 5th, 1939, the minutes of which have been published in the November Bulletin, a Divisional Medical Advisory Committee was appointed, whose function it was to be to foster co-operation during Canada's war activities between the medical profession within the Division and the Military authorities of District No. 6; and further to act as a contact between the Division and the Central Medical Advisory Committee of the Canadian Medical Association.

This Committee was named as follows:

Dr. J. H. L. Simpson............. Cumberland County.
Dr. H. A. Creighton............. Lunenburg County.
Dr. A. E. Blackett................ Pictou County.
Dr. J. S. Brean.................... Antigonish County.
Dr. L. M. Morton and
Dr. A. B. Campbell.............. Western Counties.
Dr. W. W. Patton and
Dr. L. R. Meech.................. Cape Breton Counties.
Dr. S. G. MacKenzie............. Colchester-East Hants Counties.
Dr. L. B. W. Braine............. Valley Counties.
Dr. W. L. Muir.................... Halifax.

For the purpose of conducting the routine business of the main committee a sub-committee, more easily convenable, was appointed, as follows:

Dr. J. R. Corston, Chairman...... Halifax.
Dr. K. A. MacKenzie............ Halifax.
Dr. P. S. Campbell............... Halifax.
Dr. W. L. Muir.................... Halifax.
Dr. S. G. MacKenzie............. Truro.
Dr. H. A. Creighton............. Lunenburg.

This sub-committee has held some six or seven meetings during the past six months, in each case to consider a communication relative to military medical service, received from, the District Medical Officer, the Central Medical Advisory Committee, a civilian hospital affected by a proposed military appointment, or from other interested parties.

Examples of matters upon which the advice and action of the Committee has been requested and given are—

(1) The effect upon civilian practice of the removal of certain medical men from their localities, for military service.
(2) The effect upon the teaching strength of the Dalhousie Medical Faculty of such removal.
(3) The personnel of new medical units in process of formation.
(4) The forwarding to the Canadian Medical Advisory Committee of completed questionnaire cards and additional information, in the cases of certain medical officers in this Military District.

When the matter under consideration has especially concerned a part of the Province whose representative has not been present at the meeting of the sub-committee, such representative's views have been obtained before taking action.

Condensed minutes of the sub-committee meetings have been forwarded to each member of the larger committee.

The sub-committee has been given satisfactory co-operation by the District Medical Officer, who has attended two of its meetings, besides referring to it several matters for advice and comment.

The Director General of Medical Services, during a recent visit to this District, requested a conference with the sub-committee, together with representatives from the Dalhousie Medical Faculty, the Victoria General Hospital and the Halifax Infirmary. At this meeting Colonel R. M. Gorssline, the D.G.M.S., expressed himself as being desirous that all appointments in the Military Medical Service should be filled with the best possible men, but that at the same time he wished to avoid any disastrous impairment of the civilian services. He wishes that the closest co-operation between the Advisory Committee and his Department, through the D.M.O., be maintained.

He also discussed with the group, on request, the regulations concerning the rank and pay of medical officers entering the service.

This brief account of the Committee's activities is presented at this time for the information of the profession in Nova Scotia, who are naturally interested in the working of the machinery which has been set up by the Canadian Medical Association and its Divisions for the purpose of assisting the Department of Militia and Defence.

J. R. C.

Historical Section

July 5th, 1940.

Dear Mr. Secretary:

The accompanying manuscript was found among some papers in an old trunk which was about to be disposed of, and evidently was written in 1900.

Thinking that it might be of some interest for your historical section, I am forwarding it to you for such disposal as you may deem fit.

Incidentally, I may remark that it cannot have been very long after the formation of the Colchester County Medical Society that I attended my first meeting. I have a more or less clear recollection of my father and mother and myself setting forth about daybreak to drive to Tatamagouche where the meeting was held. I was small enough to be comfortably seated on a box between the seat of the buggy and the dashboard. (Legs not as long then as now.) Don't know how long it took to drive the 40 miles; but remember spending the time after arrival sitting on the verandah of the hotel, and digging in the sand on the shore. The return journey was begun in the early evening and I do not remember the arrival home in Truro.

They took their meetings seriously in those days.

W. L. M.

Presidental Address Colchester County Medical Society
by W. S. Muir, M. D.

To the Members of the Colchester County Medical Society.

Gentlemen:

Allow me to thank you for the honour you have done me by electing me President of this Society, and in doing so I wish to express my thanks to all who have assisted in making it a success. Especially to our hard-working and painstaking Secretary-Treasurer (Dr. H. V. Kent) is the credit due of resuscitating the Colchester County Medical Society.

In February 1883, that is seventeen years ago, Dr. John W. McDonald, then of Acadia Mines, now a professor of surgery in Minneapolis, U. S. A., and an author of a standard text-book upon Surgery, and Dr. J. L. Peppard of Great Village conceived the idea of forming a County Medical Society, and with characteristic energy they called a meeting of the medical men then in practice in the County of Colchester within the historical walls of the Prince of Wales Hotel, Truro, on Feb. 5th, 1883. At this meeting there were present Drs. J. W. McDonald and J. L. Peppard of Londonderry, Drs. Page, Bent, D. H. Muir, J. H. McKay and W. S. Muir, Truro. Dr. A. C. Page was called to the chair, and W. S. Muir was appointed Secretary pro-tem. Dr. McDonald stated that every medical man in the County was anxious to have a County Medical Society formed, a committee was appointed to prepare Rules, Bye-Laws, and to present a scale of fees and to report at a meeting to be held on March 13th, 1883. For future reference I will give a list of the medical men in actual practice within the County of Colchester at that time.

Truro - - - - Drs. A. C. Page, Chas. Bent, D. H. Muir, J. H. McKay and W. S. Muir.

Acadia Mines - - Drs. John W. McDonald, Sutherland, Ellis.

Great Village - -	Drs. J. L. Peppard and J. Ross Smith.
Shubenacadie -	Dr. Duncan McLean.
Five Islands - -	Dr. Oulton.
Debert - - - -	Dr. Homer Crowe.
Economy - - -	Dr. McLeod.
Upper Stewiacke -	Drs. Robt. Smith and A. Cox.
Earltown - - -	Dr. Wm. Norrie.

March 13th, 1883, is the date of the birth of this Society, and the late lamented Doctor Alexander Crawford Page, of Truro, was the first president. Dr. John W. McDonald of Acadia Mines, now of Minneapolis, the first Vice-President, and W. S. Muir of Truro, the first Secretary-Treasurer.

At this, the first regular meeting of the Society Rules and Bye-Laws were read and adopted and the Scale of Fees adopted by the Society was published once every month in the two local papers, the *Sun* and *Guardian*. The publication of the Scale of Fees evoked the wrath of the Bass River Grange, and a letter was sent from this haven of wisdom and rectitude to the Society wanting an explanation and giving this Society their views of such an innovation and infliction as a Medical Scale of Fees. I may say that the joke of the whole matter was that in only one or two instances was the price of services rendered advanced, viz. midwifery was advanced from the awful fee of $5.00 to $8.00, and night visits were also advanced slightly.

The Society met quarterly, during the winter months in Truro and during the summer in the country towns. As I said before the Society was honoured by having as its first President the late Alexander Crawford Page. The old maxim "that like begets like" was no exception to the rule in this man's case. He was a good son of a most worthy father, and no man could have better carried out the 5th commandment to the letter of the law, and to have reaped its reward in this world than did Dr. A. C. Page. His only heritage was a good sound constitution, and the transmission of a highly moral and unselfish character which followed him through life. With a few dollars in his pocket, and some clothes in a small red trunk, this young man sailed down the Bay of Fundy from Onslow to seek his fortune in the United States. On the way the schooner was windbound and at last became unmanageable, but with that spirit and resolution which predominated through life he footed the rest of the way to Boston where he obtained work. At the same time he studied Latin and Greek and some time after entered Harvard Medical College where he graduated well up in his class. During Dr. Page's whole college career he had the respect of his teachers and fellow students as in after life he still kept up a correspondence with them. This I mention to show you the stuff the man was made of. Shortly after graduating the Doctor came back to Truro to practise his profession. How well Dr. Page succeeded in practice is as well known to most of you as it is to myself. The expression of his face was kind but strong, his manner was genial and his every instinct was honest, and all his intentions were good. He was domestic in his habits, preferring his home and the companionship of his family, his books, and a few chosen friends to anything that society could give. Dr. Page was of a studious habit and well read in his profession and alive to all its improvements, fertile in resources, prompt in action, and thoroughly to be depended upon. He was a good all-round practitioner. Obstetrics however, was his favourite branch of practice, and he was a most successful obstetrician. However I would like to see the

man who would dare to call the Doctor a specialist. To him it savoured of quackery. He looked upon the introduction of specialism as his keen foresight comprehended its antagonistic propensities to manly relations between the family physician and his patient as detrimental to a community of interests, and as most likely to be subversive of the best interests of harmony in the profession, the loss of confidence of the community in medical honour, and a gradual and steady diminution of courtesy in professional relations.

I expect that I knew Dr. Page as well if not better than any other medical gentleman living and truly I cannot find words to express my own gratitude, and to testify to the honourable treatment received from him as a consultant, friend, and medical attendant, and to do honour to his generous and noble name. If I were asked Dr. Page's strongest personal characteristic, I would most certainly say his executive ability. This was early recognized not only by his medical brethren but by the Government of his native province, as he was appointed Medical Inspector of Hospitals, Insane Asylums and Poor Asylums, a duty he performed with rare tact and ability. He was for years a most ardent militiaman and got to the top of the service before he retired, being P. M. O. at the last Militia Camp meeting he attended. He was for years President of the Provincial Medical Board of Nova Scotia, Examiner in Obstetrics and Diseases of Women and Children for Dalhousie College, President of the Medical Society of Nova Scotia, in fact Doctor Page filled any office in the Profession of his province that he could. Dr. Page was truly a religious man as well as a representative physician. He had no love for the Philosophies of pagan antiquity, the Infidelity of Paris, the Rationalism of Germany, but his belief was as sweet and sincere as that of a little child. Last autumn that uncompromising tyrant, before whom sooner or later we must all bow, touched the warm, generous heart with icy fingers, and the well-springs of his earthly life were frozen within him! Never again shall he grace our meetings with his kindly presence, his counsel or his sympathy, and may the Great Physician of souls repay him for his kindly acts towards the suffering poor of earth is my prayer for my truest and dearest friend, the late Dr. A. C. Page, our First President.

On the 24th of May, 1887, Dr. Duncan McLean of Shubenacadie was elected to fill the chair in this Society. Like his friend Dr. A. C. Page, Dr. McLean has passed on with the majority having died a few months before our first President at his home from double pneumonia. I will quote from Dr. Page's unpublished paper "History of the Medical Men of Colchester Co." to show you his opinion of the late Dr. McLean.

"Duncan McLean was born in Pictou Co. and is a graduate of Harvard University, 1860. Although living in Hants County a large part of Dr. McLean's practice is in Colchester. His field of practice is very large and laborious. He is not only very self sacrificing in his devotion to his profession but also a very safe and reliable practitioner. Having no medical friend near him to consult with he is often placed in circumstances where his tact and ingenuity carry him safely over difficulties when a Doctor not so largely endowed with those valuable qualities would fail. He is kind and considerate to the poor, a lover of sport, quick to resent an injury, but very forgiving, and generous to a fault."

