"The Spirit of Britain"

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WE live in an age of miracles. You have dealt, no doubt, with miracles of healing, of the body of man, in your deliberations here. I propose to deal with a miracle of the human spirit and shall endeavor to analyse it to get at its lessons.

We are watching today from comparative safety one of the finest exhibitions of the human spirit that history has yet revealed. Under savage and relentless attack at home, on the Atlantic, in the Near East, and in all the far reaches and waters of the earth, Britain stands, and stands firm!

Just a year ago now, with the fall of France, the greatest calamity of this century, few other countries thought that Britain could stand alone. France herself, Germany certainly, Russia, and to a large degree the United States, all underestimated British resources, the chief of which is the resource of spirit.

We have seen several spectacular displays of that spirit—the miracle of Dunkerque, the September defence of Britain against the Luftwaffe, the great Libyan campaign, the stubborn Battle of the Atlantic, the gallant attempt to defend Greece.

These are all evidences of the spirit, they constitute a weapon that it is well nigh impossible for the enemy to understand or to assess. Britain, short in arms, slow to gird herself materially, wavering in leadership early in the war, has nevertheless a "secret defence", her national character, that may well be the winning factor.

I should like to analyse some of the facets of this diamond of character. It is scarcely enough to say that the British are the bulldog breed, that Britons are stubborn, that they lose all the battles until the last one, or that they are the "champ" being met by a new challenger.

Observer after observer goes to Britain and tells us of the fact of the existence of this spirit. Wendell Wilkie perhaps has been the most influenced, and has in turn proven himself among the most influential of these observers.

Can we not, however, get a longer range point of view, get at the roots of this character, and perhaps learn something for our own benefit?

Literature is one of the finest products of the spirit of a people. Since literature reflects the quality of that spirit, is it not equally true that a people may be to a large degree the product of its own literature? I believe profoundly that such is true in the case of Britain, and that among her poets particularly we may find some clues as to the elements of her amazing character.

With that in mind, I have departed from the usual form of address to gather for you some excerpts from English literature that serve to reveal certain sides to this spirit.

1. The national character is a product of many centuries of challenge, emergency, great effort. Rapidly survey such names as Alfred, Harold, Richard I, the Black Prince, Elizabeth, Drake, Blake, Wolfe, Nelson, Wellington, Marlborough, Kitchener, Haig, Jellicoe, Beatty, Cunningham, Wavell. They illustrate defence against external aggressors.

Shakespeare says:

> This England never did, nor never shall,
> Lie at the proud foot of a conqueror,
> But when it first did help to wound itself.
> Come the three corners of the world in arms,
> And we shall shock them. Naught shall make us rue
> If England to itself do rest but true.

Emerson, three centuries later, said:

> I see her not dispirited, not weak, but well remembering that she has seen dark days before; indeed, with a kind of instinct that she sees a little better in a cloudy day, and that in the storm of battle and calamity she has a secret vigor and a pulse like a cannon.
>
> I see her in her old age, not decrepit, but young, and still daring to believe in her power of endurance and expansion.
>
> Seeing this, I say, All hail, Mother of Nations, Mother of Heroes, with strength still equal to the time; still wise to entertain and swift to execute the policy which the mind and heart of mankind require.

2. The national character involves a willingness to look Death squarely in the face. We see this time and time again. Even ordinary citizens are heroic in attitude.

Vernede, in his "Prayer for England", says:

> All that a man might ask thou hast given me, England,
> Birthright and happy childhood's long heartease,
> And love whose range is deep beyond all sounding,
> And wider than all seas;
> A heart to front the world and find God in it,
> Eyes blind enough but not too blind to see
> The lovely things behind the dross and darkness,
> And lovelier things to be;
> And friends whose loyalty time nor death shall weaken,
> And quenchless hope and laughter's golden store—
> All that a man might ask thou hast given me, England,
> Yet grant thou one thing more;
> That now when envious foes would spoil thy splendor,
> Unversed in arms, a dreamer such as I
> May in thy ranks be deemed not all unworthy,
> England, for thee, to die.

Vernede gave his life shortly afterwards.

3. There is involved a passion for the very earth of England. Any visitor in England seeing Englishmen at work or at play will realize this.

Rupert Brooke, in the poem "The Soldier", said in 1914:

If I should die, think only this of me:
That there's some corner of a foreign field
That is forever England. There shall be
In that rich earth a richer dust concealed;
A dust whom England bore, shaped, made aware,
Gave once, her flowers to love, her ways to roam,
A body of England's, breathing English air,
Washed by the rivers, blest by suns of home.

And think, this heart, all evil shed away,
A pulse in the eternal mind no less
Gives somewhere back the thoughts by England given;
Her sights and sounds; dreams happy as her day;
And laughter learnt of friends; and gentleness,
In hearts at peace, under an English heaven.

4. There is, too, a profound regard for its familiar man-created features—see London.

Wordsworth, "Upon Westminster Bridge", says:

Earth has not anything to show more fair;
Dull would he be of soul who could pass by
A sight so touching in its majesty;
This City now doth like a garment wear
The beauty of the morning; silent, bare,
Ships, towers, domes, theatres, and temples lie
Open unto the fields and to the sky;
All bright and glittering in the smokeless air.
Never did sun more beautifully steep
In his first splendor, valley, rock, or hill;
Never saw I, never felt, a calm so deep!
The river glideth at his own sweet will;
Dear God! the very houses seem asleep;
And all that mighty heart is lying still!

5. Among the most significant factors that have conditioned the spirit of Britain is the sea. She is an island state; she knows the sea; it has entered her blood. Her mariners reflect her spirit.

Campbell's "Ye Mariners of England":

Ye Mariners of England!
That guard our native seas;
Whose flag has braved, a thousand years,
The battle and the breeze!
Your glorious standard launch again
To match another foe!
And sweep through the deep,
While the stormy winds do blow;
While the battle rages loud and long
And the stormy winds do blow.

The meteor flag of England
Shall yet terrific burn;
Till danger's troubled night depart,
And the star of peace return.

Then, then, ye Ocean-warriors!
Our song and feast shall flow
To the fame of your name,
When the storm has ceased to blow;
When the fiery fight is heard no more,
And the storm has ceased to blow.

That was written 141 years ago. Can you now account for the Jervis Bay, for the Rawalpindi, for the grim labor of convoy, for the battle with the Graf Spee?

Dunkerque itself, that miracle of human courage, of dogged determination against terrific odds, would have been impossible, save for the English skill on the sea, the salt water in the veins of countless boatsmen and sailors:

Masefield, in "Sea-Fever", makes it clear:

I must go down to the seas again, to the lonely sea and the sky,
And all I ask is a tall ship and a star to steer her by;
And the wheel's kick and the wind's song and the white sail's shaking,
And a gray mist on the sea's face and a gray dawn breaking.

I must go down to the seas again, for the call of the running tide
Is a wild call and a clear call that may not be denied;
And all I ask is a windy day with the white clouds flying,
And the flung spray and the blown spume, and the sea-gulls crying.

I must go down to the seas again, to the vagrant gypsy life,
To the Gull's way and the whale's way where the wind's like a whetted knife,
And all I ask is a merry yarn from a laughing fellow-rover,
And quiet sleep and a sweet dream when the long trick's over.

6. The Englishman abroad is ever an Englishman—himself the product at home of centuries of assimilation, he is not readily assimilated abroad. Home is ever back in England.

Browning, in his "Home-thoughts from Abroad", says:

O, to be in England
Now that April's there,
And whoever wakes in England
Sees, some morning unaware,
That the lowest boughs and the brushwood sheaf
Round the elm-tree bole are in tiny leaf,
While the chaffinch sings on the orchard bough
In England—now!

Howard, in "England Her Seed is Sown About the World", strikes a note of tenderest regard for the old land:

Her seed is sown about the world. The seas
For her have pathed their waters. She is known
In swamps that steam about the burning zone,
And dreaded in the last white lands that freeze.

And she is very small and very green
And full of little lanes all dense with flowers

That wind along and lose themselves between
Mossed farms, and parks, and fields of quiet sheep.
And in the hamlets, where her stalwarts sleep,
Cow bells chime out from old elm-hidden towers.

7. There is among her people a great faith in the mission of England as a positive world-force. That is a tremendous sustaining factor in her present time of fierce trial.

Kipling stated it during the last Great War:

For all we have and are,
For all our children's fate,
Stand up and meet the war,
The Hun is at the gate.

Tho all we know depart,
The old commandments stand;
In courage keep your heart,
In strength lift up your hand.

No easy hopes or lies
Shall bring us to our goal,
But iron sacrifice
Of body, will and soul.

There's but one task for all;
For each one life to give,
Who stands if freedom fall?
Who dies if England live?

Can we catch from this an insight into that spirit that flames up when a Churchill calls it to "blood, sweat, toil and tears"?

8. Finally, there is a profound conviction that England is the best of lands, hence worthy of the utmost efforts of man in her preservation. We started with a quotation from Shakespeare, perhaps the keenest of those who have analysed her spirit. Let us conclude by a bit from his Richard II:

This royal throne of kings, this sceptred isle,
This earth of majesty, this seat of Mars,
This other Eden, demi-paradise;
This fortress built by Nature for herself
Against infection and the hand of war;
This happy breed of men, this little world,
This precious stone set in the silver sea,
Which servesit in the office of a wall,
Or as a moat defensive to a house,
Against the envy of less happier land;
This blessed plot, this earth, this realm, this England.

