VOL. XXI No. 1

The Nova Scotia Medical Bulletin

OFFICIAL ORGAN OF THE MEDICAL SOCIETY OF NOVA SCOTIA
CANADIAN MEDICAL ASSOCIATION NOVA SCOTIA DIVISION.

JANUARY 1942

Published on the 20th of each month and mailed to all physicians and hospitals in Nova Scotia. Advertising forms close on the last day of the preceding month. Manuscripts should be in the hands of the editors on or before the 1st of the month. Subscription Price:—$3.00 per year.

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* Narrative of the Cholera on Board the Steamship "England"

THE Steamship "England" of 3240 tons burden, one of the finest ships of the International Steamship Company's line of Liverpool, sailed from Liverpool, England, bound to New York, on the 25th. March last, with a crew, including the Master, of 122 persons, and 896 steerage and 16 saloon passengers. She proceeded to Queenstown, Ireland, where arrived on the 29th, and took on board 1 saloon and 289 steerage passengers, making in all on her departure from Queenstown 1202 passengers and 122 crew. There does not appear to have been any hesitancy or doubt at the time at receiving on board so large a number of persons, although a majority of them must have been of the lower class, and no apprehensions of disease were created thereby.

When four days out from Liverpool a death occurred, by a disease which was pronounced to be Asiatic cholera. This was kept as quiet as possible, and occasioned but little if any alarm. Severe weather was experienced on the seventh day out, and the hatches remained battened down for two nights. When reopened another case of cholera asserted itself, which proved fatal in four hours. The disease now began to spread, and the crew as well as the passengers were affected. Some of the passengers died within two hours after being seized. The alarm became general. The two doctors belonging to the steamship, McCollough and Heath, used their utmost energy and skill, in their efforts to control the disease. There were also two doctors among the saloon passengers, one of whom, Dr. Voegles, a German, nobly volunteered to assist his medical brethren, and zealously aided them during all the passage. The other gave some slight assistance, but declined more active interference. The hospital filled rapidly, and so dreadful was the mortality that it was found impossible to perform rites of burial, and as fast as the people died, they were thrown overboard. There were a German monk, whose name unfortunately is not remembered, Father Ambrose Martin, an Irish priest, and a Protestant minister, named Mr. Rowe, on board. The two former were unremiting in their attentions to the sick and afflicted, the latter would do nothing. No list has been kept of the number of deaths among the passengers but up to the time of the ships arrival in Halifax on the ninth of April, six of the crew had died, viz. 3 firemen, 2 sailors and one steward.

When the ship arrived in Halifax Harbour, there were reported 160 cases and 46 deaths, 30 patients sick and fresh cases appearing. On the 10th., Dr. Slayter, Health Officer of the port, went on board, and perceiving the desperate situation of the ship, voluntarily placed himself in quarantine. The agents at Halifax (Messrs. Cunard) also placed themselves in communication with the Government, and desired that medical assistance should be sent from the City, the Captain having stated to them that his staff were thoroughly exhausted, and also the crew, and that a boat laden with dead bodies awaiting burial, was then afloat at the stern of the ship. A gang of such people as

* Copied from the *Weekly British Colonist* Issue of Wednesday, July 4th, 1866.

could be induced by extra payment were sent that morning to dig graves, and Thrum Cap, the extreme southern point of McNabs Island, fronting the ocean, was chosen as the burial ground. At this time there were 18 dead bodies uninterred, and from 150 to 200 cases, the disease spreading rapidly. While the men were digging the pit at Thrum Cap, a coffin with a dead body floated ashore, and they buried it. Dr. Slayter reiterated the pressing request for more medical assistance, and corroborated Capt. Grace's statement that the doctors on board were worn out with fatigue and offered such other suggestions for isolating the disease and protecting the City from its ravages, as were warranted by the emergency.