If I were asked to write up a memoir of the late Duncan McLean I would simply refer you to Ian McLaren's famous book *Beside the Bonnie Brier Bush* to read *A Doctor of the Old School* then substitute Dr. McLean's name for that

of the hero, Dr. William MacLure. If Ian McLaren had lived in Shubenacadie and had kept a diary of Dr. McLean's work, he could not have published a truer picture of the bighearted, generous, self-sacrificing Duncan McLean. He was never supposed to be a man of great constitution, but he kept four horses busy; one will wonder how he did it, but not why if you knew the man. Dr. Page had years ago written up the late Dr. McLean as being generous to a fault. If Dr. McLean had a fault generosity was his besetting sin. His house and table were always at the disposal of the public, and well they knew it, and I can personally say took advantage of it. Shubenacadie and district must owe the Doctor's estate thousands of dollars and it may not be the people's fault as the doctor's last thought was always himself, and he was a most wretched collector. Once he said to me that the only way a man can make more than an honest living in the practice of medicine in Nova Scotia is to humbug the people, and grind the face off the poor, "two things thank the Lord I have never done" and will never do. Dr. McLean was a public-spirited citizen, a true and consistent friend. He was honest, capable and faithful to every trust, and he was a liberal contributor for the support of religion, and to any public or charitable object. His illness and death was plainly the result of over work.

Our first and second Presidents of the County of Colchester Medical Society were bosom friends during life. They were often brought together as they were both officers in the 78th Highlanders at the same time

Gentlemen I have given you a short account of the two first Presidents of and all that I can add is let the living profit by the examples of those who have this Society died, and emulate the virtues of our late friends, Drs. A. C. Page and Duncan McLean.

I cannot close my address without making a passing remark about the gentleman who is to a large extent responsible for the existence of this Society, Dr. John W. McDonald, our first Vice President. Dr. McDonald had just succeeded Dr. James Keer as medical officer to the Steel Company of Canada at Londonderry. He is a graduate of Edinburgh, a man of great energy and a first class speaker. Dr. McDonald at once set himself to work upon his arrival at Londonderry to improve the sanitary condition of affairs there. So well did he succeed that he was invited all over the Province to deliver lectures upon the subject of improved sanitation and public health. He spent much time at his own expense travelling and lecturing upon those subjects besides writing long and interesting articles for the press. He was the means of interesting the people and informing them in sanitary matters to such an extent as to merit the lasting gratitude of the public. After Mrs. McDonald's death which occurred at the Acadia Mines, Londonderry, the Doctor went to Minneapolis where he has made quite a name for himself and his native province. He is a Professor of Surgery, Editor-in-chief of *The Medical Dial* a medical journal of some weight, and has written a text book upon surgery which I understand is considered one of the best.

The First Secretary-Treasurer you still have with you and from appearances I should judge likely to for some time. (He died March 10th, 1902. W. L. M.)

Before closing let me thank you for your kind attention and suggest that ever let the watchwords upon the banner of this Society be—Correct principles—safe methods—and unselfish aims.

COUNTY OF COLCHESTER MEDICAL SOCIETY
TREASURER'S BOOK

W. S. Muir, Treasurer.

Date		Item	Amount	Total
		Cash Received, March 13th, '83.		
		Cr.		
March	13	Dr. Page	$ 1.00	
		Dr. D. H. Muir	1.00	
		Dr. W. S. Muir	1.00	
		Dr. J. W. McDonald	1.00	
		Dr. Sutherland	1.00	
		Dr. McLeod	1.00	
		Dr. Peppard	1.00	
May	15th	Dr. Bent	1.00	
		Dr. McKay	1.00	
		Dr. Cox	1.00	
				$10.00
		Dr.		
Mar.	13	To A. L. McKenzie rent	$ .50	
		To D. H. Smith & Co.	.70	
May	8	Postal cards	.20	
				1.40
		Balance		$ 8.60
1883		Cr.		
May	22nd	From last page Balance	$ 8.60	
"	22	Dr. McLean	1.00	
August	21	Dr. Roach	1.00	
		Dr. Ellis	1.00	
				$11.60
		Dr.		
May	22	Posting Scale of Fees.		
"	23	R. McConnell for "Scale" in Guardian and Printing Cards	8.50	
Nov.	10	16 postal cards	.16	
				$ 8.81
		Cr.	$11.60	
		Dr.	8.81	
		Balance on hand		$ 2.79
1884				
Feb'y.	19	Balance on hand	$ 2.79	
"	19	To 17 Postal Cards	17	
		Bal. on hand	$ 2.62	
May	10	25 Postal Cards	.25	
"	20th	Balance on hand	$ 2.37	
		A. C. Page	1.00	
		D. H. Muir	1.00	
		D. McLean	1.00	
		J. H. McKay	1.00	
		C. Bent	1.00	
		R. Cox	1.00	
		McDonald	1.00	
		W. S. Muir	1.00	
		M. C. McLeod	1.00	
				11.37

May	21	W. B. Alley—To cash per bill	11.05	
"	21	Bal. Due on hand	.32	
Aug.	11	17 Postal Cards	.1'	
"	19	Balance on hand	.15	
Nov.	5	Postal cards	.15	
		Cr.		
Feb.'y.		Cash from Dr. Reid	$ 1.00	
		Dr.		
May	8	Postal Cards	.15	
"	19	Cash on hand	.85	
		Annual Dues Paid		
May	19	Page, A. C.	1.00	
		McKay, J. H.	1.00	
		McLeod, M. C.	1.00	
		McLean, D.	1.00	
		Roach, E.	1.00	
		Cox, R.	1.00	
		Peppard, J. L.	1.00	
		W. S. Muir	1.00	
		McDonald, J. W.	1.00	
Aug.	19	Dr. Morris	1.00	
		Dr. Pearson	1.00	
			11.85	
		Less for Cards, etc.	.20	
			11.65	
1886				
May	8	To Postal Cards	.16	
"	14	To W. B. Alley's bill	10.20	
		To A. C. Mills do.	.50	
				10.86
		Bal. due the Medical Society May 16/86	.79	
May	17	Annual dues for 1886		
"		Dr. McDonald	1.00	
		Dr. Morris	1.00	
		Dr. D. H. Muir (2 yrs.)	2.00	
		Dr. W. S. Muir	1.00	
			$ 5.79	
1887				
May	10	Postal Cards	.20	
		Balance Due Col. Co. Med. Soc.	$ 5.59	
"	24	Annual Dues		
		Dr. Cox	1.00	
		McKay	1.00	
		Dr. Page	2.00	
"	29	Dr. McLean	2.00	
"	29	W. S. Muir	1.00	
				$12.59

July	3	Paid Isaac T. Winnans for Dinner for N. S. Medical Soc.	$15.00	
1888				
June	1	Postage & cards	.16	
				$15.16
June	6	Balance due W. S. Muir	$ 2.57	
"	6	Due W. B. Alley	2.60	
				$ 5.17
		Cr.		
1888				
June	6	Dr. Page—dues	1.00	

NOTICE

Regarding the Annual Meeting

The plans for the annual meeting have been changed. The scientific programme, the dinner, the dance, and the golf tournament have been eliminated. The annual meeting of the Executive will be held on Tuesday, August 27th, at 3.00 p.m., Atlantic Daylight Saving Time, at the Dalhousie Public Health Clinic, Halifax. The general session will be held at the same place on the same date immediately following the Executive Meeting.

H. G. Grant, M.D.,
Secretary.

NOTE: The minutes of a special meeting of the Executive which was held on July 2nd appear in this issue and explain the above notice.

The Nova Scotia Medical Bulletin

Official Organ of The Medical Society of Nova Scotia.

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Editorial Board, Medical Society of Nova Scotia.

DR. H. W. SCHWARTZ, Halifax, N. S.
Editor-in-Chief

DR. J. W. REID, Halifax, N. S. DR. A. L. MURPHY, Halifax, N. S.
and the Secretaries of Local Societies.

It is to be distinctly understood that the Editors of this Journal do not necessarily subscribe to the views of its contributors, except those which may be expressed in this section

VOL. XIX. JULY, 1940 NO. 7

MEDICAL CARE FOR OUR JUVENILE GUESTS

WHEN the writer was asked if he thought Canadian physicians should provide free medical care for the young people coming to this land of peace and plenty in order to escape from the terror by night and the destruction that wasteth at noonday he promptly answered "of course". Now that the head has been prompted to function and reason rather than impulse is having her say, one is not quite so sure that the answer given is the correct one.

A few extra hundred children in a city like Halifax would not mean very much but let that number be multiplied ten, twenty or thirty fold or more and it becomes quite another matter. With so many medical men entering the Army the burden of free services falling on those left to care for the indigent staff our free clinics and the public wards of our hospitals and where medical and nursing schools exist to carry on the teaching is becoming to assume fearsome proportions. If this is a national undertaking it should be done in a national way and not pushed off on less than one-tenth of one per cent of the population. Medical men will do their part and there will be few throughout this Dominion who will not entertain a guest and care for him or her in case of illness. Why is it suggested that they care for other people's guests in a like manner? Take for example a country practitioner who has taken into his home one or two children of a fellow physician in Britain for whom he is prepared to give of his best, why in the name of common sense and fairness should that man be expected to drive ten or twenty miles to care for a guest child with pneumonia or the subject of a fracture entirely at his own expense and the hundred and one people whose homes he passes on the way just take it for granted that it is nothing more than he should do. It may be suggested that the sick be sent to the public services of our hospitals. One would point out that this would not modify but aggravate the situation—the load being shifted from the shoulders of one-tenth of one per cent to those of a fraction of this fraction. It may be suggested that the temporary guardians be responsible for minor conditions and physicians for the major disorders. This half way measure has little to recommend it, apart from its unsurpassed possibilities

as a trouble maker. A conservative estimate of the number of cases that would probably be disputed could be placed in the vicinity of eighty-five per cent.

The problem can be quite easily, readily and equitably solved by following the practice already in operation in Ontario in relation to a part of their population and which has proven so eminently satisfactory to the three parties concerned, viz. the Provincial Government, the Ontario Medical Association (Ontario Division of the Canadian Medical Association) and those entitled to the benefits. Such an arrangement would be fair to all the people of Canada as all would share in the medical care of our guests through the medium of taxation. Doubtless there are many people who after due consideration with pad and pencil feel able to assume responsibility for an extra member to the family, but hesitate to do so because of the unknown expense that is inevitable should illness or accident occur. The physician would be reimbursed for direct expenditure and receive an honorarium for his services, and furthermore, the parents of these children would be relieved of a sense of personal obligation for medical services.

The suggestion is that the Federal Government allocate an agreed sum per capita per month for each juvenile guest to the Provincial Branch of the Canadian Medical Association to be administered in the best interests of those entitled to the benefit and with fairness within its own membership. In short, follow a tried, proven and well established plan that would place no extra administrative burden on our governmental departments beyond issuing nine cheques per month.