*Some Chronic Suppurative Conditions of the Lungs

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THIS morning I wish to discuss with you some of the more common suppurative conditions of the lungs, indicating briefly their causes, course, and treatment. The time at my disposal is short for such a comprehensive subject, and my remarks of necessity will have to be sketchy. Views expressed will be rather dogmatic, and will not be elaborated upon or discussed at any great length as would be possible in a longer paper.

There is a rather large number of rare suppurative conditions of the lung, which hardly deserve consideration at a meeting such as this. These will be passed over and my remarks will be confined largely to the two large and common groups; namely, Bronchiectasis, and Lung Abscess, and illustrative cases shown.

Bronchiectasis, as you know, is a diseased condition of the bronchi in which they are dilated to a very considerable degree and infected to a variable amount. This dilitation may be either cylindrical or saccular. The condition may be very simply divided into two main groups; namely, the obstructive and non-obstructive types. From the first it is important to recognize early what type the particular case falls into, as it is upon this recognition that rational therapy depends.

The obstructive type of bronchiectasis develops, as the name implies, when a bronchus is obstructed for one of many reasons. The obstruction may be complete, or incomplete. If complete, the portion of the lung supplied by the bronchus becomes atelectatic, which in turn results either in bronchiectasis or abscess. If incomplete, the walls of the bronchi become infected and are subjected to abnormal pressures resulting in dilitation.

The obstructing factor may be an aspirated foreign body, a stenosis due to old ulceration or local infection, or to growth, either benign or malignant.

The non-obstructive type is either due to congenital abnormality or preceding pulmonary infection such as a delayed resolving pneumonia, or a prolonged purulent bronchitis.

The symptoms and course are familiar to all and need no detailed reiteration at this time. As you know, these people are in a chronic state of ill health, complaining of lassitude and easy fatigueability. They have a chronic cough most troublesome in the morning, which is often of the emetic type. The sputum is copious, and purulent, and very frequently, foul, thus being extremely disagreeable both to the patient and his associates. Repeated pulmonary infections, most frequently diagnosed as pneumonias, are the rule, and following each infection, the condition progresses, permanently, to a more advanced state.

A detailed and carefully planned investigation, at an early date, is most important in these cases as it is upon this that rational treatment must be

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based. In particular in the obstructive type, the obstructing cause must be accurately determined and quickly removed, if possible. By so doing many serious operations can be avoided. We are frequently asked to do lipiodol investigations in cases suspected of having bronchiectasis. These investigations, of course, are carried out and an opinion expressed, but for some reason or other, once a diagnosis of bronchiectasis and not tuberculosis is given, this is the last we see or hear of many of them. The investigation is left incomplete and, I suppose, the case is untreated.

The first important procedure in investigation is bronchoscopy, and is only of value and safe when done by a competent bronchoscopist. We are fortunate in that we have several such men in the province and there is no reason why such procedure should not be carried out. Lipiodol investigation should be done *after* bronchoscopy.

In regard to treatment, the cause must be determined and attacked. If a foreign body has been inhaled and lodged in a bronchus, early bronchoscopic removal is indicated, followed by repeated bronchoscopic aspirations if necessary. By so doing, early cases can be improved and spared the necessity of lobectomy for cure. If stenosis exists, it should be kept open and free drainage made possible. Some benign tumors can be bronchoscopically removed. If malignant tumor is found, the bronchiectatic component is forgotten and pneumonectomy proceeded with. In the non-obstructive type, lobectomy is *the* treatment. We hear a lot about postural drainages. That is merely a pallative treatment which empties the lungs more quickly and effectively of pus than does coughing, but is not curative in cases that are advanced to any degree. It, of course, should be used previous to operation.

The technique of lobectomy and pneumonectomy will not be discussed as to do it justice more time would be required than this paper allows. There are many dangers, but once these have been recognized, safeguards against them can be taken to the extent that the operation can be considered as one of the relative safe procedures. Just a word in regard to anaesthesia in major chest surgery. Here we prefer high spinal, and since we started using it, we have used it in some three hundred cases without serious regret in a single incident. Excellent anaesthesia is obtained as high as one wishes. The cough reflex is not abolished and co-operation of the patient is maintained, with the result that contralateral spread of disease is much less frequent than we used to experience.

The second condition that I wish to briefly discuss before presenting a few cases, is that of lung abscess.

The common causes of abscess of the lung are:

1. Aspiration of infected blood or tissue in nose and throat operations.
2. Aspiration of foreign bodies, such as teeth or tooth fragments, tartar, peanuts, pins, etc.
3. Following pneumonia (rare).
4. Following post-operative atelectasis.
5. Lung wounds.
6. Carcinoma of the bronchus, lung or oesophagus.
7. Infected emboli.

The course of lung abscess is usually run in two phases. First, there is the acute stage which is followed in a matter of a few weeks by the chronic

stage. During the acute stage, the patient is extremely ill. They have a high fever and are extremely toxic. The amount of cough and sputum depends upon whether the pus is draining into a bronchus or not. When drainage exists, cough is very marked and the sputum copious, purulent and very foul. The smell of lung abscess, or lung necrosis, permeates much farther than the immediate surroundings of the patient.

The cause of the abscess, in the particular case, should be determined at the first possible moment, and this means bronchoscopy as early as it is deemed safe to carry out the procedure. Due to the acuteness of the illness, however, this may have to be postponed for several days. Cases of unsuspected foreign body and relatively early carcinoma can thereby be discovered at a date when they are most suitable for proper and complete treatment.

Once an abscess has been established in what I might term as an early chronic stage, it should be energetically treated either by bronchoscopic or surgical drainage. The reason for this is that as time goes on, the abscess is converted into a cyst, due to the fact that the bronchial epithelium grows around its walls and in such state is more difficult to cure.

The treatment depends upon three main factors. First, the condition of the patient at the time he is seen. Secondly, the causative factor, and thirdly, the location of the abscess.

During the acute stage, the patient should receive supportive and symptomatic treatment only. This very acute stage usually subsides in a matter of days as bronchial drainage becomes established. This should be followed by bronchoscopy, and foreign bodies or material removed, if found, and the abscess, or draining bronchus, aspirated. Bronchoscopic drainages may be continued if the abscess is centrally placed and near the hilus. The majority of these cases can thus be completely cleared up. Most post-tonsillectomic abscesses are of this type and location, and can be satisfactorily treated by the bronchoscopist, but I feel, should only be done so in close collaboration with the surgeon. When it is seen, after three or four weeks, that closure is not being effected, open surgical drainage should immediately be resorted to without further delay. The possibility of rupture into the pleura with resultant empyema should be avoided at all costs. Peripherally placed abscesses are not favorable for bronchoscopic drainage and are best treated by open surgery.

There are a relatively large number of abscess which will rupture into a bronchus and proceed to spontaneous cure. (I will show you such a case). Waiting and hoping that this will occur, however, is not a safe attitude in the majority of cases as one usually gets into more trouble than he avoids by so doing. Various complications are prone to occur during this hoping and expectant period. I feel that no more than two or three weeks should so be used, before proceeding with some surgical measure.

I will take a few moments at this time to mention a few of the important points in connection with surgical drainage, because it is not a simple operation and is one that is accompanied by many dangers. In the first place, the site of entry has to be chosen with extreme accuracy. One must come down on the lung at a point where it is adherent as drainage across a free pleural space would result in massive empyema. There is usually a spot, sometimes no larger than a 50c. piece where the lung is adherent. This must be found. If no adherent spot can be found, one must be created over the most superficial part of the abscess and the operation delayed until pleural union has taken

place. A second great danger is that of air embolus during operation. To avoid this, operating should be done with the patient in a high Trendelenburg position so that if air is sucked into the pulmonary veins, it will go to the feet and not to the brain. Incision of lung tissue should be made with a low coagulating cautery and never with a sharp instrument such as a scapel, in order that the veins may be sealed off as they are divided.

The following are a few illustrative cases, as they come to us. In some, unnecessary delay is obvious and I hope I will be forgiven for showing them:

The following are some cases in brief, exemplifying the conditions mentioned above:

1. D. S.—Age 19

Complaints: 1. Cough
2. Expectoration
3. Lassitude
4. Repeated attacks of "pneumonia"
5. Total inability to lead a normal life.

History of Present Illness: The patient states that she was quite well up until the age of 4 years, at this time she was having some tonsillar infection, and the tonsils were removed. There appeared to be no complication at the time of the operation, but one year later, she developed what was called a pneumonia on the left side. This illness was long and protracted and recovery was slow; following it she had some chronic sputum and cough. She, however, recovered to a fair extent but again developed a left pneumonic attack two years later. Recovery was again slow. There was an increase in the chronic cough and sputum. Following that she had pneumonic attacks about every two years and with each one, was very sick and recovered slowly. She had been an invalid for periods as long as a year. Her last pneumonic attack was in May 1935. This was also on the left side. She was in bed in the hospital for a period of three weeks and after coming home, had a relapse and was very sick for some weeks to follow. Following the very first attack of pneumonia, cough and sputum made itself apparent and this has been increasing with each subsequent attack of pulmonary infection. The sputum is brought up chiefly in the morning in large quantities. It is thick, and foul smelling. At the present time she is expectorating about 8 ounces daily and sometimes as much as twelve. This is brought up in spasms during the day. It settles out into the typical three-layer bronchiectatic sputum. Blood was noted in the sputum for the first time following her last flare up. At this time she was coughing up considerable old blood mixed with the sputum. Since then she has been streaking frequently. During all these years she has not run a fever, except with her acute flare-ups, and except during these periods she has maintained her appetite, strength and weight well. She, however, is completely incapacitated on account of cough and large quantity of expectoration and is always in fear of acute flare-ups.