On the evening of the 10th., Drs. Gossip and Garvie, who had previously volunteered their services should medical services be required on being requested proceeded to the ship accompanied by Dr. Garvie's brother, Frank Forbes Garvie, medical student, and met Dr. Slayter on board the England at 1 o'clock. On that day a few of the sick passengers had been removed to the Pyramus, receiving ship, which on application to the Admiral, had been placed at the disposal of the Authorities, and was then at the quarantine ground. The dead had accumulated so fast previously, and coffins were at first so scarce, that it had been deemed prudent to throw some of the bodies overboard, heavily weighted. It is probable that many of the dead had also been thus disposed of off the harbour, and before the Health Officer had visited the ship. When the doctors met in consultation, the circumstances were sufficiently appalling. There was one boat load of dead bodies anchored between the ship and the lighthouse, another astern of the Pyramus, and a number of the dead in coffins suspended astern of the ship. These were all cases occurring since the England had made the harbour, and at this time there were none that would bury them. Deaths were hourly taking place, and new cases making their appearance. The Doctors remained on board, and having cast lots, it fell to Dr. Gossip to take charge of the ship that night, who immediately addressed himself to the fulfilment of his duty. Dr. Garvie always ready for any act involving professional resolution, kindly offered to accompany his friend, and they two frequently went the rounds of the ship until midnight, when Dr. Garvie retired, and Dr. Gossip continued to perform his allotted service alone until 4 a.m. of the next day. The filth below is said to be indescribable. It was literally wading in human ordure and ejection, caused by the most virulent disease that has ever afflicted the human race—rank with epidemic poison and infection. The state of many of the poor people exposed to these noxious accumulations was something awful to contemplate. More than three times that night the medical officer went the rounds of the ship amidst the dead and the dying, and incessant calls for aid—and besides this periodical inspection, and attention to the sick, sanitary precautions were to be considered, and suggestions embodied for the removal of the dead and cleansing of the living, and the cleansing and purifying of this receptacle of all that was loathsome and deathly, and repulsive to the best feelings of humanity. (1) Nineteen died that night aboard the ship and several aboard the Pyramus and there were more than 100 sick. The disease was ascertained to be of the most malignant nature—many cases without any premonitory symptoms—collapse at the first stage, and death taking place sometimes in four hours from commencement of the attack. The arrival of the Doctors from the City gave those of the ship a short respite from their labours and time to procure the rest so needful to their exhausted condition.

The next day, Dr. Slayter, as directed by the Government, landed a portion of the emigrants on McNabs Island. To prevent all communication with the ship a police force was sent from the City to act by his directions, and regulations suggested for the isolation of the disease. A military guard was sent to the Island to confine the passengers to a particular locality, and to prevent all communication with them on the part of the inhabitants, or from adjacent shores. This was demanded from the unruly and demoralized character of the people, who could not be kept within bounds by persuasion, and were inclined to set the police at defiance. The necessary regulations were enforced by these means. The sick were promptly separated from those who were well, and placed on board the Pyramus, which was converted into a hospital, the apparent healthy were removed to tents ashore, and made as comfortable as circumstances would permit, and cleanliness insisted on. A small vessel was moored near the middle of the harbour to guard the approach to the quarantine station, a police boat lay a short distance from the shore, and a posse of special constables was stationed at the wharf where the stores were landed, to prevent intercourse with the encampment. The good results of these precautionary and remedial measures were soon apparent, and the disease by judicious treatment gradually and slowly yielded to the influence of pure air and immediate separation of the sick from the healthy. Up to the 13th no new cases had made their appearance on shore.

The special exemption from sickness of the saloon passengers, which seems to afford a clue to the cause of the disease, is well worth noting here, and may be of the utmost importance with reference to the sanitary precautions to be adopted by emigrant ships to prevent the generating or spreading of cholera. None of them were attacked—none of them left the ship to live on shore—and they appeared to consider themselves in comparative safety. Isolation was perfect between them and the poor people who crowded the steerage, and ventilation was pure and ample. It has been stated that similar exemption, evidently to be attributed to the same causes, occurred on board of the steamships Virginia and Peruvian, sister ships of the England, which arrived at New York with cholera on board, shortly after the England had arrived in Halifax.

As fast as tents could be procured and erected, more of the passengers were removed from the Pyramus to the encampment on the Island, which at first was made in the woods, north west of Capt. Hugonin's mansion, and adjoining an open cultivated space south, to which last Dr. Slayter's successor had them afterwards removed, with much benefit to the general health. On the mornng of the 11th. Drs. Slayter, Gossip and Garvie and Frank Garvie, took thirty dead bodies to Thrum Cap to inter them. No one would assist, so lost were the people to all proper feelings, even to those for their own safety. The disagreeable nature of this service, which nothing but absolute necessity and an imperative sense of public duty, involving the safety of the City, could have demanded from gentlemen is modestly described in the Health Officers report to the Provincial Government, as extremely arduous. Some estimate may be formed of it when it is known that the bodies had to be towed round and outside the lighthouse to Thrum Cap beach, then carried across by the doctors themselves about 200 yards to the other side, and finally deposited by them in their last resting place at Great Thrum Cap, the southern extremity of the Island, facing the ocean. The establishment of proper communication with the City, and a regular supply of everything necessary, put an end to all irregularities of this description.