Supposing 1,500 children were being cared for in this province and fifty cents was the sum allocated, then the Treasurer of the Medical Society of Nova Scotia (Nova Scotia Division of the Canadian Medical Association) would receive a cheque each month for $750.00. Doctors would render their bills based on a fixed schedule, say $2.00 for an office call, and $3.00 for a house call, and beyond certain limits a mileage allowance. Certain specific attentions such as laparotomy, types of fracture, refraction or mastoidectomy, could be based on those fees allowed by the Insurance Companies. Local committees, nominated by the County Medical Society and familiar with the circumstances, would review the accounts on the fifth of each month for the preceding month and make any adjustments that may be deemed desirable and pass on to the Treasurer for payment. Supposing the doctors' accounts totalled $1,125.00 for the month, then each doctor would receive 750/1125 or 2/3 of his account. If Doctor MacD's. account for the month is $120.00, according to money available he would receive 2/3 of his account, which is $80.00.

In case of a surplus such money will be carried forward for the succeeding month when the bills may be higher and the percentage received by the individual even lower.

These observations are prompted by a sense of the injustice of what 99.999 per cent of the population are quite willing to inflict on the .001 per cent. They are a protest against the carefree, nonchalant and debonair manner in which groups of citizens, from service clubs to governments, take for granted that the exploiting of the medical profession is a well established routine of community life.

H. W. S.

Minutes of a Special Meeting of the Executive of The Medical Society of Nova Scotia, 1940

A SPECIAL meeting of the Executive of the Medical Society of Nova Scotia resident in Halifax was held at the Dalhousie Public Health Clinic, Halifax, N. S., on Tuesday, 2nd July, 1940, at 8.30 p.m.

The meeting was called to consider (a) changing the plans for the annual meeting which were made by the Executive at its semi-annual meeting in October, 1939; and (b) a suggestion from the Director of Public Welfare of the Department of Public Health of Nova Scotia that the physicians of our province provide free medical care to evacuated British children who are coming to Nova Scotia. The members of executive resident outside of Halifax were notified of the meeting and were given the opportunity of registering their votes by mail.

Dr. H. K. MacDonald, President, of Halifax, presided. Those present were Dr. J. W. Reid, Dr. W. L. Muir, Dr. Smith Henderson, Dr. H. W. Schwartz, Dr. J. A. Langille, Dr. J. R. Corston, Dr. J. V. Graham, Dr. K. M. Grant and Dr. H. G. Grant. Dr. J. R. Corston, our representative on the executive of the Canadian Medical Association, attended by invitation.

The President called the meeting to order at 8.30 p.m.

The first item to be considered was the annual meeting and the Secretary read the letter which had been sent to the outside members of the Executive.

"With so many of our members in military service and war conditions still serious it has been suggested that the programme for our annual meeting in August, which was arranged by executive on October 5th, 1939, be changed.

"The suggestion is that the scientific part of the programme, the annual dinner and dance, be eliminated, and that the annual meeting consist of the usual meeting of the executive followed by two general sessions to conform with our constitution and by-laws.

"Dr. H. K. MacDonald, the President, is calling a meeting of the executive on Tuesday evening, July 2nd, at 8.30 p.m., Daylight Saving Time, at the Dalhousie Public Health Clinic, to discuss this and other matters, but does not wish to put the members of the executive outside of Halifax to the inconvenience of coming in especially for this meeting. Will you therefor register your vote on the following questions and mail immediately.

1. Are you in favour of eliminating the scientific part of the annual meeting, the dinner, etc.?

   Yes...No...

2. Are you in favour of the Medical Society of Nova Scotia providing free treatment for the refugee children who will soon arrive in Nova Scotia?

   Yes...No...

"The committee in charge of the Refresher Course for Dalhousie University have already considered the advisability of calling off the Refresher Course for this year, and have decided to do so provided this is agreeable to the Medical Society of Nova Scotia."

Replies had been received from Dr. J. B. Reid, Truro; Dr. J. S. Munro, North Sydney; Dr. J. L. MacIsaac, Antigonish; Dr. A. B. Campbell, Bear River; Dr. P. S. Cochrane, Wolfville; Dr. W. A. MacLeod, Hopewell; Dr. S. G. MacKenzie, Truro; Dr. J. J. Roy, Sydney; Dr. J. S. Brean, Mulgrave; Dr. G. V. Burton, Yarmouth, ten in all, eight of whom were in favour of

eliminating the scientific part of the annual meeting, the dinner and dance. (The day following the meeting replies were received from Dr. G. A. Barss, Rose Bay; Dr. J. W. Sutherland, Amherst; Dr. J. C. Wickwire, Liverpool; all of whom voted in favour of eliminating the scientific part of the programme, the dinner and dance.) As all members present were also in favour of cancelling the scientific part, the dinner and dance it was moved by Dr. W. L. Muir and seconded by Dr. J. W. Reid that the scientific part of the annual meeting, the dinner, dance and golf tournament be eliminated from the annual meeting, and that the necessary business meeting take place. Motion carried.

It was decided that the executive meeting of the Medical Society of Nova Scotia would be held at 3.00 p.m. (Daylight Saving Time) on Tuesday, August 27th, and that one business session be held the same evening at 8.00 p.m.

The next item was the question of medical treatment for evacuated children who will soon arrive in Nova Scotia from Great Britain. A letter was read by the Secretary from Judge E. H. Blois, Director of Child Welfare of the Department of Public Health, the Province of Nova Scotia, as follows:

"June 21, 1940

"Dr. H. G. Grant,
Dalhousie Health Centre,
Morris St., Halifax, N. S.

Dear Dr. Grant:

You undoubtedly know about the scheme for bringing a number of evacuated British children to Canada. Nova Scotia is expected to take care of its share. The Department of Public Health will probably be charged with the responsibility of placing these children and for their supervision and care while in our Province. That is the present plan and we are working on that basis.

At a recent Conference held at Ottawa I was told by Dr. Jackson of Manitoba that the Medical Association of that Province had undertaken, as its contribution to this worthy cause to look after all these children free of charge during their stay in that Province, and a similar undertaking had been assumed by the Dental Association.

I am, therefore, today writing Dr. Langille, President of the Nova Scotia Dental Association, asking if the dentists of Nova Scotia will render like service in this Province and I am asking you to place before your Executive or Association, as the case may be, our request—or perhaps I should say suggestion—that the Medical Association of the Province undertake to render all necessary medical care to these children free of all charge while they are guests of the public in this Province.

This will be a big help as many people would be willing and able to take a child, or children, into their home and be able to give very good care and a good home to such child, but would be unable to provide medical service in case of sickness or accident.

I may state that the Department of Immigration will make a check-up on the children before leaving England and they will again be checked on arrival in this Province by a representative of the Provincial Health Department, but it is in the home after they have been placed that we want a guarantee of free medical service if that be possible to obtain.

I should be glad to hear from you as early as possible as we are making plans which will be announced to the public as soon as possible.

Yours faithfully,
(Sgd.) Ernest H. Blois,
Director."

After some discussion it was decided that the executive were not in a position to guarantee free medical treatment, as they could not speak for the whole medical profession, and that the matter should be dealt with at

the annual meeting in August, and that in the meantime the Secretary should consult with Judge Blois and obtain more information on the subject.

The Secretary next read a letter from Dr. T. C. Routley, General Secretary of the Canadian Medical Association, re children of doctors in the British Isles being sent out to Canada, as follows:

"184 College Street, Toronto 2,
June 24th, 1940.

Doctor H. G. Grant,
Dalhousie University,
Halifax, Nova Scotia.

Dear Doctor Grant,

RE REFUGEE CHILDREN

It is quite evident from the appeals which have already reached us that many Doctors in the British Isles are most anxious to send their children to Canada. What the number will be we of course do not know, but I have been instructed to communicate with the British Medical Association in regard to the whole problem. Meanwhile, the President and I spent some time together this morning discussing the situation and we feel that no time should be lost in asking the Divisions to put in motion the necessary inquiries to ascertain the number of children to whom we may offer homes.

It should be stated that, so far as we know, refugees will not be able to bring money out of the British Isles. Therefore, these children are likely to be non-paying guests, although in some letters which are now before me the suggestion has been made that recompense in whole or in part will be made when the war is over. I think it would be safer at this juncture for our people to regard the matter as voluntary service.

Please advise me just as soon as you possibly can what help may be expected from your province. When all the Divisions have been heard from, we shall then be in position to let the British Medical Association know what we have to offer.

With kind personal regards, I am

Yours sincerely,
(Sgd.) T. C. Routley,
General Secretary."

After a short discussion it was decided that both these letters should be published in the BULLETIN and that a letter be sent by the Secretary to the members of the medical profession in Nova Scotia, but that before doing so the Secretary should consult with Judge Blois so that there would not be any duplication of effort, as all these children will be under the direction of the Child Welfare Department.

The Secretary reported a total of 259 members to the Medical Society of Nova Scotia for 1940 as compared with a total of 312 for 1939. It was decided that the Secretary send a personal letter to each doctor who had not yet paid his dues.

Dr. Muir stated that at the secretaries meeting held in Toronto during the annual meeting of the Canadian Medical Association, at which he represented Dr. Grant, the suggestion had been made that each province contribute towards the expenses of its secretary to attend annual meetings, which suggestion he would bring up at the annual meeting. Also that a contribution be made towards the expenses of Mr. H. H. Wolfenden, who is being retained by the Canadian Medical Association at $1,000.00 a year, in connection with his trip to the Maritime Conference at Moncton which was held in May. It was decided that this matter be brought up at the annual meeting.

The meeting adjourned at 9.30 p.m.

H. G. GRANT, Secretary.

Since the Executive meeting was held on July 2nd, the following letter has been received from Judge E. H. Blois.

July 5th, 1940.

Dr. H. G. Grant,
Secretary,
The Medical Society of Nova Scotia,
Dalhousie Clinic Building,
Morris Street, Halifax, N. S.

Dear Dr. Grant:

At the present time it is impossible for anyone to say how many evacuated British children will be placed in Nova Scotia. You will understand that the conditions which govern the placement of these children are so complicated and uncertain and change so rapidly that we can only speak in general and rather uncertain terms.

Our present information is that 200 children will arrive in Nova Scotia about the middle of this month and that thereafter we may expect small groups of perhaps from thirty to fifty every day while shipping facilities are available and conditions generally are favourable for the removal of children to Canada. We all realize quite fully that the number may be quite large or it may be that there will be only a few of these children arrive in the Province. We can quite appreciate the reluctance of the Executive of the Medical Society to commit themselves to undertake to give free medical service to a very large number. However, it would appear that in some of the Provinces at least such assurance has been given to the Provincial authorities by the Medical Societies without reference to the number of children involved.

With regard to the extent of the medical treatment: I would draw your attention to the little leaflet enclosed. It is my understanding, and I think I can say the generally accepted principle laid down, that people who take these children into their homes will agree to treat them in all respects as members of the family and to assume all expenses, including ordinary medical care. That is, if a child is taken into a home and requires treatment in the home, the family doctor would look after the matter, the same as if the child was an ordinary member of the household, but if that child requires to be sent to a hospital, either for medical care or for an operation, then the expense incurred, both for hospital costs and medical care, would be paid for from another source. No private person will be required to assume such hospital or medical costs. If, as in some cases, the family is able financially and willing to assume such costs, that of course will be quite in order.