Personal History: Had measles 16 years ago. Whooping cough, 4 years ago. Had influenza in the spring of 1933 which caused no progression in her disease. No history of scarlet fever, diptheria, or rheumatic fever. No symptoms referable to any of the systems. Menses 15/4-52/8. No pain.

Examination of Chest:

Inspection: Fairly well-developed chest, possibly slightly retracted on the left at base.

Palpation: Slightly increased respiratory movement on the right. Voval fremitus increased at left base.

Percussion Rt: Slight dulness to 3rd rib and 7th vertebral spine.

Lt: Slight dulness to 3R and 6V. S., dulness to base front and back.

Auscultation Rt: Broncho vesicular breathing, roughened to 3R and 6V. S. increased vesicular to base front and back. Numerous rhonchi over chest but these cleared on coughing, only an occasional rhonchi being constant. Vocal resonance slightly increased over apex. On coughing an occasional rale at base posteriorly and in lower axilla.

Lt: Roughened vesicular breathing at 2R and 6V. S. then breath sounds are bronchial in character, very roughened, near base an area of broncho vesicular breathing. Numerous friction rubs 3R and 7V. S. to base. Numerous rhonchi over chest, especially near base. Vocal resonance considerably increased 7 to 9V. S. On coughing numerous moist, coarse rales 3R to 6V. S. to base. Probable vomica opposite 8V. S.

LIPIDOL INVESTIGATION—Sept. 17th, 1935

Studies of the left lung following the injection of lipiodol presented the following findings: The left stem bronchus was somewhat narrowed; there were numerous sacculated areas in mid portion of chest somewhat laterally, indicative of a saccular bronchiectasis. Behind heart were several honeycomb dilations not filled with the lipiodol.

Summary: Saccular lower lobe bronchiectasis.

LIPIDOL RIGHT—Sept. 20th, 1935

Studies of the right lung following the injection of lipiodol revealed as satisfactory visualization of the right lower lobe bronchus and its branches. We can detect no evidence of dilatation or sacculation. The middle lobe bronchus and its branches were also injected and normal findings are noted.

Summary: No evidence of right-sides bronchiectasis (middle and lower lobes).

Sputum: Foul and purulent. Streptococcus and staphlococcus.

Lung found to be totally adherent.

Operation: Left lower lobe lobectomy.

Progress: Patient developed both empyema and bronchial fistula. The space became small and drainage wound closed causing expectoration of pus from the empyema through the bronchus. This required secondary drainage, and the space slowly filled. Patient is now well and married.

2. E. S.—Age 21.

Complaints: 1. Cough
2. Sputum
3. Loss of Strength
4. Lassitude

History of Present Illness: At the age of three years the patient had a left lower lobe pneumonia. At this time she was sick for several weeks and since then has really not been well and strong. After this attack of pneumonia she was left with a chronic cough and some sputum. However, this was not severe and she got along moderately well with the exception of having frequent res-

piratory infections and colds during the winter months. In the fall of 1934 she had measles which was followed soon after by scarlet fever. This was again followed in the spring of 1935 by another attack of pneumonia of the left lower lobe. At this time she was in hospital for two weeks and at home in bed for another two weeks or so. The attack cleared up very slowly. The cough was very persistent and troublesome and she brought up a great deal of sputum. Since then her condition has been a great deal worse. She has constantly coughed up sputum to the amount of about 4 ozs. daily and this has been increasing in amount of late. This has never been blood-tinged, but during the past year or so it has had a very foul odor. She catches cold very easily which accentuated the condition considerably. She has complained of lassitude and loss of strength. Her weight, however, has been maintained and her appetite is fair. Several months ago the case was investigated at the Nova Scotia Sanatorium and Lipiodol pictures were taken which showed marked bronchiectasis of the left lower lobe with no disease in the other lobe of the lung. Postural drainage has been tried but without much good effect. On May 8 of this year she was admitted to this hospital for further investigation. Pneumothorax was induced in the left side and the lung found to be completely free. This was carried on until about 70% and the lung powdered and re-expanded as a preliminary to lobectomy.

Personal History: Pneumonia at the age of three. Measles and scarlet fever in spring of 1934, whooping cough as a child, pneumonia spring of 1935. There is no history of other diseases. Patient is not subject to headaches or dizzy spells. There is no history of frequent sore throats.

Examination of Chest: Well-developed adult female chest. No deformities and no retractions. Percussion note on right shows normal resonance throughout. On the left side there is slight dullness from 3R to base and 7V. S. to base.

Auscultation on rt: Breath sounds are of normal vesicular type. No rales and no frictions made out.

Lt: On the left breathing is broncho-vesicular from 3R to base and also 7V. S. to the base.

Lipiodol X-rays: Cylindrical bronchiectasis of left lower lobe. Other lobes free of disease on both sides.

Bronchoscopy: No bronchial obstruction. Pus seen to be exuded from left lower lobe bronchus in large amounts.

Operation: Left lower lobe lobectomy.

Progress: Uneventful recovery. Developed neither bronchial fistula or empyema. Remaining lung had expanded and completely filled the space eighteen days after operation. The patient has been without symptoms of any kind since operation and now feels perfectly well.

3. G. McC.—Age 25

Complaints: 1. Cough
2. Sputum, 3 or 4 ozs. daily
3. Weakness
4. Loss of weight

History of Present Illness: Patient states that she has always had some cough as long as she can remember, but in the early days there was no sputum. For years she has contracted colds easily and states that she has had one cold after another. This was equally true for the summer as the winter. Three

years ago the cough became more marked and at this time she began to have some rather thin, watery sputum. However, the sputum was not thick, purulent, or foul at this time. This increase in sputum and cough followed a series of severe colds. At this time she states she had no weight loss and no fever. Her appetite was good and she felt well generally. On the 5th day of March 1939 she was taken with chest pains on the left side, chills, cough, and a marked rise in temperature. She was seen by her family doctor who diagnosed a left-sided lower lobe pneumonia. Sputum was at first brownish, but later became thick and purulent. At this time she was treated with dagenan which resulted in a decrease in the temperature in a few days. However, the cough and sputum continued. From March until May she was in bed at home running some slight fever, but had a marked cough and sputum which at this time was foul and amounted to from 4 to 8 ozs. daily. One day in May 1939 she had a severe coughing spell and brought up an extreme amount of sputum probably 16 or 18 ozs. At this time she became very short of breath and distressed. She was taken to the hospital and her doctor reported the presence of a large lung abscess. She stayed in the hospital for 17 days and then went home until August 1939. During this time she took postural drainages, but cough became worse and she had a great deal more purulent sputum. She lost weight and strength and her appetite became poor. She felt, however, that she was not running any marked degree of temperature. In August 1939 she was transferred to the Victoria General Hospital. Dagenan was again given without marked improvement. In the latter part of August under the advice of attending physician, pneumothorax was started which resulted eventually in a fairly good collapse of the lung. With this she improved and cough and sputum decreased. However, it was always present. The sputum was still foul and postural drainages were continued. She gained 14 lbs. in weight and returned home on Sept. 4 and stayed in bed for one month. Since then she has continued pneumothorax treatments every 11 days until seven weeks ago. During this time sputum and cough continued and it was decided to re-expand the lung to get a proper X-ray picture. This was done and the lung stuck and the space was obliterated. An attempt was made to re-establish pneumothorax at several points, but it was unsuccessful and patient was then referred here for observation and treatment. She has never had any frank hemorrhage, but has occasional streaking after a pneumothorax. She has had no fever for months, but has lost 10 lbs. in the last seven weeks.

Personal History: Patient had measles and chicken pox only as a child. There is no history of whooping cough, scarlet fever, diptheria, rheumatic fever, or typhoid. At the age of seven years she had a pneumonia. She does not know on which side this was. Her cough does not date from this illness. She had her tonsils removed at the age of nine. Again this was uncomplicated. She has had some nasal discharge for years, but other than this there is no history of sinus disease. There is no history of diseases of the other systems.

Local Condition: Chest: There is rather marked retraction of the left side and this moves to a lesser degree to the right. The percussion note shows a normal resonance throughout on the right side, both front and back. On the left, the percussion note is hyper-resonant from the apex to the 4th rib posteriorly with a marked decrease in the resonance from the 4th or 5th rib to the base. On the right, the breath sounds are of normal vesicular type, both front and back. There are no rales and no friction made out. On the left posteriorly,

the breath sounds are of broncho-vesicular type from the apex to the 6th rib, but are very distant. From the 6th rib to the base the breath sounds are of a decided bronchial type, almost blowing, and an occasional moist rale is to be heard. On coughing there are a few coarse rales. Voice transmission is decreased over the entire chest, posteriorly. The same findings are to be noted in front.

Bronchoscopy: No bronchial obstruction or stenosis. Marked purulent discharge from the left stem bronchus.

Lipiodol Investigation: Extensive and marked bronchiectasis in an atelectatic left lung involving the whole lung. Right lung normal.

Operation: Complete left pneumonectomy.

Progress: Patient made excellent recovery and developed only mild empyema but no fistula. Is now free of symptoms. No attempt has been made to close the pleural space.