There were at first a scarcity of tent accommodations for all whom it was deemed necessary to send ashore, but this was soon remedied. It led, however, to some disgraceful conduct. The weather on the night of the 11th. will long be remembered as a bitter storm, and many kind hearts in the City felt for the condition of the sick exposed to its inclemency, with no shelter save the slight covering of a canvas tent.

Amongst the emigrants themselves there was a great amount of brutal indifference. There would have been room for all under the canvas with some inconvenience, and no one supposed that it could be denied, but those who had shelter would only suffer a certain number to remain in each tent, and the strong expelled the weak without mercy. Women and children who had lost all through the cholera, all their earthly relatives, were driven forth and if any exhibited what were deemed symptoms of disease, they were immediately ejected. Human sympathy did not exist among them or those who possessed it did not dare to show it. From the exposure of that night some of the people contracted disease of which they never recovered. On this as well as on other nights, some of them still more severe, the Medical officers on duty ashore, gave up their tents to all who could crowd into them and wrapping themselves up as they could, lay down outside in the open air, and tried to sleep.

A large proportion of the passengers were Roman Catholics, German and Irish, the rest were German Lutherans. There was in fact, a sprinkling of all the German nationalities. It was, however, impossible to classify them or to ascertain from personal communication exactly where they came from, or to what religious persuasion they belonged. Even if it could have been done other duties were then of much greater urgency. Death also came so quick as to stop anything like deliberate inquiry, and to make the attempt a mockery. If the ships registry does not give such information it is not likely ever to be obtained. And yet where ships carry thousands of passengers lengthy voyages, there does appear to be a necessity for statistics of this nature, and that they should always be registered at the port of departure before the ship sails. If regulations of this kind do not exist, it is a matter which may well claim consideration on the part of enlightened governments.

Up to the 30th. April, although there had been a number of deaths on shore, no fresh cases had appeared there. It was far different in the hulk Pyramus, which had received the sick, and which at first must have been somewhat overcrowded. Fifteen died on the night of the 12th. The average mortality was 25 a day, and on the 13th. there were between 50 and 60 cases on the sick list. Several cases also of malignant typhus contracted in England, had terminated fatally. Up to this time, so incessant had been the labours of the Doctors, that they had not rest day or night, and never went to bed, or slept on an average two hours out of twenty-four. This continual occupation had its wonted effect and while walking the deck of the ship, as they sometimes did to breathe the fresh air, they would frequently turn to answer calls for assistance, which they then found existed only in their perturbed imaginations.

The Honourable Provincial Secretary, Archbishop Connolly, and the Mayor of the City visited the Quarantine station on the 14th. The Rev. Father McIsaac, of St. Mary's, had been previously sent by the Archbishop to administer to the spiritual necessities of the Irish and German catholics, and was during his stay on the Island, unremitting in the performance of his Spiritual duties. The Archbishop also sent down 3 of the Sisters of Charity, who devoted themselves to the orphans and convalescents, but were not permitted

to incur the risk of visiting the sick. They were of great assistance and materially lightened the labours of the Medical men. On the 22nd. when there were no more deaths from cholera, and no new cases, they returned from their errand of mercy to the Archbishop's residence at the North West Arm, and remained a few days and after destroying the clothes they had worn, resumed their work of Christian Charity. The Rev. Father McIsaac remained at Quarantine a week longer.