I think perhaps I should state further that it is proposed to appeal to the public generally for funds to take care of these hospital costs and other expenses connected with the movement. It was proposed that a national appeal be made to be controlled by trustees appointed by the Dominion Government. I am telling you this in order that it may be clearly understood that the Government do not propose to absorb these hospital and medical costs and it was argued by some with whom we have discussed this matter that the medical profession would be making their contribution to such national fund by giving services voluntarily in the way indicated in this letter. I think perhaps I should further add that this free medical care would only extend to those brought under Government auspices. It would certainly not apply to those who are coming by private arrangement or through groups or individuals who will assume full responsibility for the care and maintenance of these children. This point should be kept clearly in mind by the Society when considering our request.

Yours faithfully,
(Sgd.) Ernest H. Blois,
Director.

Correspondence

To the Editor:
NOVA SCOTIA MEDICAL BULLETIN.

Complying with the request to send you for publication a short account of my recent visit to Toronto and Ottawa I may say, at the outset, that I left Halifax on the morning of June 30 and arrived at Toronto on the afternoon of the following day. As far as Montreal I enjoyed the good companionship of Dr. Harry Morton, F.R.C.S., of Halifax, who regaled me with terse medical anecdotes.

At Toronto I was joined by my daughter who was returning home after the close of her College at Raleigh, North Carolina. We spent three or four pleasant days in the Queen City, visiting friends, motoring about the City and admiring objects of interest such as Casa Loma, the erstwhile noted residence of the late Sir Henry Pellatt, and which ultra-loyal Torontonians have already designated as the future palace of our beloved King and Queen unless the German megalomaniac's machinations are thwarted and up-rooted beyond future recognition.

Then we set off for Ottawa where the idea of Toronto being selected as the Canadian home of Royalty was treated with the greatest scorn. If such a tragedy as the removal from Britain of King George and Queen Elizabeth should, by any means, eventually occur, there was only one place within the confines of the Empire where they should be appropriately located and that was the beautiful Capital of the Dominion of Canada. However, speculation among the worthies, on such matters, has been effectually set at rest by the expressed resolution of Their Majesties to remain on British soil in contact with their well-beloved subjects in the motherland.

We lost no time at Ottawa in making our way to Parliament Hill. In a commodious private office there we were greeted by Mr. W. C. Macdonald M.P., for Halifax County and Dr. MacGarry, M.P., for Inverness County. In the course of conversation reference was made to the many memorable men who had first seen the light in the Island of Cape Breton. I noticed that at this stage in the deliberations Mr. Macdonald became very reticent, apparently appreciating the audacious gumption of two Cape Bretoners assiduously extolling the achievements of their Island folk, and evidently placidly forgetful of the claims of Pictou County along the same lines. The name of Archbishop Kiley of Milwaukee, U. S. A. came up and, with a show of innocence, I asked the doctor if he had ever *heard* of him. "Why," he replied, "I am a first cousin of his." I ventured to suggest that I could claim an even greater honor in having been, at one time, his school teacher and thus contributed to one, at least, of the spheres of eminence to which His Grace has attained. I had just commenced to relate how I had the temerity to write the distinguished prelate about the above circumstance, and his touching letter in reply, when we were all hushed into appalling silence by the news of Hon. Norman Rogers' death which had occurred shortly before and was now made known to the members. In the afternoon of that day I heard from the gallery

of the House of Commons the Prime Minister's pathetic account of the accident, and the expression of profound regret by members of both parties.

In the restaurant of the House of Commons on the following day I met the Hon. Mr. Ralston who was very much affected by the catastrophe. I imagine he could visualize the additional strain he himself might be subjected to in the probability of being asked to take over the vacant portfolio and thus to enter on work in a new field after toiling with the intricacies of the Finance Department for the past six or seven months. But he did not refer to such matters at all: his mood was a disconsolate one over the sad loss of a very dear friend, an exceptionally able colleague, and an admired parliamentarian. Thus in one day two heavy blows had been sustained by the country—the entrance of Italy into the World War, and the death of the Minister of Defence for Canada.

It would take up too much of your space to give a description of the Parliament Buildings, especially the Senate Chamber, the Library, the Hall of Fame, the wonderful Tower and the Carillon, the Parliament grounds, the statues of notable statesmen, and so forth and so on. I will refrain; but I must linger a moment to mention our visit to the Dominion Archives where we were cordially welcomed by Mr. Alvin Macdonald and Miss Kinnear, both former residents of Halifax. For a whole hour they showed us about and kindly gave us a good insight into the work that is being done there, and the wonderful collections of bound volumes, precious manuscripts, and other documents of untold value. I saw unpublished letters, some written by noted Nova Scotians one hundred years ago, that were as legible as on the day they were written. Many of the latter are kept under lock and key and only accessible through the medium of the custodian.

We were far from being satiated with entertainment and sight-seeing (for which we were under special obligation to Mrs. John McCharles, sister of Dr. J. J. MacRitchie of the Provincial Health Office, and to Mrs. Percy Gordon, wife of the Commissioner of Finance for the City of Ottawa) when the time for our departure arrived as I had promised His Honor Mr. Justice. Doull to accompany him to Cape Breton on a motor trip commencing June 17 So I reached Halifax on the 16th and set out for the east early the next morning. While away I visited my old home at Englishtown, Victoria County in company with my brother, Dr. J. C. Morrison of New Waterford; and there along with another brother we spent a pleasant day on the verandah of the latter's house reminiscing about old times, old things, old people and contrasting them with corresponding features of the present time. Then the beautiful St. Ann's Harbor—one of the finest sheets of water in Nova Scotia—and the majestic mountain ascending from the beach in bewitching symmetry brought back to me a flood of memories and a spiritual warmth that may not revisit me very soon again.

As a re-invigorating mental and physical tonic for weary medical men I would earnestly advise all of them to sojourn occasionally at the home of their childhood and there explore the old house, the old barn, the old well, the old pathways in the back settlements; yea, to climb up to the top of the elevated spots in the neighbourhood and, therefrom, to gaze rapturously east, west, north, and south while calling up in Imagination the joys and disappointments of days gone by, the boys and girls who were merry playmates of those days, the inspiring hopes and firm resolutions that pushed some of us forward when, maybe, the prescribed stride was slackening!

While realizing that communications of this character should not seek, as a rule, an adequate repose in a professionally scientific journal yet I am under the impression that an unpretentious report, such as this letter purports only to be, may not prove unacceptable to your readers.

M. D. M.

Halifax, N. S.,
July 6, 1940.

July 12, 1940

Dr. W. H. Schwartz,
Halifax, N. S.

My dear Schwartz:

May I extend to you my congratulations regarding your recent editorial in the BULLETIN. It was both timely and tragically necessary.

I am enclosing for your perusal a copy of a letter that I sent Dr. Routley, chairman of the Canadian Advisory Committee, a long time ago, relating to the same subject. I received the usual courteous and thankful letter in response, and of course, nothing has been done.

I will also make one other reference: some two or three years ago, I wrote an editorial for the BULLETIN which I dubbed "Totem-poles" in which I mixed up irony, satire, comedy, etc., etc., which possibly may have spoiled the article in the fact, that nothing came out of it.

The theme of that article was the stupid, indifferent attitude of the medical profession toward society in general, and the problems of society, which affect the medical man in every possible manner.

In this article, referred to ourselves as "Totem-poles" standing forth placidly, and stupidly exposed to all the elements, and happily content to remain so.

Our whole medical set-up is a positive disgrace; our societies are inert; inefficient; back-slapping; resolution passing, and useless to the profession as a medium either for medical advancement, or social benefit to its members.

It is the most amazing thing to me, that individual medical men, who are well educated, and influential in their respective communities, are so impotent as a group. Our public health endeavour; our sociological relationship toward government, and municipal bodies, involving the care of the indigent poor; and many such matters too numerous to mention, leave so much to be desired, that it really amounts to no effort whatsoever.

These are just a few of the many matters with which we have not dealt, and apparently cannot handle. Regarding the military phase of it, there are many successful medical practitioners who would like to do something for their country, but unfortunately, the whole medical service is so cumbersome; so wrapped in "red tape" and is so antiquated that unless these efficient and independent persons who have risen high in their professional rank are content to serve in a very menial and subordinate capacity, they are denied this privilege. Apparently, the keen and experienced man who has kept himself up to date through repeated post-graduate courses, has no more recognition or is of no more value to the army, than the recent graduate or the chap, who has been "down and out".

Unfortunately, the army seems to place more stress on seniority and authority, than they do on efficiency. It is recognized by most medical men

that if they carried on their practice along the established lines of military procedure, they would be "on the street" in a very short time.

The medical man of substance who desires to enlist cannot be expected to maintain a family, a car, his dependents, and his necessary insurance, on a lieutenant's or captain's pay. It is a mystery to me, why the government persists in refusing to pay the medical man for his services, in whatever department it may be; while our professional brethern, the lawyer, is paid colossal amounts on every possible occasion, for his services and advice which do not take him half as long to obtain; or half the money to obtain; and which necessitates very little physical exertion, and much shorter hours.

Coming to the military matter again. One meets plumbers, telephone line-men, insurance agents, clerks, etc. etc., with captains rank or majors rank; and the same pay, or better pay than the usual medical man. This is neither just, nor common sense and it is not a healthy situation to exist, and I believe that until the authorities do something about it, the army medical service will leave much to be desired.

Why our brother medical men, higher up, in charge of these services do not stand up and see that their medical confreres get a decent deal, is beyond me. I feel as you do, that medical men entering army service should be recognized on their civilian standing; not on the seniority in the military service, and should be paid a much higher fee than the usual officer. That is, an amount which is commensurate with their training and technical skill.

Finally: I agree with you most emphatically, as to the disinterest shown by the officials of our parent and branch societies in this matter, and in like matters concerning the members to whom they owe a duty, and an obligation. I think I have said enough.

With kindest personal regards,
Sincerely,
J. P. McGrath.

P.S. I would like to see you consult Dr. Atlee on this matter. I have great respect for his ability and effort in the common good. Also you may print this or any part of it.

March 9th, 1940

Dr. T. C. Routley,
Sec'ty Canadian Medical Association
184 College Street,
Toronto.

Dear Dr. Routley:

I noticed in the Journal of this month, that you would like to have some comments regarding your series of Broadcasts. I heard your latest one, regarding children and sleep. It came through very clearly, and I thought was very instructive, and complete.

My reason for writing you, today, is to take up some phases of military service; concerning the medical profession, which has occurred to me.

I am writing you as a medical practitioner, who is not in the army, but may be at a later date, if conditions necessitate, especially as I am on the reserve of officers from the last war; and further, because it may be difficult

for one already in military service, to make suggestions regarding possible improvements or revision.

Secondly; I believe that there is a Canadian Medical Advisory Committee to the Department of National Defence, that has the information, and is the proper medium through which one should deal with our relationship, rather than through a district medical officer.

It appears to me, that the whole matter of medical military service should be revised, and approached from a different angle altogether, as the medical man is in a higher specialized class, doing a work, non-commercial in character, and regarded by non-medical people as a "doctor"; irrespective of his field of service, whether military or civil.

It occurs to me, that it might be far more satisfactory to place the medical men on military service, in a different classification from officers of combatant services, either, they should be known as "medical officers" only, *all having the same rank*, but being in different degrees of promotion, according to their ability, with different rates of pay; or some other scheme, such as giving them a higher rank, at the onset of military service, than the regular military officer; viz,—all beginners to have the rank of captain on enlistment, with the pay and allowance of a major; ranking specialists to have the rank of major, with the pay and allowance of a colonel; and those in executive positions, either general or specialists, who have had, naturally, a military training, to be colonels, with or without staff allowance. The second of these two suggestions seems to me, to be the more practical and logical.