4. V. B.—Age 57

Complaints: 1. Cough & Sputum
2. Loss of weight
3. Loss of strength

History of Present Illness: The patient was well until March of 1940. At that time he had an illness that he regarded as flu. This consisted of pain in the chest, cough and sputum. He did not have fever at this time. He remained in bed for a period of two weeks. Since then he has not felt well and continued to bring up a purulent foul sputum, amounting to 4 ozs. daily. He was X-rayed in May 1940, and told that he had a probable tuberculosis or unresolved pneumonia of the right upper lobe. Sputums were negative for tuberculosis. He was advised to be re-X-rayed in one month and although all symptoms increased he did not return to the Yarmouth clinic until December 1940, when it was found that the upper lobe was atelactatic and opaque. In the interval in July, he had a rather severe hemorrhage. There was a steady loss of weight. He was sent to the Victoria General Hospital and from there to Kentville.

Local Condition: Right: There is a slight decrease in the percussion resonance of the right apex. Breath sounds are of broncho-vesicular type. On coughing scattering rhonchi are heard over the entire lung, both front and back. A few friction rubs are heard at the base posteriorly. Left: There is a normal percussion resonance throughout both front and back. Breath sounds are of broncho-vesicular type, no rales and no friction made out.

Bronchoscopy: Carcinoma of the right upper lobe bronchus almost completely obstructing it, but discharging pus. Obstructive bronchiectasis behind the growth.

Operation: Upper lobe found to be a solid mass of growth and extremely adherent to all structures. It was separated with great difficulty. On exposing the mediastinum and hilar structure it was found that extensive infiltration had occurred and that no good would have been accomplished by completing the pneumonectomy, so the operation was abandoned. The patient is slowly progressing down hill.

A number of interesting cases of bronchiectasis secondary to tuberculous ulceration and stenosis could be shown but as they represent somewhat different problems from the point of view of management, they will not be dealt with here.

A few cases of lung abscess and allied conditions will be shown:

1. Mrs. E. C.—Age 43

Complaints: 1. Severe cough and foul expectoration
2. Fever
Loss of weight and strength

History of Present Illness: For the past thirteen years the patient had been subject to attacks of asthma and bronchitis. During an acute attack in November 1937, she experienced chills, pain in the chest, cough and expectoration, and an elevation of temperature to 103 degrees. For the next few weeks the patient was extremely ill, with temperature running from 101 to 103 degrees and expectorated large amounts of foul sputum. X-ray at the time showed a large lung abscess at the right base but situated near the hilus. The symptoms slowly subsided without active intervention of any kind and repeated X-rays showed the abscess to be smaller. By the latter part of December there were no symptoms, and X-ray showed complete closure of the cavity.

This case represents the spontaneous closure of an acute abscess, but it is to be noted that it is situated very close to the hilus, where good drainage after rupture is possible. This type of abscess is well treated by bronchoscopic drainage.

2. R. B.—Age 57

Complaints: 1. Cough and foul expectoration
2. Fever
3. Loss of weight and strength

History of Present Illness: In August of 1936, the patient had 20 teeth removed under a general anaesthetic. All were accounted for. Two or three weeks later noted a loss of weight and strength and appetite. He complained of an unpleasant odor and taste in the mouth. He had a cough with a daily expectoration of 6 ozs. of foul sputum. Temperature ranged around 102 degrees. X-ray showed abscess of the right upper lobe. For some reason or other bronchoscopy was not done. He continued with all symptoms until January of 1937 when the abscess was surgically drained at another hospital. This had been advised but refused at an earlier date. Following the drainage, there was general improvement, but a low-grade fever and some sputum persisted for some months. A broncho-cutaneous fistula persisted requiring the wearing of a small tube. The persistance of the fistula in this case is due, in large part, to the fact that drainage was instituted at such a late date. The cavity had a chance to epitheliaze and form a secondary cyst. Under such circumstances closure is more difficult.

3. Mr. G. R.—Age 51

Complaints: 1. Coughing
2. Expectorating
3. Coughing up blood
4. Loss of weight
5. Loss of strength

History of Present Illness: For the past five years the patient says he has had a dry cough in winter. He, however, has had no sputum during this time with the exception of an occasional small amount of mucoid material. He states he was perfectly well until approximately two years ago when he was suddenly seized with a severe pain in the epigastric region. This pain, he

stated, persisted for several days when a lump appeared in this region. The patient said it got about the size of a large orange. This was treated by short wave diathermy when it suddenly disappeared with a relief of pain. The bowel movements following this were very foul for several days and of a greenish watery constituency. Two weeks following this episode, upon getting out of bed one morning he was suddenly seized with a severe pain in the right lower chest. This was associated with some shortness of breath and coughing. However the cough was non-productive. He called a Physician who X-rayed his gall bladder which was found to be alright. Four or five days after this he coughed up a large amount of pus and blood. This had a moderately foul odor. During this time he was running a temperature of 103 to 104 which subsided following the rupture of the abscess. Following the rupture of abscess he had profuse expectoration for several days and since then has been coughing up some foul sputum but in smaller amounts. At first the blood was bright red but recently only a little old dark blood has been coughed up with pus. X-rays of chest were taken at Nova Scotia Sanatorium at this time and further investigation advised. He was treated with short wave diathermy. He gained strength and weight following this initial attack after the establishment of drainage. He felt fairly well until last November although constantly bothered with a cough and expectoration. Since then he has been going down hill. He is running a low grade fever daily. He coughed up about three or four ounces of foul sputum. The bulk of it coming up about every second day. About the first of December he had a similar attack of pain as the original with the appearance of a mass as he had in the beginning of the illness. This again disappeared spontaneously with relief of pain and again associated with very foul stools. These stools were again green and watery. Since last November he has lost forty-three lbs. in weight. He has complained of no chest pain. For the past six weeks has been feeling particularly weak and looking gray and has remained in bed since that date. He states that he had a daily rise of fever from 99 to 100. Still complains of no shortness of breath.

Repeated X-ray examination showed abscess at the right base which from the first, was suspected of being due to carcinoma of the bronchus. It was repeatedly advised that bronchoscopy be done, but he was not finally referred for complete examination and treatment until nearly two years after the onset of symptoms.

Bronchoscopy at this time revealed carcinoma of the right stem bronchus, originating near the orifice of the lower lobe bronchus, with abscess behind it.

Although the case was not a favorable one for operation, from the point of view of time element and general state of the patient, the situation was explained to him, and he decided to accept the risk.

He was prepared in the usual manner for operation and complete right pneumonectomy done. This was very difficult on account of the lung being extremely adherent. It was so adherent at the apex that it had to be separated extrapleurally. Extreme adhesions existed around the hilus, distorting the structure.

The patient did well for four days following the operation, but suddenly had a massive hemmorrhage and died. Autopsy showed that the deep silk ligature which had been used to tie the pulmonary vessels had caught the azygos vein causing a piece to slough out of it about the size of a ten-cent piece.

4. L. S.—Age 23

Complaints: 1. Cough
2. Sputum
3. Hemoptysis
4. Loss of weight
5. Loss of strength

History of Present Illness: In February of 1940 this patient was operated upon for combined tonsils and septum. This was done under general anaesthetic. She did well for several days, but following this developed some pain in the right chest, and fever. Examination of the chest at this time indicated the presence of Broncho-Pneumonia in the right lower lobe. She was discharged home. There was steady improvement in her condition and she was X-rayed on March 13/40 at the Nova Scotia Sanatorium. She remained in bed for a week or so following this and then was allowed to be up. Her cough and sputum lessened and on April 13 she was again X-rayed, which showed marked improvement. Following this she took more liberties and was out of doors. She still had some slight cough and sputum. This increased rather quickly and she began to run a fever. She lost her appetite and strength and weight. She was X-rayed again in May 1940 which showed rather marked extension over the previous films. She was again put to bed and treated with Dagenan and similar drugs. Following this there was slight improvement and on June 25 X-ray examination confirmed her clinical improvement. Symptoms persisted, however, and by August there was an increase in the amount of sputum and she had had several small haemorrhages. X-ray examination in August showed a large old consolidated area. Sputum became very purulent and foul and there were a number of rather large haemorrhages followed by streaking for several days. During this time she has run fever constantly. From that time until admission to the hospital there has been a steady progress downhill with loss in weight, strength and appetite, constant fever, and a variable amount of sputum, very foul, amounting from 1 to 6 ozs. daily.

Local Condition: *Right*: There is a normal percussion resonance throughout the upper half of the lung. At the base posteriorly the percussion note is slightly decreased. Over this area a few rales and ronchi are to be heard. *Left*: There is a normal percussion resonance. Breath sounds are vesicular. No rales or friction made out.

This patient was bronchoscoped on a number of occasions and no disease or blocking of the bronchi found. Pus was found to be coming from the right stem bronchus. Preoperative pneumothorax was given to stabilize the mediastimum. The upper lobe and part of the lower lobe were found to be free. Thinking that the disease involved both the upper and lower lobe a complete pneumonectomy was planned and as a consequence the lung was now powdered and stuck.

Operation: Lower lobe lobectomy. It was found that the disease was completely confined to the lower lobe, the middle and upper being healthy. Examination of the lung after removal showed a complete necrosis of practically the whole lower lobe. It had not broken down to form true abscess.

Following operation, negative pressure was applied and maintained with satisfactory expansion of the lung. However, a small bronchial fistula developed in the stump before the lung became completely stuck, thus allowing of some collapse and a small, mild empyema. The fistula itself closed promptly

The patient is now well and without symptoms, but there is still a small pleural space which is obliterating.