Possibly, you have already surmised the reason for these suggestions. In the first place, the function and training of a medical man, is the care of the sick and the injured; this he does in civilian, military, or any other phase of world life.

Regarding the army, he is not in the position of an infantry, or other officer, who is primarily concerned with army manoeuvres; the medical man need know very little about military routine, or detail, to perform his services; a matter of a very few weeks will acquaint the average medical officer, highly educated as he is, with the various forms, regulations and routine, for his particular work.

A knowledge of military tactics, gun fire, marching manoeuvres etc., are not vital or necessary to his work, and furthermore, "it bores him to death". I think the medical viewpoint is, that previous militia, or military service is not necessary.

The situation as I hear it, in this district, discussed by the medical men, seems to be this:—that most of them, who are now on military service, were called up with the militia; on mobilization; and they feel a great deal of dissatisfaction, that they have left established practices, for a matter of seven or eight dollars a day. I think I can say, that the feeling is, that they are making a financial sacrifice, that the other officers or ordinary ranks are not making.

Over a period of years, they have worked themselves into a position, in their various communities, of responsibility; have families, and a fair sized insurance to keep up; as that is the only safeguard, in medicine, for the future; the whole thing involving a daily overhead of ten or twelve dollars; and on captains pay, for any length of time, they feel themselves steadily getting deeper into the financial "mire," most of them, carrying along with this, a few "dead horses" from the depression, and stock market era.

As soon as more medical men are needed, it is evident that the better qualified, successful men are not going to volunteer; for financial reasons, only; *and to make matters worse*, those without previous militia experience would be given the rank of lieutenant, with pay, in the region of five dollars per day.

I am simply writing you to place the attitude of the rank and file of the profession, as I have heard it, before you. They feel that a good carpenter or plumber would earn five dollars a day or more; also that many of the infantry—lieutenants and captains and even majors and colonels, are barbers, electricians, insurance agents, and such: most of whom are earning as much, or more money than they previously did.

Also, many have left their businesses, farms, stores or positions, which are being conducted by some member of their family or a head clerk, rather than have any loss of income, they will have the army pay, in addition: not so, the medical man, whose practice stops completely, and at the end of the war period, may have completely vanished; while the other officer's business is intact.

Another matter of comment that I have heard, is that a nurse, who has far less training, and who has had far less financial outlay, and who in civilian life is very much in a junior position to a medical man; has the same rank as the newly enlisted medical officer.

I have had these matters in mind for some time, and while this letter is long, I am glad to hand them on to you.

In summarizing,—most of the men around here seem to be very anxious to do their bit; but the feeling is, that the government set-up is wrong, as they are penalized by losing their practice, and jeopardizing their future at a great financial loss to themselves, in contradistinction to ranks in the other services; and that they have not the recognition their education and position in the community entitles them to, due to their being required to accept a low rank in the service, on account of lack of knowledge of military matters, which, to them seem non-essential.

With kindest personal regards,

Very truly yours,

Dr. J. P. McGrath

Suggestion from the Joint Relations Council for change in final year examinations of medical students.

184 College Street, Toronto, Ontario,
July the 11th, 1940.

Dr. H. G. Grant,
Dean, Faculty of Medicine,
Dalhousie University,
Halifax, N. S.

Dear Dr. Grant:

On the occasion of the recent convention of the Canadian Medical Association, the Joint Relations Council on Medical Education, Hospitals and Licensure met under the chairmanship of Dr. F. J. H. Campbell of the University of Western Ontario. As you know, this body, formed in 1939, is made up of representatives of the medical colleges, licensing bodies, Royal College of

Physicians and Surgeons of Canada, Medical Council of Canada, Canadian Hospital Council, Canadian Public Health Association, Federation of the Medical Societies of Quebec and the C.M.A. and its provincial divisions. It is planned that this body should meet annually on the occasion of some general medical gathering, such as the convention of the C.M.A., to discuss matters of mutual interest to the organizations participating.

At its last meeting the enclosed resolution, relating to the examination of the medical colleges and of the Medical Council of Canada, received unanimous approval. You will note that the universities are requested to furnish certain information to the registrar of the Medical Council of Canada at Ottawa not later than July the 31st. We would be very grateful if you could arrange to have this information sent to Dr. J. Fenton Argue, 116 Nepean Street, Ottawa.

Yours very sincerely,
HARVEY AGNEW

Secretary, Joint Relations Council on Medical Education, Licensure and Hospitals.

Resolution—Joint Relations Council of Medical Education, Licensure and Hospitals—June 18th, 1940

Resolved That, in view of the fact that the Medical Council of Canada will be impelled by the war situation to give consideration to the ways and means whereby the graduates in medicine of Canadian Universities in 1941 (and possibly in the succeeding years) may obtain their Licentiate of the Medical Council of Canada as soon as possible after graduation and thereby be qualified to become licensed in any Province and be in a position to undertake either military or civil practice with the least possible delay—

The Joint Relations Council begs to recommend that the Medical Council of Canada make arrangements with each Canadian University Medical Faculty to conduct the Medical Council examinations and the graduating examinations of the University as a single procedure and thus save six to eight weeks delay that occurs under the present system and avoid, at the same time, the unnecessary duplication of these examinations. And further, in order to facilitate the consideration of the above action by the Medical Council of Canada, the Universities be requested by this Joint Relations Council to forward the following information to the Registrar of the Medical Council of Canada, not later than July 31st:

1. The subjects and dates during the last five years of—
   (a) written paper examinations
   (b) clinical examinations
   (c) oral examinations
2. The names of the examiners in each subject during the last five years—
   (a) written paper examinations
   (b) clinical examinations
   (c) oral examinations
3. The approximate date of the announcement of the results of the final examinations in the last five years.

4. The date of Convocation at which the degree in Medicine was conferred, in the last five years.
5. The number of students who have graduated in Medicine in the last five years.
6. The number of students, in the last five years, who have failed on their final examinations and who were not eligible to write the Medical Council of Canada examinations.
7. The approximate number of students who will graduate in Medicine and take the Medical Council of Canada examinations
   (a) in 1941
   (b) in 1942
   (c) in 1943
8. The total fees paid to the University by the individual student during the medical course (excluding the pre-medical years).
9. Any further pertinent information or suggestions.

June 18th, 1940.

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184 College Street,
Toronto 2, July 11th,
1940.

TO SECRETARIES OF DIVISIONS

Re British Guest Children

Dear Doctor:

Along with a number of other persons interested in the problem, I have just returned from a two hour conference with the Minister of Welfare of the Province of Ontario, when plans were discussed in considerable detail with respect to the reception of British children as war guests in Canada. I came away from the conference with the distinct understanding that the following plan has been agreed upon by the Dominion and Provincial Governments:

(1) That the Dominion Government will be fully responsible for the transportation and necessary care of children between the ages of five and sixteen years, from the point of embarkation in the British Isles to the designated town or city in Canada, at which point the Provincial Government assumes responsibility and exercises authority.

(2) The Provincial Government through its Welfare Department or department performing welfare service, will be responsible for the placing of the children in their foster homes.

(3) The homes which are offered, are to be listed with the Welfare Department through its local office in the area, by which department the homes will be inspected and approved.

(4) Hosts will be expected to provide maintenance and all other costs of these children in a manner similar to the care they would give their own children, with the exception that the Dominion Government will be responsible under certain conditions. Here let me quote from the official memorandum issued by the Department of Public Welfare of the Province of Ontario:

"Should illness develop after the child has been placed, the host will be expected to provide ordinary medical care in the same manner as he would if the child were his

own. Under no circumstances, however, will the host be called upon to bear the cost of hospitalization or of major medical care. This responsibility continues to rest with the Dominion Government. In the case of serious illness, the local Children's Aid Society must be notified immediately."

(5) Careful records will be kept in the Province of the foster homes designated for any special groups of children such as Doctor's homes for British Doctor's children. As Doctor's children arrive in Canada they will be placed in Canadian Doctors' homes.

(6) The question of preference as to sex, age, religion, etc., will of course be observed and it will remain, in the last analysis, for the foster home to accept or reject, as the case may be.

(7) At present there is no indication as to whether or not funds will be released from Britain to pay for the maintenance of any of these children in Canada. Therefore, they must still be regarded as non-paying guests. This provision, of course, is open to change at the discretion of the respective Governments, but it would be wiser at this juncture to look upon the service as a voluntary one.

(8) At this time I am able to report that information reaching me from three of the nine provinces indicates that medical homes in these provinces are ready to receive more than 1,000 British Doctors' children. Accordingly, I am cabling the British Medical Association to this effect and suggesting that all arrangements with respect to sending their children to Canada must be made through the proper authorities in England, but that they may rest assured that, when the children arrive here, homes for the number of children designated will be available. It would, therefore, seem proper for each Division in the Association to take the following steps:

(a) Contact the medical profession of the Division to ascertain their wishes with regard to the acceptance of children.

(b) Notify the proper provincial authorities of the homes offered —giving names and addresses or advise Doctors offering homes to contact the local welfare office.

(c) Advise the Doctors offering their homes that all further negotiations leading to the placing of children in their homes will be carried on between the Governmental agency and the Doctor.

(9) It would seem desirable that each Division keep this office notified of the developments within the province.—i.e. as to the number of Doctors' children the province will absorb.—in order that the details may be communicated from time to time to the British Medical Association.

(10) Furthermore, it would seem proper, depending upon the extent to which advantage is taken of our hospitality, that the Divisions should organize either provincial or local Medical Advisory Committees which would be responsible for taking a corporate interest in these Doctors' children, depending upon the needs which might develop. I am thinking of such things as special attention, recreation or holiday privileges and matters of a like nature which will occur to our profession.

(11) I would suggest that as soon as possible after receipt of this letter, you contact your provincial authorities—

(a) to enter into the necessary arrangements in your province for the reception of these children; and

(b) to confirm the understanding which I have presented in this letter which, while emanating from the Ontario Government, I am given to understand is in the main applicable to all the other provinces.

Yours sincerely,
T. C. ROUTLEY,
General Secretary.

The above letter was received from Dr. Routley, General Secretary of the Canadian Medical Association. There has been no action so far taken on this letter, as the British Government have postponed for the time being the sending of children to Canada.

July 4, 1940

The Editor,
MEDICAL BULLETIN.

Dear Sir:

I was greatly interested in your editoral "Where is the Voice of the C.M.A.?" in the June number of the BULLETIN. I believe that the entire Medical Services of the Canadian army should be taken over by a Board acting for the Canadian Medical Association. At this time Canadians expect our army to have the best that can be given of medical and surgical care. Can we expect this under the set-up of the R.C.A.M.C.? I think not. I have no reason to believe that things have changed very much since 1914-1918 and things then were pretty bad. I know something of this because I served in England and France in administrative and professional positions from 1915 to 1919. It will be no good to reopen old wounds, but to anyone who doubts I recommend the report of Colonel Herbert Bruce embodied in the book, *Politics and the Canadian Army Medical Corps.* Such conditions must never exist again. Already one can detect sinister signs. It is reasonable to believe that the small peace-time organization of the R.C.A.M.C. is quite incapable of administrating the service that we expect to see functioning for the care of our army. I feel sure that every Medical Officer who served with the Canadian Forces in the last war would be sorry to see repeated the misuse of splendid professional talent that was so common at that time. If the Canadian Medical Association took charge of the Medical Service, the medical men enlisting in the Medical Corps could feel that they had efficient and sympathetic management, unhampered by petty, bureauocratic, red tape methods or political and social aspirations. The army and the public would feel that the medical profession of Canada was serving to the best of its ability. We would all feel that the Canadian Medical Association, to quote from your editorial, was standing for "something in the right way". When we see this "something" a doubt will be removed from the minds of some of us.

Yours truly,
J. A. M. HEMMEON, M. D.

Are You A Member?

THIS year has been one of the busiest in the history of the Nova Scotia Division of the Canadian Medical Association. The most important activity has been the putting into effect the agreement between the National Department of Defence and the Canadian Medical Association. Our District Advisory Committee has been in touch with the military authorities since the beginning of the war, and every effort is being made to see that physicians are provided for the army, without inflicting any hardship on the civilian population. (A report from the Advisory Committee appears in this issue).

Another matter that has been dealt with in a most comprehensive manner is that of Health Insurance or Co-operative Medical Service. Mr. H. H. Wolfenden, the advisor of the Canadian Medical Association in this respect, has written extensively on this subject in the Canadian Medical Association Journal, and also gave a most instructive talk on the subject at the Maritime Conference at Moncton. Any member of our Society has the privilege of consulting Mr. Wolfenden, who is an authority on Health Insurance or Co-operative Medical Service.

Recently our Society has been requested to provide free medical care to the evacuated children who are coming to Nova Scotia and action has been deferred until further information is available, and the feeling of the profession is ascertained.

So although this year we are foregoing the social side of our annual meeting, the dinner, the dance, etc., the Society has been most active.

Every physician in the province should consider it his duty to become a member of the Nova Scotia Division of the Canadian Medical Association, and yet this year there are over fifty prominent physicians in the Province who have not yet paid their dues. The Secretary has sent out drafts and bills followed by a second letter to those in arrears. It is embarrassing to him to do more. It is most essential that our Society carry on at full strength during this trying period.

If you have not yet paid your fees do so immediately, and help us carry on the work of the Society.

Sincerely,

H. K. MacDonald, M.D.,
President.

To the Medical Profession of Nova Scotia

GENTLEMEN:

The BULLETIN needs contributions. We realize that under present conditions, with many of our colleagues withdrawn from practice and the extra burden that is thus thrown on those who remain that it requires considerable effort to prepare papers and case reports. If the BULLETIN is to go on then it must continue to receive the active support of all the physicians in the province. We would like to have an article from you just as soon as possible. Kindly let us know within a few days what you propose to do so that we may plan our work accordingly.

Sincerely yours,

The Editors.

The Refresher Course Has Been Cancelled

July 16, 1940.

Dr. Hugh Schwartz,
Editor,
NOVA SCOTIA MEDICAL BULLETIN,
Halifax, Nova Scotia.

Dear Doctor Schwartz: **Re Refresher Course.**

Will you kindly publish this for the information of the medical profession of the Province.

At a meeting of the Executive of the Nova Scotia Division of the Canadian Medical Association held July 2nd, 1940, it was decided that the scientific and social programme should be cancelled for this year. The Refresher Course Committee had been taking care of the scientific programme. This committee finds a number of papers being cancelled owing to the men concerned being engaged in military service. Further, we have been advised that so many medical men from the Province have been taken into the medical service that only a few of those remaining would be likely to attend the Refresher Course. It has therefore been decided to cancel the Course for this year.

Yours truly,
JUDSON V. GRAHAM,
Chairman,
Refresher Course Committee,
Dalhousie University.

SOCIETY MEETINGS

Western Nova Scotia Medical Society

The regular annual meeting of the Western Nova Scotia Medical Society was held at Yarmouth on May 31st, 1940, when the following officers were elected for the coming year:—

President - - - - - - Dr. P. E. Belliveau, Meteghan.
Vice-Presidents:
Shelburne County - - Dr. J. A. Donahoe, Barrington Passage.
Yarmouth County - - Dr. R. M. Caldwell, Yarmouth.
Digby County - - - Dr. E. A. Brassett, Little Brook.
Secretary-Treasurer - - - Dr. T. A. Lebbetter, Yarmouth.
Members to the executive of the Medical Society of Nova Scotia:
Dr. G. V. Burton, Yarmouth.
Dr. L. P. Churchill, Shelburne.

Department of the Public Health

PROVINCE OF NOVA SCOTIA

Office—Hollis Street, Halifax, N. S.

MINISTER OF HEALTH - - - - HON. F. R. DAVIS, M.D.,F.A.C.S., Halifax

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Chief Health Officer - - - - - - -	DR. P. S. CAMPBELL, Halifax.
Divisional Medical Health Officer - - -	DR. C. J. W. BECKWITH, D.P.H., Sydney.
Divisional Medical Health Officer - - -	DR. J. J. MACRITCHIE, Halifax.
Divisional Medical Health Officer - - -	Dr. J. S. Robertson, D. P. H., Yarmouth.
Statistician and Epidemiologist - - -	Dr. Harold Robertson, C. P. H., Halifax.
Director of Public Health Laboratory - -	DR. D. J. MACKENZIE, Halifax.
Pathologist - - - - - - - -	DR. R. P. SMITH, Halifax.
Director of Social Welfare - - - -	E. H. BLOIS, Halifax.
Psychiatrist - - - - - - - -	DR. ELIZA P. BRISON, Halifax.
Psychologist - - - - - - - - -	MISS JESSIE A. HARDING, Halifax.
Sanitary Engineer - - - - - - -	R. DONALD MCKAY, B.Sc., A.M.E.I.C.
Superintendent Nursing Service - - -	MISS M. E. MACKENZIE, Reg. N., Halifax.

OFFICERS OF THE PROVINCIAL HEALTH OFFICERS' ASSOCIATION

President - - - - -	DR. H. E. KELLEY - - - - - - -	Middleton
1st Vice-President - - -	DR. R. C. ZINCK - - - - - - -	Lunenburg
2nd Vice-President - - -	DR. C. I. MACMILLAN - - - - - -	Baddeck
Secretary-Treasurer - - -	DR. P. S. CAMPBELL - - - - - -	Halifax

COUNCIL

DR. W. D. FORREST - - - - - - - - - - - - -	Halifax
DR. J. E. LEBLANC - - - - - - - - - - - -	West Pubnico
DR. T. R. JOHNSON - - - - - - - - - - -	Great Village

MEDICAL HEALTH OFFICERS FOR CITIES, TOWNS AND COUNTIES

ANNAPOLIS COUNTY

Stone, O. R., Bridgetown.
Braine, L. B. W., Annapolis Royal.
Kelley, H. E., Middleton (Mcpy. & Town).

ANTIGONISH COUNTY

Cameron, J. J., Antigonish (Mcpy).
MacKinnon, W. F., Antigonish.

CAPE BRETON COUNTY

Tompkins, M. G., Dominion.
Fraser, R. H., New Waterford.
MacDonald, M. R., Sydney Mines.
Sutherland, Harvey, Glace Bay.
McLeod, J. K., Sydney.
O'Neil, F., Sydney (County, South Side.)
Murray, R. L., North Sydney.
Townsend, H. J., Louisbourg.
Gouthro, A. C., Little Bras d'Or Bridge, (Co. North Side).

COLCHESTER COUNTY

Eaton, F. F., Truro.
Havey, H. B., Stewiacke.
Johnston, T. R., Great Village (Mcpy).

CUMBERLAND COUNTY

Bliss, G. C. W., Amherst.
Gilroy, J. R., Oxford.
Hill, F. L., Parrsboro, (Mcpy).
Cochrane, D. M., River Hebert (Joggins)
Withrow, R. R., Springhill.
Henderson, C. S., Parrsboro.

DIGBY COUNTY

Brasset, E. A., Little Brook, (Clare Mcpy).
Dickie, W. R., Digby.
Wier, A. F., Freeport, (Mcpy).

GUYSBORO COUNTY

Chisholm, D. N., Port Hawkesbury (Mulgrave).
Sodero, T. C. C., Guysboro (Mcpy).
Moore, E. F., Canso.
Monaghan, T. T., Sherbrooke (St. Mary's Mcpy).

HALIFAX COUNTY

Morton, A. R., Halifax.
Morton, A. McD., Halifax (Mcpy).
Payzant, H. A., Dartmouth.

HANTS COUNTY

Bissett, E. E., Windsor.
MacLellan, R. A., Rawdon Gold Mines (East Hants Mcpy).
Reid, A. R., Windsor, (West Hants Mcpy).
Shankel, F. R., Windsor, (Hantsport).

INVERNESS COUNTY

Chisholm, D. N., Port Hawkesbury.
Ratchford, H. A., Inverness.
McNeil, A. J., Mabou, (Mcpy and Town of Port Hood)

KINGS COUNTY

Bishop, B. S., Kentville.
Bethune, R. O., Berwick, (Mcpy).
de Witt, C. E. A., Wolfville.
Cogswell, L. E., Berwick.

LUNENBURG COUNTY

Marcus, S., Bridgewater (Mcpy).
Donkin, C. A., Bridgewater.
Donaldson, G. D., Mahone Bay.
Zinck, R. C., Lunenburg.
Zwicker, D. W. N., Chester, (Chester Mcpy).

PICTOU COUNTY

Blackett, A. E., New Glasgow.
Chisholm, H. D., Springville, (Mcpy).
Whitman, H. B., Westville.
Crummey, C. B., Trenton.
Young, J. Fraser, Pictou.
Granville, F. J., Stellarton.

QUEENS COUNTY

Ford, T. R., Liverpool.
Smith, Harry, Caledonia (Mcpy).

RICHMOND COUNTY

Digout, J. H., St. Peters, (Mcpy).

SHELBURNE COUNTY

Corbett, J. R., Clark's Harbour.
Fuller, L. O., Shelburne.
Dinsmore, J. D., Port Clyde, (Barrington Mcpy).
Lockwood, T. C., Lockeport.
Churchill, L. P., Shelburne. (Mcpy).

VICTORIA COUNTY

MacMillan, C. L., Baddeck, (Mcpy).

YARMOUTH COUNTY

Hawkins, Z., South Ohio, (Yarmouth Mcpy).
Caldwell, R. M., Yarmouth.
Lebbetter, T. A., Yarmouth, (Wedgeport).
Melanson, F., St. Anne du Russeau, (Argyle Mcpy).

Those physicians wishing to make use of the free diagnostic services offered by the Public Health Laboratory, will please address material to Dr. D. J. MacKenzie, Public Health Laboratory, Pathological Institute, Morris Street, Halifax. This free service has reference to the examination of such specimens as will assist in the diagnosis and control of communicable diseases: including Kahn test, Widal test, blood culture, cerebro spinal fluid, gonococci and sputa smears, bacteriological examination of pleural fluid, urine and aeces for tubercle or typhoid, water and milk analysis.

In connection with Cancer Control, tumor tissues are examined free. These should be addressed to Dr. R. P. Smith, Pathological Institute, Morris Street, Halifax.