5. S. A.—Age 12

Complaints: 1. Coughing and Expectorating
2. Pulmonary haemorrhage
3. Loss of weight and strength
4. Vomiting

History of Present Illness: The patient was quite well until six years ago. In December of 1933 the patient had what was diagnosed by the family physician as influenzal pneumonia. At that time he was coughing and had expectoration, also running a high temperature. This illness lasted for two months. In February, his temperature was not subsiding and it was decided that he had a left-sided emphysema. He was transferred to Yarmouth Hospital for operation. An open thoracotomy with drainage was done. The patient remained in Hospital for some weeks. According to the history, he was discharged from the hospital with a tube still in place with instructions to report to the family doctor for dressings and further care. According to the parents the wound healed over in a period of weeks, but since that date the patient has never been in robust health. He, however, has been active and has been up and about all the time. It has been noted that he catches cold very easily and that these hang on for a long time. During these times he always has had some coughing and expectoration. There, however, has never been any discharge from the side or old operative wound. With the exception of the cough and frequent colds, he has been in moderately good health until three weeks ago. At that time he contracted what his family physician diagnosed as influenza and following it had a very severe pulmonary hemmorrhage. This bleeding was severe and lasted for three days. Since then, has had three recurrences of hemorrhage, but of a lesser amount. The coughing has increased and he has spit up rather thick foul sputum. His family physician reports that his temperature has not been elevated above 99, or between that and 100. He has lost appetite and for the past two days has been vomiting. He was X-rayed in Yarmouth Hospital where the discovery was made that there was still a large tube within the chest. The parents were not aware that this was present until chest X-ray.

Local Condition: *Right Chest*: There is a normal percussion resonance throughout both front and back. Breath sounds are harsh and of bronchial vesicular type. There is a normal transmission of voice sounds. There are no rales and no frictions to be made out. *Left Chest*: There is a normal resonance in apex to about 6R posteriorly. From here to the base there is decreased resonance. At the apex the breath sounds are harsh, broncho-vesicular, and a number of rales to be heard of a coarse type. From 6R to base the breath sounds are very distant being over 6 and 7R and are of the bronchial type. There is a decrease in voice transmission over this area. There is a small clear area directly at the base. In front, the breath sounds are broncho-vesicular with a number of rales at lower portion.

X-ray: Large abscess of the left lower lobe in the center of which a piece of rubber tubing about 3″ long is to be seen.

Operation: The abscess, which was large, was drained through the proper site, and the tube removed.

At the time of the operation while cauterizing through the lung to reach the abscess, acute air embolus developed. The patient ceased to breathe and pupils dilated widely. Due to the quick action of the anaesthesist, and an easily and quickly controlled operating table, the patient was very quickly tilted with his head very low and soon was perfectly alright.

This patient has made a complete recovery and is now perfectly well, with no symptoms whatsoever. The chest wound and fistula closed rapidly.

6. Mrs. J. P.—Age 40 years

Complaints: 1. Pain in the left chest
2. Cough
3. Sputum
4. Hemoptysis
5. Loss of weight
6. Loss of strength

History of Present Illness: About five years ago this patient complained of vaginal bleeding and foul discharge. When seen at this time she had a far-advanced carcinoma of the cervix. She was transferred to another doctor for radium treatment. She received a course of radium treatment and several of deep X-ray therapy. The growth did remarkably well and in a matter of a few months nothing more was to be seen of it. Repeated pelvic examinations have failed to reveal any recurrance. About three months ago, however, she began to complain of pain in the right chest. This became more severe and was associated with some cough and sputum and occasional streaking. X-ray examination done at this time at the Nova Scotia Sanatorium showed a dense mass situated in the mid-portion of the right lung. This was diagnosed as secondary carcinoma. During the next month she had several haemorrhages, sputum increased and became purulent. Repeated examination showed that the dense shadow had increased in size and had also broken down to form an abscess. The possibility of secondary abscess had to be considered. Later examination showed erosion of the anterior end of the 3rd rib. It was decided to admit the patient to the hospital for drainage of the abscess and diagnosis as to the cause.

Operation: The abscess was entered through an anterior approach. A portion of the carcinomatous rib was removed. The lung was adherent only under this part and was cauterized through to the abscess. The anterior wall consisted of carcinomatous tissue. The abscess was drained and a tube has been left in place. Since operation there has been no sputum or blood and only an occasional mild fever.

This case is of interest in that carcinoma of the cervix rarely metastasized to the lungs or forms abscess. The symptoms also were not those of secondary carcinoma, as secondary growths do not bleed. It was for the reason of haemorrhage that a second X-ray was taken, and when cavity was found, the diagnosis of simple abscess had to be considered.

Editor's Column

Milton, Mass., May 8th, 1941

Sir:

I have a letter dated July 18th, 1827, from "Clements, N. S.", written by Dr. Charles Jackson, brother-in-law of Ralph Waldo Emerson, to his brother. This is the Jackson who discovered ether, which Dr. Morton first used at the Mass. General Hospital. As a young man he travelled about the Province, and took over for a while the practice of a venerable Dr. Bohme in Clements (port). He has remarks on King's College, and the geology of the region, and various persons he met. The letter would print two or three pages, and should provoke a lot of comment on the practice and practitioners of those days.

I am sorry to say that he does not mention any of my Kentville ancestors. I should be glad to have the letter transcribed and sent to you for your journal. I am a brother of Dr. C. A. Webster of Yarmouth.

Yours sincerely

(Sgd.) K. G. T. Webster

To the Editor of the MEDICAL BULLETIN.

Halifax, N. S., 15th May, 1941

Mr. K. G. T. Webster
427 Hillside Street
Milton, Mass.

Dear Mr. Webster:

It is indeed very thoughtful of you to offer to have transcribed for the BULLETIN of the Medical Society of Nova Scotia so intimate and interesting a letter as that written by Dr. Charles Jackson, discoverer of ether, to his brother. The Editors are interested in publishing anything bearing upon the history of medicine in the Province, as we feel that this journal should be the repository of communications which reflect the medical and social life of their times as seen through the eyes of the physician.

Thanking you for your interest and gratefully accepting your offer, believe us to be

Yours sincerely

(Sgd.) H. W. Schwartz, M.D.
Editor-in-chief

Sir:

This letter turned up among the papers in the possession of the Ralph Waldo Emerson Association. The writer, Charles Thomas Jackson, (1805-1880) was born in Plymouth, Mass., and began his medical training under the private tutoring of Doctors James Jackson (1777-1867) and Walter

Channing. He took his M.D. at Harvard in 1829, winning the Boylston Prize with a dissertation on Paruria Mellita. Intensely interested in geology, he twice visited Nova Scotia with Francis Alger to collect and to study. An account of his trips was published in the American Journal of Science, 1828-29. He attended lectures at the Sorbonne in 1829, and travelled rather extensively abroad, making many friends there. In 1836 he gave up medicine for chemistry, and did notable research in electricity; indeed he asserted that it was he who gave Morse the idea for the electric telegraph. He likewise maintained that he was the inventor of gun-cotton, and of many substances and processes credited to others. He made a state geological survey of Maine, Massachusetts, Rhode Island and New Hampshire, and was for a time head of a survey of the mineral land of Lake Superior. In 1837 he studied chloroform; in 1837 nitrous acid; and in 1841-42 chlorine, and etherized himself. On September 30th, 1846, he suggested to the dentist, W. T. G. Morton, that he employ ether for tooth extraction, and provided him with the ether. So it was Morton who first used ether for an operation, though its effects were not then entirely unknown. Jackson always claimed the credit for it. There is no doubt that he was one of the foremost scientists of his time. So much I gather from the recent Dictionary of American Biography.

The letter throws light on the state of medicine, and on geological studies in Nova Scotia in the early eighteen hundreds. I hope that it will call forth elucidation, personal, historical and anecdotal about those days. Too little has been published about the social history of the period, and a lively account of medicine, and of the interesting—not to say extraordinary—characters who flourished then, is greatly to be desired.

I wonder who that German, Dr. Bohme, was.

(Sgd.) K. G. T. Webster

This interesting letter will be found under the Historical Section and on your behalf we thank Mr. Webster. (Editors)

Clements N. S. July 18th 1827

Dear brother,

Twice have I written to you from this place & yet I have not received any communication from you altho' you have had a good opportunity of sending a letter by Mr Alger who arrived at this place yesterday from Boston—Nevertheless I am disposed to be charitable & suppose you expected I had left this country on my return home before now & all news good or bad might be verbally communicated.