All orders for Vaccines and sera are to be sent to the Department of the Public Health, New Provincial Building, Halifax.

Province of Nova Scotia Division of Vital Statistics

Provisional Monthly Report—April 1940

	April 1940 Total	April 1940 Male	April 1940 Female	April 1940 Rate	April 1939 Rate
No. of live births	1038	542	496	23.1	22.3
No. of stillbirths	52	35	17	47.7**	38.2**
No. of deaths	474	254	220	10.6	13.7
No. of deaths under 1 year of age	62	33	29	59.7*	75.6*
No. of deaths from puerperal causes	1	...	1	1.0*	6.0*

Causes of Death	Int. List No.	April 1940 Total	April 1940 Male	April 1940 Female	April 1940 Rate	April 1939 Rate
Typhoid Fever	1	1	..	1	.....	.....
Measles	..	.				.....
Whooping Cough	9		2	3	11.1	13.3
Diphtheria	....	..	..	..	.....	.....
Influenza	11	17	13	4	37.8	155.4
Cerebro Spinal Meningitis	18	1	..	1	.....	.....
Pulmonary Tuberculosis	23	23	13	10	51.2	88.8
Other forms of Tuberculosis	24-32	10	5	5	22.3	13.3
Cancer and other Malignant tumors	45-53	68	32	36	151.4	144.3
Cerebral hemorrhage, thrombosis and embolism	82a 82b	14	9	5	31.2	66.6
Diseases of the Heart	90-95	76	35	41	169.2	213.1
Diseases of the Arteries	96, 97 99, 102	37	23	14	82.4	111.0
Pneumonia (all forms)	107-109	37	23	14	82.4	88.8
Diarrhea and Enteritis under 2 yrs. of age	....	..	..	..	.....	.....
Nephritis	130-132	30	16	14	66.8	71.0
Diseases of Early Infancy	158-161	24	12	12	23.1*	30.8*
Accident	176-195	20	14	6	44.5	51.1

* Rate expressed as number of deaths per 1000 live births.
**Rate expressed as number of stillbirths per 1000 total births.

Provisional Monthly Report of Births and Deaths April, 1940.

	Births: Total Births	Live Births: Total	Legitimate M.	Legitimate F.	Illegitimate M.	Illegitimate F.	Still Births: Total	Still Births M.	Still Births F.	Deaths: Total	All Causes M.	All Causes F.	Infancy	Under 1 year of Age	Whooping Cough	Influenza	Pulmonary Tbc.	Other forms of Tbc.	Cancer	Cere. hem. Embolism Thrombosis	Heart Disease	Disease of the Arteries	Pneumonia All Forms	Diarrhea under 2 years	Nephritis	Diseases of Infancy	Accident
Nova Scotia	1090	1038	502	462	40	34	52	35	17	474	254	220	62	..	5	17	23	10	68	14	76	3.	37	..	30	24	20
Annapolis	31	30	13	12	3	2	1	..	1	19	10	9	3	..	..	..	..	..	3	1	2	2	1	..	1	2	..
Antigonish	27	27	16	10	..	..	..	..	..	19	6	13	3	..	..	1	2	3	5	..	1	..	1	..	..	2	..
Cape Breton	188	179	87	83	5	4	9	9	..	51	32	19	12	..	..	3	..	..	5	1	5	3	7	..	4	3	6
Colchester	47	43	27	16	..	..	4	2	2	22	13	9	3	..	..	1	..	1	5	1	4	1	2	..	..	1	2
Cumberland	91	88	43	43	..	2	3	2	1	38	20	18	3	..	..	1	5	1	5	..	9	3	3	..	1	2	1
Digby	35	32	16	10	4	2	3	..	3	18	14	4	6	..	1	2	..	1	1	..	..	2	3	..	4	1	..
Guysboro	29	28	9	13	3	3	1	1	.	9	8	1	1	..	..	..	2	..	1	1	1	..	3	..	..	..	..
Halifax	243	227	114	101	4	8	16	11	5	117	60	57	10	..	..	2	5	2	24	1	18	11	8	..	5	5	7
Hants	49	47	22	19	3	3	2	2	..	25	18	7	3	..	..	1	1	..	2	1	5	3	2	..	..	2	..
Inverness	47	45	21	20	3	1	2	1	1	24	12	12	3	..	..	1	..	..	2	2	4	2	1	..	5	1	1
Kings	85	83	41	40	1	1	2	1	1	32	23	9	5	..	2	..	3	1	6	1	4	1	1	..	4	2	1
Lunenburg	54	50	23	22	3	2	4	..	1	28	12	16	1	..	..	1	..	1	3	1	11	1	1	..	2	..	..
Pictou	66	66	25	34	4	3	..	..	..	22	9	13	1	..	..	1	3	..	3	..	2	3	..	..	..	..	2
Queens	23	21	10	8	2	1	2	1	1	7	2	5	1	..	..	1	..	..	..	1	2	1	1	.	..	..	..
Richmond	15	15	7	7	..	1	1	1	..	6	3	3	2	..	..	..	..	..	..	..	1	1	..	..	..	2	..
Shelburne	22	20	10	8	2	..	2	1	1	14	5	9	2	..	..	1	1	..	1	1	3	..	1	..	2	1	..
Victoria	10	10	4	5	1	..	..	..	..	6	1	5	2	..	2	..	..	..	1	..	2	..	..	..	..	..	.
Yarmouth	27	27	14	11	1	1	..	..	..	17	6	11	1	..	..	1	1	..	1	1	2	..	2	..	2	..	..

Note: These figures are based on the Birth and Death certificates received by the Division of Vital Statistics, Halifax. N. S., up to and including May 10, 1940 and represent the number *registered* with the Division Registrars during the month of April, 1940.

Province of Nova Scotia Division of Vital Statistics
Provisional Monthly Report—May 1940

	May, 1940				May 1939
	Total	M.	F.	Rate	Rate
No. of live births	1,012	515	497	21.8	22.4
No. of stillbirths	45	26	19	42.6**	23.2**
No. of deaths	515	287	228	11.1	12.5
No. of deaths under 1 yr. of age	63	37	26	62.3*	70.3*
No. of maternal deaths	5	...	5	4.9*	3.0*

Causes of Death	Int. List No.	May, 1940				May 1939
		Total	M.	F.	Rate	Rate
Whooping Cough	9	5	2	3	10.8	11.1
Influenza	11	10	5	5	21.5	66.6
Pulmonary Tuberculosis	23	29	18	11	62.5	84.4
Other forms of Tuberculosis	24-32	6	3	3	12.9	8.9
Cancer	45-53	73	38	35	157.3	153.2
Cerebral Hemorrhage, embolism and thrombosis	82a, 82b	13	4	9	28.0	46.7
Heart disease	90-95	77	47	30	165.9	146.6
Diseases of the arteries	96, 97, 99, 102	69	37	32	148.7	95.5
Pneumonia	107-109	33	18	15	71.1	102.1
Nephritis	130-132	33	20	13	71.1	104.3
Early Infancy	158-161	28	17	11	27.7*	37.6*
Accidents	176-195	26	22	4	56.1	57.8

* Rate expressed as number of deaths per 1000 live births.
**Rate expressed as number of stillbirths per 1000 total births.

Provisional Monthly Report of Births and Deaths May, 1940.

	BIRTHS									DEATHS																
	Total Births	Live Births					Still Births			Total	All Causes		Maternal Deaths	Under 1 yr.	Whooping Cough	Influenza	Pulmonary Tbc.	Other forms of Tbc.	Cancer	Cerebral Hemorrhage	Heart Disease	Diseases of the Arteries	Pneumonia	Nephritis	Early Infancy	Accidents
		Total	Legit-imate M.	Legit-imate F.	Illegit-imate M.	Illegit-imate F.	Total	M.	F.		M.	F.														
Nova Scotia	1057	1012	479	464	36	33	45	26	19	515	287	228	5	63	5	10	29	6	73	13	77	69	33	33	28	26
Annapolis	35	33	15	15	1	2	2	1	1	14	7	7	..	4	1	1	1	..	4	1	1	1	1	..	..	..
Antigonish	29	28	17	11	..	..	1	1	..	20	11	9	..	3	..	..	2	..	..	..	3	3	..	2	1	3
Cape Breton	216	207	91	93	11	12	9	6	3	65	40	25	2	20	3	2	4	..	6	1	7	5	6	5	6	1
Colchester	50	50	33	14	3	..	..	..	..	24	16	8	..	..	..	..	..	..	2	1	4	7	3	1	..	1
Cumberland	80	79	36	39	1	3	1	1	..	33	22	11	..	3	..	1	2	1	4	2	4	4	1	3	3	2
Digby	35	33	15	16	..	2	2	1	1	13	10	3	..	1	..	..	..	..	1	..	1	3	..	1	1	4
Guysboro	38	35	9	23	2	1	3	3	..	10	4	6	..	..	..	..	2	..	2	..	1	1	2	1	..	1
Halifax	211	194	93	90	7	4	17	7	10	123	74	49	1	11	..	1	3	3	21	1	14	22	11	7	7	6
Hants	36	35	13	19	2	1	1	1	..	28	13	15	..	2	..	1	1	..	6	1	5	5	..	1	1	..
Inverness	31	29	12	14	1	2	2	..	2	18	10	8	..	3	..	..	..	..	5	..	2	1	3	2	1	..
Kings	41	41	18	22	..	1	..	..	..	33	15	18	..	2	..	..	5	..	2	1	6	3	..	1	1	5
Lunenburg	53	50	26	21	1	2	3	2	1	37	19	18	1	2	..	2	3	..	5	4	10	4	..	1	2	..
Pictou	63	60	35	22	2	1	3	2	1	48	18	30	..	5	1	2	4	..	8	1	7	6	3	6	3	..
Queens	39	39	18	19	1	1	..	..	..	12	5	7	1	2	..	..	..	1	1	..	2	2	..	1	1	1
Richmond	13	13	4	8	1	..	..	..	..	5	3	2	..	1	..	..	..	..	2	..	..	1	..	..	1	..
Shelburne	24	23	12	10	..	1	1	1	..	10	6	4	..	1	..	..	..	..	2	..	5	..	..	1	..	..
Victoria	12	12	7	4	1	..	..	..	..	8	5	3	..	2	..	..	..	..	..	..	2	..	3	..	..	..
Yarmouth	51	51	25	24	2	..	..	..	..	4	9	5	..	1	..	..	2	1	2	..	3	1	..	..	..	2

Note: These figures are based on the Birth and Death certificates received by the Division of Vital Statistics, Halifax, Nova Scotia, up to and including June 10, 1940 and represent the number *registered* with the Division Registrars during the month of May, 1940.

Personal Interest Notes

Dental Clinic in Colchester.

A DENTAL clinic is now being operated throughout Colchester County under joint supervision of the Department of Public Health and the Nova Scotia Dental Association. This clinic is in charge of the Public Health Nurse, Miss Lettie Turner of Glace Bay, with headquarters at Halifax. The purpose of the clinic is to serve rural sections and to instruct children in oral hygiene. Services are restricted to school children between the ages of six and sixteen. Truro dentists working in conjunction with the clinic are Dr. R. A. Casson, Dr. P. Kitchen, Dr. N. MacG. Layton and Dr. V. D. Crowe.

Dr. and Mrs. S. W. Williamson of Yarmouth were recent visitors in Toronto where Dr. Williamson attended the annual meeting of the Canadian Medical Association.