Mr Alger informs me that you called at his house in South Boston & that he told you I had gained considerably in health &c—but you sent no word or letter—I feel quite anxious to know what may be going on among my friends in Boston & Plymo & must say I was disappointed in not receiving any letters—

As to my proceedings since I wrote to you last. I have only to say—That I have been traveling slowly over the country examining its geology & collecting specimens of minerals &c in company with Francis Alger—We have just finished our survey of the North Mountains & the coast of ye Baison of Minas embracing an extent of country about 170 miles in length & about 50 wide—from Cape D'Or in Cumberland County to Long Island at ye extremity of Digby Neck—Yesterday we returned from Windsor to this place & I had made calculation for returning to Boston the last of this week as my proposed objects are accomplished—but I have been prevailed upon by many considerations to remain about 3 weeks longer in this province to make an excursion to Halifax (which I have not yet seen) & to examine ye Coal mines of Pictou—After which *If Life remain* you may soon expect to see me in Boston—My health I am sorry to say is but yet little improved the extreme irregularity of life in regard to food diet & exercise has rather worn upon my constitution, if I may so expreſs it, & the fatigue of our long & laborious excursion is little too much for any one who is not in perfect health—Mr Alger tells me that I appear in better condition than when I came into this country & *if I have* gained any *flesh* under so great fatigue I certainly must be able to hold my own when I come to rest & recruit on regular habits.—One principal reason for my not returning to Boston at present is the intolerable hot weather you must have in July would certainly prevent my studying & I have as good opportunities to gain practical knowledge in this place as I should have any where under similar circumstances—as I have become known here as a surgeon I have frequent calls for operations and those which I have Instruments to perform I generally do & have opportunities to gain that *manual dexterity* which is so very useful to a practitioner—While I am in Clements I have frequent calls for Bleeding—opening of Abſceſses &c I have had several interesting *Medical Cases* infammatory fever—producing when neglected (in two cases which I have seen) large phlegmonous abſceſses &c—white swelling of ye knee joint—Inflamatory fever (*called Cauma*) 3 cases of Meaſles—Relapse from inflammatory fever by imprudence in diet on convalescence with convulsion fits &c &c—All of which have terminated favourably or are now doing well—Old Dr Bohme (the German surgeon of whom I wrote in my last letter) gives me all ye Cases which are brought to him as he is *old half blind* & retired from practice, He has a case of old instruments & some medicines with which I manage to get along—& he is glad to get clear of ye trouble & to prevent some ignorant practitioners who are in this vicinity from getting the cases—I have always offers of payment, but as conscientously

refuse any thing saying that as I am not to settle in this place I shall not take pay—without doubt altho' apparently disinterested this management brings many to me who might otherwise go somewhere else so it is an advantage in the end in giving me opportunities for practice.

While in Windsor I visited Kings College & was treated very politely by ye Vice President Mr. Wm King, with whom I became previously acquainted at Wilmot, This College endowed by the Mother Country is a large wooden building about equal to the building Maſsachusetts at Cambridge—it contains a large & elegant library of about 10,000 volumes & a good supply of philosophical instruments—It has about 50 students all of whom are intended for ye Church—as the college was established for the support of the English Church. They hold no publick examinations & make no display of oratory on Commencement of the Terms—the Degrees are conferred only before the government of the College & with a great deal of cerimony—All the exercises are (as at Oxford England) in the Latin language—There is an Academy connected with ye College at which the boys are fitted for the College at which they reside the years for the degree of A. B. and three terms a year more for the degree of A. M. No Medical degrees are conferred by this institution—The inhabitants of Windsor are remarkably given to dreſs & the young ladies of this town are more uniformly beautiful than in any town I ever visited—I had letters of introduction to Judge Halliburton who received me and treated me with great politeneſs. He has a niece residing with him to whom I had letters from Miſs Georgiana Halliburton her sister in Boston. At Windsor I heard that you had received my letter which I sent some time since.

Oh dear how I am scribbling!—but I can't help it. I must finish all I aim to write in half an hour as Mr Watkins is then going to Anapolis with my package to send it by steam boat which goes now to St. John N. B.—I rec'd several letters when at Windsor which I promised to take to Boston but as I have altered my plans I shall put them all up together and send them to you requesting you to deliver them to Mr. Dunlap who will take care of them. Mr Van Horn* is the genti. who has the politeneſs to take this package to Boston. (* of New York.)

If my Medical friends enquire for me tell them I am here in pretty good practice & hope to arrive in Boston on the first of August in good health enough to endure our next winter's Campaign without "flinching"—I still hold the Human body to be the most interesting study of the Naturalist altho' I believe that it is neceſsary to be acquainted with the Lower Kingdom's of nature in order to be a good Physiologist. That our studies if arranged in what might be strictly call a natural manner would first make us acquainted with the Mineral Kingdom then the vegitable then the Animal, with a consideration of the manner in which changes take place in these bodies as explained by chemistry. Then having learned the relations of these bodies to each other we should finally arrive to the consideration of Intellectual & Moral relations which would naturally lead us to a *Religion* or a consideration of our connection with the World to come—

Mr George Hallet and Mr Same Billings two of the Aldermen of Boston are at this place they arrived yesterday with Mr Alger & are traveling for pleasure—they will go to Halifax with us tomorrow. There are no Stage Coaches in this country the mail bag is Carried from Anapolis to Halifax in a

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*Britain Keeps Fit

THE NATION'S HEALTH AFTER THE 'BLITZ'

MEDICAL authorities in Britain are everywhere expressing astonishment at the robust state of health shown by the inhabitants of the "island fortress". After a winter of crowding in air-raid shelters, exposure by day and night in all weathers on A.R.P. and fire-watching duties and subjection to a nervous tension unparalleled in history, not only have prophesies of epidemics and lowered vitality been confounded, but the nation's health is in many respects better than it has been for years past.

In the first place, the winter has made quite a favourable showing in regard to the general incidence of disease. A review made by the Ministry of Health reveals that cases of scarlet fever in 1940 were fewer than in any year for the last ten years, while the number of diphtheria cases was the second lowest in this period, being 6,000 below the average. As regards influenza, the peak period has now been passed, and the total number of deaths in London and the 126 great towns up to April 12 was less than half the corresponding figure for 1940 (2,336 against 4,742). Measles remained fairly constant, and whooping cough showed a slight rise. Pneumonia, like influenza, was well down on last winter. There were only ten deaths from typhoid fever in the first fourteen weeks of this year compared with eleven in the same period of 1940.

The only disease with a large increase was cerebro spinal fever (meningitis) which was more prevalent even than in the previous record year of 1915. Incidence in the services, however, was much less than a quarter of a century ago, there being one-third of the total in 1915 and only one-seventh in 1940. Moreover, the figures are steadily declining week by week—returns for the four weeks of March were 434, 400, 370 and 330—and it must be remembered that this disease never declines below a certain residum—in 1940 it was one hundred cases a week.

What are the reasons for the comparatively healthy state of the Kingdom under such trying conditions as those of last winter? For a full answer it will be necessary to await the findings of a Ministry of Health committee of epidermiologists who are making a special inquiry in the London shelters. Nevertheless, some interesting conclusions may be drawn from a brief review of events since the "blitz" opened in the autumn.

It will be recalled that in the beginning there was some agitation for deep bomb-proof shelters. The Government, however, realising the enormous technical difficulties of providing these in time for effective use, had decided before the war that the best policy was dispersal of the population. Evacuation of women and children from densely populated areas was encouraged and assisted, and for those unable to leave the big towns the local authorities provided family steel shelters, communal shelters, street surface shelters and compulsory refuges for all new buildings.

But as the "blitz" intensified many thousands of people crowded into the deep underground railway stations, warehouses, and tunnels, which were not

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* Industrial Publicity Unit: Department of Trade, London, England.

intended to be used as shelters and were not equipped to accommodate a large number of people for long periods. And as the dark days brought the rains, fog and snow of Britain's winter months, these people queued up for hours each day, sometimes from early in the forenoon, clutching bundles of bedding. When, in the late afternoon, they reached their haven, it was to be crowded together in conditions which were inevitably uncomfortable and insanitary. Everything, in fact, pointed to a plethora of epidemics such as has never been known before.

Presented with a *fait accompli*, there was, inevitably, some confusion among the various authorities, and during this period the initiative taken in particular by the Underground railway staff to improvise sanitation for the invaders of their properties showed a public spirit which has not been sufficiently praised. The Government appointed a special committee under Lord Horder, which endorsed the policy of dispersal but recommended immediate improvements in the provisions for health and comfort in all types of shelters. Many basements in large buildings were requisitioned and equipped as shelters. Bunks were provided—not only in the Underground stations and large shelters—but also in the family shelters; comprehensive sanitary arrangements introduced; ventilation and lighting improved; coal stoves installed in the surface shelters; and medical aid posts instituted in all large shelters. In January, the Ministry of Health became responsible for the interior management of shelters.

As has already been stated, there were no "shelter diseases" as such, and no outbreak in any shelter, and the community, as a whole, remained remarkably healthy. What are the conclusions to be drawn?

In an admirable survey of the situation, read before the Royal Society of Arts recently, Lord Horder has suggested, among other things, that rough and ready as some of the improvisations were, shelter conditions may in many cases have been better than those of the people's own homes.

Sir Wilson Jameson, Chief Medical Officer to the Ministry of Health, has proposed other possible factors. With children's diseases, he says, dispersal must be considered a main safeguard. It is true that measles occurs even in the most remote country districts, but it is noticeable that where children are evacuated from tenement life to housing estate conditions, the disease, though still present, becomes a school disease, whereas in tenement areas it affects children of pre-school age when the malady is most fatal.

With regard to shelter conditions, Sir Wilson Jameson points out that even there, families tend to group themselves, thus exchanging only their own family germs.

A factor which has no doubt had due weight is the policy of the Ministry of Health of providing increased health education. An advertising campaign has been instituted, consisting of the unwearying repetition of simple rules for the avoidance of infection, posters and leaflets have been distributed in the shelters and there is already evidence that these are forming good habits and eradicating bad ones. The importance of ventilation, exercise, dispersal and adequate sleep is being stressed.

An important part has also been played by the emergency Public Health Laboratories set up to meet war conditions, for these have resulted in a much earlier notification of the outbreak of disease, for example, in institutions. Doctors and nurses in the shelters have been able to diagnose infectious cases quickly and have them removed to hospital.

But there is no doubt that there are factors in the situation not directly connected with medical science. Among his other suggestions, Sir Wilson Jameson mentioned that people were not going to the cinema as frequently, nor congregating in other ways as they did in peace-time. There is no doubt that the spread of infection has been much reduced, in this way. Then, too, there are an incalculable number of office workers who have of their own accord moved to temporary quarters in the country or on the outskirts of the large towns. There they live more or less the life of the countryman, rising early to catch their trains and going to bed at a correspondingly early hour. "Digging for victory" in gardens old and new has no doubt induced health by the exercise it provides as well as by making fresh vegetables available to the household.

Lastly, there is the psychological effect of the "blitz" itself. Those who live dangerously have no time to brood over ailments, and when sudden death may fall on them at any moment there is no inducement to lie defenceless on a bed of sickness.

But whatever the reasons for Britain's excellent state of health, there is no doubt that when the full story of the war is written, this will be one of its most interesting chapters. At the present time, to a nation faced with the most critical six months of its history, it may well be a decisive factor in the situation.

Personal Interest Notes

AT the twenty-seventh annual meeting of the Provincial Association of Medical Health Officers held at the "Cornwallis Inn", Kentville, on July 8th, Dr. R. C. Zinck of Lunenburg was elected President for the coming year, and Dr. P. S. Campbell, Chief Health Officer of Nova Scotia, re-elected Secretary.

The Hon. F. R. Davis, Minister of Health, in addressing the gathering expressed his pleasure at the evidence of increased interest in public health by the Nova Scotian public. He said that the good health of the province was due in no small measure to the medical health officers of the various municipalities. He also pointed out that more trained men are going into the field each year in this way greatly strengthening the central department.

The programme followed by the Association was as follows:

"Cancer Control"—Dr. J. K. McLeod, M.H.O., Sydney.

"Immunization"—Dr. C. L. MacMillan, M.H.O., Victoria County.

"Some Aspects of a Diphtheria Outbreak"—Dr. S. Marcus, M.H.O., Lunenburg.

"Results of Schick Testing in the Halifax Area"—Dr. A. R. Morton, D.P.H., Commissioner of Health, Halifax.

"The Schick Test in Certain Groups"—Dr. J. J. MacRitchie, D.M.H.O., Halifax.

"Suggestions for the Further Control of Some Communicable Diseases"—Dr. C. A. Herbin, M.H.O., Lockeport.

"Recent Changes in Communicable Disease Regulations"—Dr. J. S. Robertson, D.P.H., D.M.H.O., Yarmouth.

"The District Nurse as an Index to Community Health"—Dr. D. K. Murray, M.H.O., Liverpool.

"The Importance of the Dick Test in the Control of Scarlet Fever"—Dr. C. J. W. Beckwith, D.P.H., D.M.H.O., Sydney.

"The Eradication of Tuberculosis"—Dr. T. W. MacLean, M.H.O., Westville.

"The Result of Tuberculin Patch Testing"—Dr. E. L. Eagles, D.PH., D.M.H.O., Windsor.

"Present Public Health Services from the Standpoint of a Country Practitioner"—Dr. G. D. Donaldson, M.H.O., Mahone Bay.

"A Recent Epidemic of Sore Throat"—Dr. G. G. G. Simms, D.P.H., D.M.H.O., Pictou.

"Typhoid and Typhoid Carriers"—Dr. E. A. Brasset, M.H.O., Clare.

"Disease Control from the Laboratory Standpoint"—Dr. D. J. Mackenzie, Director of Laboratories, Halifax.

"The Handling of Venereal Disease Contacts Reported by the Services"—Dr. J. A. Webster, M.H.O., Yarmouth.

"The Outpatient Department"—Dr. G. M. Peters, M.H.O., Glace Bay.

Dr. J. S. Munro of North Sydney attended a border cities district conference of the Rotary organization at St. Andrew's, N. B., the end of June.

Dr. T. A. Lebbetter and Dr. L. M. Morton of Yarmouth flew from Halifax to Winnipeg to attend the annual meeting of the Canadian Medical Association June 23rd to 27th.

Dr. D. B. Morris of Windsor, Dal. '37, and Dr. D. G. McCurdy of Sydney, Dal. '41, have been appointed to commissions in No. 6 Detachment, R.C.A.M.C., A.F.

Dr. and Mrs. H. L. Scammell of Halifax are enjoying a month's holiday at Northumberland Lodge, Toney River.

Dr. M. D. Morrison of Halifax spoke before the Kiwanis Club the end of June, taking as his subject "Memoirs of Princess Victoria, Empress of Germany".

Dr. O. C. Macintosh of Antigonish, Dal. '40, who has been doing post-graduate work in surgery at the Saint John General Hospital, Saint John, N. B., for the past year, has received an appointment at the Sir Frederick Banting Institute in Toronto and will continue his studies there under Professor Boyd for the next year.

Dr. Clyde S. Marshall, Dal. '24, for the past ten years a member of the Faculty of the Yale University School of Medicine, New Haven, Connecticut, has returned to Halifax to take up practice with his brother, Dr. A. M. Marshall. Dr. Marshall and family have taken up residence at 2 Lilac Street.

Dr. and Mrs. J. W. MacIntosh and family of Halifax have returned from a motor trip over the Cabot Trail.

The BULLETIN regrets to learn of the serious accident to Dr. E. P. Atkinson of Oxford which occurred on July 11th, when a car driven by a girl from Springhill jumped the sidewalk, as she had pushed the accelerator instead of the brake, and hit Dr. Atkinson. Dr. Atkinson suffered a broken bone in one leg and several cuts on his head.

Halifax City Council Vote to Increase Health Department

At a meeting of the Halifax City Council held on July 3rd the recommendations from the Health and Welfare Committee to add ten nurses to the staff and also to employ an assistant commissioner were unanimously approved. The request, however, to increase the bed accommodation at the Tuberculosis Hospital to one hundred and fifty was referred back to Committee.

Slum Clearance in Halifax Advocated by Dr. H. B. Atlee

Dr. H. B. Atlee in an address before the Rotarians on July 15th referred to the slum conditions in the City of Halifax. Dr. Atlee said there were at least two thousand homes in Halifax unfit to live in, and that it was high time something be done to eradicate these conditions. He spoke about the influence of poor housing on the health of the city and also the degrading effect on those who had to live in such places. He also referred to deplorable conditions of some of the country school houses throughout the province and said that these and the slum conditions which had been tolerated for past years were a challenge to our democracy.

Dr. Hugh R. Peel of Truro paid a recent visit to his mother, Mrs. W. S. Peel of Whittier, California, who was seriously ill. The Doctor went by train to Moncton then flew to Vancouver and again by plane to Los Angeles.

Dr. and Mrs. Lewis Morse of Lawrencetown, where Dr. Morse has been practising for two years, have gone to Montreal, where Dr. Morse has entered the Royal Victoria Hospital for advanced work in Urology. Dr. Frank Morse, who has been doing post-graduate work in the Montreal General Hospital for the past three years, is expected home shortly to begin practise in his brother's place.

The marriage took place in New Glasgow on June 28th of Dorothy Elizabeth, only daughter of Mr. and Mrs. Gerald S. Bauld, and Dr. James Alton Ross, son of Mr. and Mrs. James C. Ross of Stellarton. Dr. Ross, who graduated in May, 1941, is practising at Albert, N. B.

The wedding took place in Springhill on June 18th of Doris Cavelle, only daughter of Mr. and Mrs. William J. Pippy and Dr. Sidney Rhonddah Bennett, younger son of Rev. and Mrs. Sidney Bennett of Bonavista, Newfoundland. After the ceremony the bridal couple left by car for a trip through Quebec and Ontario.

The BULLETIN extends congratulations to Dr. and Mrs. J. M. Stewart of Halifax on the birth of a son on August 10th.

Dr. and Mrs. E. I. Glenister of Dartmouth were on a short holiday during the latter part of July.

Dr. W. A. McIntosh of the International Health Division of the Rockefeller Foundation of New York City was visiting the province the first part of August. As many of our readers will remember Dr. McIntosh made a survey of the Provincial Health Department some years ago at the request of the Minister of Health. Dr. McIntosh addressed the Committee on Health and Welfare of the City of Halifax and other members of the City Council were present by invitation.

Dr. and Mrs. Arthur Young of Dingwall are at present visiting Mrs. Young's parents in Georgia.

An interesting and pretty wedding took place on August 15th in King's College Chapel, Halifax, when Sheila Margaret, daughter of Mr. and Mrs. W. A. Winfield, became the wife of Dr. Frank W. Morse, son of Dr. and Mrs. L. R. Morse of Lawrencetown. Dr. Morse and his bride are on a motor trip in the Maritime Provinces and will later make their home in Lawrencetown. The bride is a graduate of the Halifax Ladies College and received her Bachelor of Arts degree from Dalhousie University. Until recently she has been a technician on the staff of the Montreal General Hospital. Dr. Morse is a graduate of Acadia University and Dalhousie University ('38) and interned at the Victoria General Hospital in Halifax and at the Montreal General Hospital.

Obituary

DR. MURDOCH ALEXANDER MACAULAY, one of the province's leading medical men, director of medical service in Nova Scotia and Prince Edward Island for the Department of Pensions and National Health, director of Camp Hill Hospital and a member of the Halifax Board of School Commissioners, died at Camp Hill Hospital, Halifax, on July 31st, following a heart attack, at the age of sixty-one.

Dr. Macaulay was born in Glace Bay, the son of the late Peter and Charlotte (Harold) Macaulay, and received his early education at Pictou Academy, later going on to Dalhousie University for his medical course. After graduating from the Dalhousie Medical School in 1904 he took post graduate work at Bellevue Hospital, New York, later returning to Halifax to take up private practice.