Ten graduates from the school of nursing at the Nova Scotia Hospital, Dartmouth, received their diplomas at graduation exercises held on June 12th. The address to the graduates was given by Dr. H. L. Scammell, who spoke on the history of the care of the mentally sick.

Dr. A. R. Morton, Halifax City Health Officer, recently arrived home after spending a year studying under the Rockefeller Fellowship. He received his degree of Master of Public Health at Johns Hopkins University on June 4th. After graduation Dr. Morton visited the cities of Richmond, Va., Durham, N. C., and Detroit, Mich., and made a thorough study of the health departments of those cities.

Dr. F. B. Day of Thorburn who was suddenly stricken with illness on June 12th is improving. Dr. Day served as a physician and surgeon in England and France during the greater part of the last war. His eldest son, Dr. G. F. Day, Dal. '39, is practising in New Glasgow and assists his father in the rural districts.

The marriage took place at South Milford, Annapolis County, on June 1st of Miss Leota Wilcox, elder daughter of Mr. and Mrs. G. Wilcox of South Milford, and Dr. J. A. Donahoe, son of Mr. and Mrs. Thomas Donahoe of Roseneath, P. E. I. Miss Wilcox graduated from the Victoria General Hospital, and Dr. Donahoe graduated from Dalhousie Medical College in 1939, and is now practising at Barrington Passage.

Dr. T. M. Creighton, of London, England, recently visited his parents, Mr. and Mrs. C. E. Creighton, Dartmouth, and is now in Ottawa.

The Pictou Town Council have granted Dr. J. A. F. Young, now with the R.C.A.M.C. leave of absence as Medical Health Officer, and approved the appointment of his father, Dr. M. R. Young, as substitute.

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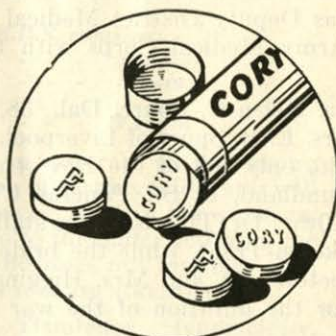

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Mobilization of Medical Resources in Canada Urged.

Complete mobilization of Canada's medical resources and adequate preparation for urgent future requirements should be effected without delay, Dr. Frank S. Patch, Montreal, retiring president of the Canadian Medical Association, said in his valedictory address at the Canadian Medical Association annual meeting at Toronto on June 20th.

The war and Canada's part in it dominated Dr. Patch's address. He related what the Canadian Medical Association already had done towards assisting the war effort and gave his opinion that the medical profession as a whole would be prompt and willing in responding to any plea for help. The association, he said, started a registration of members after the outbreak of war so that doctors would be easily available for emergency work. A questionnaire had been sent to all members and eighty-five per cent had completed the forms. On the basis of that information a complete register had been prepared.

Dr. G. H. Murphy of Halifax delivered the address to the graduating class of St. Francis Xavier University at their annual closing exercises in May.

Chlorination Recommended.

Suggestion that a chlorination plant be installed to safeguard northside water consumers against possible contamination was made by Dr. C. J. W. Beckwith, district medical health officer for Cape Breton, at a Public Utility Board hearing at North Sydney on May 27th. Dr. Beckwith said tests taken semi-monthly during the past five years showed variations in contamination.

Dr. C. E. A. deWitt of Wolfville is now with the Canadian Active Service Force as Deputy District Medical Officer and is attached to the Royal Canadian Army Medical Corps with the rank of Major.

Dr. Helen C. Spurr, Dal. '38, younger daughter of the Reverend Canon and Mrs. E. B. Spurr of Liverpool, N. S., was married to Dr. George D. Tulk, Dal. '36, only son of the Reverend and Mrs. A. T. Tulk of Portugal Cove, Newfoundland, at St. Pancras Church, Chichester, England, on Saturday, April 20th. Dr. Tulk is on the staff of the North Staffordshire Royal Infirmary at Stoke-on-Trent, while the bride for the past year has been an assistant to two doctors, Dr. and Mrs. Higgins at Hanley. They plan to remain in England for the duration of the war and will live in Winchester.

Lieutenant W. J. Lamond, who has been attached to the 16th Coast Brigade, R.C.A.,C.A.S.F., has been taken on the strength and transferred to No. 6 District Depot, C.A.S.F.

Lieutenant W. G. Morson, Royal Canadian Army Medical Corps, C.A.S.F., has been transferred to No. 6 District Depot, C.A.S.F., from attachment to the 1st Halifax Coast Brigade, R.C.A.

Dr. and Mrs. O. Fletcher Best of Providence, R. I., have arrived in Yarmouth to spend the summer.

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Bismuth Subsalicylate - - - - - - - - -	*4 grains*
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Captain J. Arnold Noble, M.D., F.R.C.S., Halifax, has been elected a Fellow of the Royal College of Surgeons, Canada.

Dr. R. G. A. Wood of Lunenburg, who has been at Cleveland, Ohio, taking a refresher course and in attendance at the annual meeting of the Canadian Medical Association at Toronto has returned home.

Dr. G. Harvey Agnew, Associate Secretary of the Canadian Medical Association, attended the meeting of the Nova Scotia and Prince Edward Island Hospital Association at Bridgewater on June 27th and 28th. Dr. Agnew spoke on the subject of "Hospital Administration of To-day".

Results of Examinations Announced.

The Registrar of the Medical Council of Canada has announced that 355 candidates were successful in recent council examinations held at eight centres throughout Canada. Nineteen of the candidates were women. These candidates now may become licensed to practise in any province in Canada, without further examination, on the payment of the necessary fee and meeting other provincial requirements.

Successful candidates and the centres where they tried the examinations include:

At Halifax: Wilfred E. Boothroyd, Shediac, N. B.; John R. Cameron, Grand River, N. S.; Owen H. Curtis, Charlottetown, P. E. I.; Arnold A. Epstein, New Waterford, N. S.; Koon S. Fong, Hong Kong, China; Karl A. Garten, Halifax, N. S.; Howard I. Goldberg, Halifax, N. S.; Joseph K. L. Irwin, Port Morien, N. S.; O. Carvell MacIntosh, Antigonish, N. S.; S. Gordon MacKenzie, Truro, N. S.; F. Harold MacLeod, Port Hawkesbury, N. S.; Hazen C. Mitchell, Campobello, N. B.; George H. Murphy, Jr., Halifax, N. S.; Howard R. Ripley, Amherst, N. S.; Samuel J. Shane, Yarmouth, N. S.; Gerald A. Smith, Angle Brook, Newfoundland; Robert G. Wright, Inverness, N. S.

Dr. W. J. Egan and family of Sydney, were recently on a holiday trip in Halifax.

Dr. and Mrs. J. H. L. Simpson of Springhill were also recent visitors to Halifax on a short pleasure trip.

The wedding took place at Inverness on June 20th, of Miss Georgina Evelyn, daughter of Mr. and Mrs. J. B. Henderson, and Dr. Eric Boyd, Dal. '40, son of Mr. and Mrs. Hedley Howell of Carbonear, Newfoundland. A reception was held at the home of the bride's parents. Immediately after the reception Dr. and Mrs. Howell left for a short motor trip, and on their return they will reside in Scotsburn, Pictou County, where the groom is practising medicine.

Dr. C. J. Macdonald, Dal. '37, who has been assistant superintendent at the Victoria General Hospital, Halifax, for the past three years, has entered the Royal Canadian Army Medical Corps.

Dr. A. I. Mader of Halifax attended the annual meeting of the Canadian Medical Association in Toronto in June. While in Toronto he attended the reunion of the McGill class of 1891, the fiftieth anniversary of graduation.

PICTOU LODGE

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Here, in its restful atmosphere, fanned by invigorating sea air, there is golf, tennis, sailing, canoeing on a fresh-water lagoon, and smart new facilities for surf-bathing.

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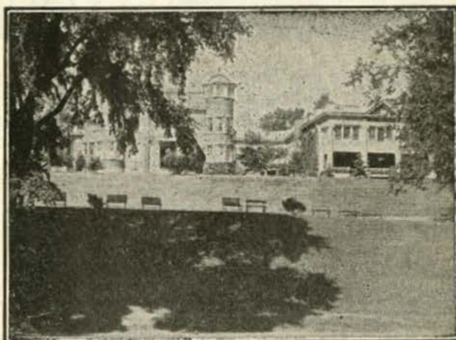

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Mild and incipient mental cases.

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Medical Superintendent

Upwards of 34% of the class of 1891 are still living. While in Toronto Dr. Mader was the guest of his daughter, Mrs. Charles Macdonald, the former Dr. Eva Mader.

New Hospital Annex is Formally Opened.

In the presence of municipal leaders and representative guests the formal opening of the $264,000.00 annex to the Cape Breton County Hospital took place at Sydney River on June 26th. The annex is constructed along modern lines and is one of the finest equipped institutions of its kind in the Maritimes. Instrumental in bringing about its erection were members of the Cape Breton Joint Expenditure Board and the County Hospital Commission.

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Suction and Ether Administrating Machine.

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THIS YEAR—as every year, February and March will see pneumonia at its worst.

But this year, people who fall victim to pneumonia and act promptly, will have a better chance than ever before of coming through it safely.

In fact, if *you* should happen to be one of the unlucky 400,000 your chances for recovery may be as much as *fifty per cent* better than in previous years—*if* you will summon your doctor at once.

There are many types of pneumococci, each of which can cause pneumonia. But research men have made exact diagnosis easier and quicker. They have developed more and better serums and very valuable new drugs; and they have greatly improved the methods of using oxygen.

But all these newest blessings of medical science are useless unless you do *one thing*—call your doctor in time to take advantage of them.

So—if you, or any of your household, have a chill, a pain in the chest, labored breathing, or a cold with fever—don't ignore it. Don't try to be an amateur doctor. This is no time to experiment, or hope "it will be gone tomorrow."

Pneumonia acts fast—and so must you! True, your doctor can work wonders with pneumonia today. But the *one* thing he must have is TIME. He *must* be called promptly!

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A new "Ciba" product which exhibits, according to the dose, a sedative-antispasmodic effect of a central and peripheral nature, or acts as a mild soporific—

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Neuro-Trasentin should undoubtedly be of great value in the following conditions:—

Excitability, states of agitation,
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Climacteric disturbances, dysmenorrhoea,
Pruritus, hyperthyreosis, etc.

ISSUED:

Tablets, in bottles of 30 and 100; also in bottles of 500 for hospital use.

DOSAGE:

As a sedative and antispasmodic: 1 tablet 3 to 6 times during the day.

As a hypnotic: 2 to 3 tablets half an hour before retiring.

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Whether or not there is a baby in your family Pablum is a convenient, nutritious food to include in the vacation kit. This unique cereal can be served in an instant... almost anywhere, any time. No cooking is required. All that's needed is to add water or milk of any temperature. As a physician you will appreciate the advantage that Pablum, unlike so many camp rations which tend to be concentrated carbohydrate lacking in minerals and vitamins, supplies generous amounts of calcium, phosphorus, iron and vitamins B_1 and B_2 (riboflavin). Packed without water, Pablum is light and easy to carry, yet its iron and calcium content is far higher than that of bulky, perishable vegetables.

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