On the outbreak of the First Great War, he went overseas with the 18th contingent Medical Corps, later transferring to the Dalhousie Hospital Unit under Dr. John Stewart.

Returning from overseas, he became superintendent of the Cogswell Street Military Hospital, before going to Camp Hill and had the honour of conducting the then Prince of Wales, now the Duke of Windsor, through the hospital on his post-war visit to Halifax, and presenting the men to him. Again in 1939, when Royalty visited Halifax, the doctor had the honour of presenting his patients to their rulers when Their Majesties, the King and Queen, visited Camp Hill Hospital.

Dr. Macaulay was at one time chairman of the City Board of Health. He was appointed to the Board of School Commissioners in 1939 by the Governor-in-Council, and was a director of the Halifax Industrial school at the time of his death. He was also a member of the Halifax Curling Club.

He had been a member of St. David's Presbyterian Church ever since its inception, and took a keen interest in its work, being at one time one of the church managers.

Surviving are his wife, Juanita, and two daughters, Eileen, Mrs. Freeman L. Smith of Toronto, and Ruth, Mrs. Ralph Morton of New York; two granddaughters, Sandra Smith and Maura Morton, three sisters and three brothers.

The funeral was held from St. David's Presbyterian Church on August 2nd.

Dr. Edward Payson Atkinson of Oxford died on July 23rd at All Saints Hospital, Springhill, where he had been a patient since the accident occurred which resulted in his illness and subsequent death. Dr. Atkinson was born at Bay Verte, N. B., seventy-six years ago, the son of the late Mr. and Mrs. Christopher Atkinson. He graduated from Dalhousie Medical School in 1899, and practised his profession in Oxford for many years, going there from Northport. One daughter, Miss Helen, survives him, at home; his wife predeceased him a few months ago.

The Late Dr. M. A. Macaulay

Address given by the Rev. Dr. C. M. Kerr in St. David's Presbyterian Church, Halifax, N. S on August 2, 1941

It is the wish of his family, as well as what I feel confident would have been his own desire, that my address today about our departed friend should be quite short and simple.

Obituary notices and articles in the press have already paid tribute to the varied activities of Dr. Macaulay, to the many and valued services which he rendered to his community and country, as well as to his rich qualities of heart. Few men were more popular than he was; few have lived a fuller and more useful life. Probably it was because he gave himself so freely in public service as well as in tending the sick that he over-taxed his strength. Latterly he became aware of this, and decided to lessen the burden on his shoulders. But the decision came too late. Even so, he fulfilled that precept of Christ that "he who spends his life for others best saves it." And he attained the expressed desire of his heart that he should die in harness.

But it is more of Murray Macaulay the man that I would speak. When I came to this country about sixteen years ago, he was one of the first and greatest friends that I made. And that friendship has continued ever since. We can all recall the sparkle and raillerie of his talk, how he loved to chaff and to be chaffed in return. He was the life and soul of any company. But there was a deeper side to Dr. Macaulay's nature. He was intensely proud that his ancestors came from the Island of Skye, and he had in him many of the marks of the true highlander. His was a gallant and chivalrous nature; that of a "bonnie fechter" as well as a trusty friend, a spirit without any meanness or narrowness, and a heart that gave itself to the full in any cause which it espoused.

There was, too, in Dr. Macaulay that other mark of the highlander—a sense of mysticism and inner longing. You find this expressed in The Canadian Boat Song:

> "From the lone sheiling of the misty island
> Mountains divide us and the waste of seas;
> Yet still the blood is strong, the heart is highland,
> And we in dreams behold the Hebrides."

The same thought is expressed in the words of Scripture that "Here we are strangers and pilgrims on earth, and it is one of the major themes in Lord Tweedsmuir's last book "Sick Heart River". Now that touch of mysticism, what the Romans called "desiderium", was strong in Dr. Macaulay. Probably that is why his favourite hymn which we sang today was "Unto the hills around do I lift up my longing eyes".

It was on our fishing trips that I got to know him best. Sometimes when out in a boat on a lake, with the beauties of nature all around—and Dr. Macaulay was a great lover of nature—we would get talking about the deepest things. More than once he told me that he was not a religious man

and that he hadn't it in him. But in that he sorely misjudged himself. As it was written of another, so it might be said of him:

"What was his creed?
I do not know his creed, I only know
That here below, he walked the common road
And lifted many a load, lightened the task,
Brightened the day for other's toiling on a weary way.
. . . Perchance he never thought in terms of creed.
I only know he lived a life in need."

And now he is gone. He has left behind him a fragrant memory which will help to assuage the grief of the many who mourn his loss.

Dr. Macaulay was blessed in his wife, upon whose love and wise council he so greatly relied. To her, to the two daughters, Aileen and Ruth, and to other relatives, our hearts go out in deepest sympathy.

C. M. KERR

PHYSICIAN WANTED

26th July, 1941

The Dean
Faculty of Medicine
Dalhousie University
Halifax, N. S.
Canada.
Dear Sir:

There are several vacancies at present in the Medical Service of the Bahamas Government, and possibly graduates of your school may feel like applying for these positions.

The position is that of District Medical Officers with a salary of '450 per annum, and free passage to and from Nassau.

Vacation leave of four weeks on full pay and four weeks on half salary per annum, cumulative for three (3) years.

I would appreciate if you would have this information posted where those who might be interested will see it.

In the event of candidates being interested, their application accompanied by two recommendations should be submitted to me.

Yours sincerely
L. W. FITZMAURICE, M.D.
Acting Chief Medical Officer

TRY PABLUM ON YOUR VACATION

Vacations are too often a vacation from protective foods. For optimum benefits a vacation should furnish optimum nutrition as well as relaxation, yet actually this is the time when many persons go on a spree of refined carbohydrates. Pablum is a food that "goes good" on camping trips and at the same time supplies an abundance of calcium, phosphorus, iron and vitamins Bl (thiamine) and G (riboflavin). It can be prepared in a minute, without cooking, as a breakfast dish or used as a flour to increase the mineral and vitamin values of staple recipes. packed dry, Pablum is light to carry, requires no refrigeration. Here are some delicious, easy-to-fix Pablum dishes for vacation meals:

PABLUM BREAKFAST CROQUETTES

Beat three eggs, season with salt, and add all the Pablum the eggs will hold (about 2 cupfuls). Form into flat cakes and fry in bacon fat or other fat until brown. Serve with syrup, honey or jelly.

PABLUM SALMON CROQUETTES

Mix 1 cup salmon with 1 cup Pablum and combine with 3 beaten eggs. Season, shape into cakes, and fry until brown. Serve with ketchup.

PABLUM MEAT PATTIES

Mix 1 cup Pablum and 1½ cups meat (diced or ground ham, cooked beef or chicken), add 1 cup milk or water and a beaten egg. Season, form into patties, and fry in fat.

PABLUM MARMALADE WHIP

Mix ⅔ cup Pablum, ¼ cup marmalade, and ¼ cup water. Fold in 4 egg whites beaten until stiff and add 3 tablespoons chopped nuts.

REGISTRY OF MEDICAL TECHNOLOGISTS OF THE AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS HAS BEEN MOVED FROM DENVER TO MUNCIE

It has recently been announced that the Registry of Medical Technologists of the American Society of Clinical Pathologists has been moved from Denver, Colorado, to Muncie, Indiana. Since its organization in 1928 the Registry has been located in Denver, where its work has been carried on under the administration of its distinguished chairman, Doctor Philip Hillkowitz, and Mrs. Anna R. Scott, the registrar. The increasing burden of the office, together with a recent serious illness, prompted the resignation of Doctor Hillkowitz as chairman of the Board of Registry. His successor, who was chosen by the members of the Board to fill the vacancy, is Doctor Lall G. Montgomery, the pathologist of the Ball Memorial Hospital, of Muncie, Indiana. The Registry will be situated at the hospital.

Following the resignation of Doctor Hillkowitz, the Registry suffered a further loss in the retirement of Mrs. Scott, the registrar of the Board. Her untiring and capable services will be sadly missed by the Board as well as by her many friends among the registrants. The newly appointed registrar is Miss Carlita R. Swenson, who comes from Philadelphia, where she has been associated with the United States Pharmacopoeia.

This event in the history of the Registry is a reminder that over twelve years have passed since the first handful of registrants received their certificates from the Denver office. Since then, under the skillful and friendly guidance of Doctor Hillkowitz and Mrs. Scott and their associates on the Board of Registry, the number of registered Medical Technologists has increased to the present impressive figure of 6,856. Twice a year this total is further increased by the addition of several hundred successful candidates from the spring and fall examinations held by the Board.

A further rapidly increasing responsibility of the Board of Registry is the investigation and approval of schools for the training of Medical Technologists. The standards adopted for the approval of these schools have been raised gradually during the past twelve years and yet at the present time there are more than one hundred and fifty schools which have met all the requirements and therefore are approved for the training of student technologists. In this important work the Board of Registry has received the invaluable assistance of the Council on Medical Education and Hospitals of the American Medical Association, who have very kindly assumed the expense and responsibility of making the surveys of the various schools who make application for approval.

The great success of the work of the Registry has been due in large part to the enthusiastic support which has been given the work by pathologists, hospitals, and educational institutions throughout the country. It is the hope of the Board of Registry and the Registry staff that the change in location will in no way interrupt the success of the work.

February 10, 1941