There is too much reason to apprehend, that after the first feelings of alarm and consternation on the part of the passengers, and when danger had become familiar, a hardened indifference to human misery succeeded, and some of the vilest instincts of human nature were strongly developed. In many instances the dead were plundered, and some of the dying also. It was quite impossible to prevent this. It has been stated that the dead were buried in the clothes in which they died, but it is as well to write the fact, that but little that was valuable escaped the greedy search of these ruthless survivors. Retributive justice no doubt overtook many who had thus acted towards their fellow creatures, and they suffered in their own persons the penalty of their unhallowed deeds. It was remarked that of those who were thus brutalized, none could be found to attend upon the sick, or assist in the burial of the dead, or in cleansing the ship. It might have been supposed that suffering, such as the emigrants in the England suffered, would have called forth towards each other the tenderest feelings. That nothing of the kind prevailed may be inferred, as immediately on landing them on McNabs Island, the Irish and Germans engaged in what may be termed a "free fight"—the Irish accusing the Germans of bringing the cholera on board the ship. They were separated with difficulty, and to preserve the peace it was found necessary to divide the two nationalities into an Irish town and a German town and to place them at a distance from each other. The distinction remained until the reembarkation for New York, and the results were satisfactory, if not in the extinction, at least in the postponement of the feud.

Seven deaths took place on board the Pyramus on the night of the 15th. and two on the Island. From this time the doctors may be said to have had the disease under control, and could estimate with some degree of certainty the probable further mortality. About twelve were dangerously sick on board the hulk, and four on the Island.

There is now a sadder portion to relate of this sad narrative. Dr. Garvie was attacked on Sunday, the 15th. by the disease, but was sufficiently recovered on the 16th. to go about, although weak. Frank Garvie was attacked on the 16th. on board the England. Dr. Slayter, who was ashore, and had felt unwell for a few hours previously from it, went off to the ship, and was there seized with unmistakable symptoms of cholera. Heroic to the end his last almost unconscious act was to administer remedies to Frank Garvie, who was lying near him, and whom he solicited to be careful of his health, as he felt assured that he himself would not get better. Dr. Gossip who had escaped the disease, stayed with him that night until eleven o'clock, and then left for the Pyramus, between which and the shore he was engaged until seven next morning, when he went again on board the England. Dr. Slayter experienced much pain at first, never rallied, and gradually sank, was perfectly sensible, but soon his speech became unintelligible. All proper remedies were used, and he expired at 9 a.m. on the 17th., Dr. Gossip and one of the medical men of the England standing by; and during the momentary absence of his other two friends.

The Rev. gentlemen on board, Father McIssac and Father Martin, in the true spirit of Christian philanthropy, untinctured by exclusiveness paid several visits to his bedside, and strove to cheer and sustain his spirit in its last earthly conflict.

When the melancholy tidings reach the City, along with the profound respect for the deceased, admiration for his noble conduct, and sorrow for his loss, and the bereavement which his family had sustained, it heightened the general alarm, and the most stringent precautions were deemed advisable. The dread that prevailed was curiously illustrated by some remarks of the boatman Power, who twice every day, from the arrival of the ship to the departure of the emigrants, went down to the quarantine ground, and was the medium of communication between the Island and the Agents. "I thought I had plenty of friends," said Power, "and all were anxious to hear the news before Dr. Slayter's death, but when that came to town no one would speak to me, and everybody shunned me." There were few new cases after Dr. Slayter's death, and none proved fatal. The disease was fast abating, many of the sick were out of danger, and the destroying angel had well nigh fulfilled his mission.

The body was placed in a coffin with Masonic ceremonies, and in a boat at a short distance from the ship, from which it was afterwards transferred by his three friends and associates, aided by Dr. McCollough of the ship and Signor Orsini, a passenger, to a leaden coffin sent from the City, and was then taken ashore to the foot of the hill, on the summit of which it was afterwards buried. The funeral took place on the evening of the 18th. after the England had sailed. It was with extreme difficulty that the little band, assisted by some of the working party, conveyed the corpse to the place of interment. There was no clergyman to read the burial service of his church, but they did what they could, and what the deceased himself would have wished. Dr. Slayter was a Free Mason, and almost without exception, so were those who followed him to the grave. They buried him with Masonic Honors. The grave is at the top of the hill where encampment was made, conspicuous from the harbour and visible from the City, and it is to be hoped it will ever be permitted to remain a hallowed spot, a memento of devotion, and an endearing record of the sad event. Before they left the Island his brethren had the space enclosed with a railing, and a neat headstone erected,(temporarily until honoured by some fitting monument) bearing the following inscription—

SACRED TO THE MEMORY
OF
JOHN H. SLAYTER, M.D.
HEALTH OFFICER OF THE PORT OF HALIFAX
who died of cholera
IN THE DISCHARGE OF HIS DUTY ON BOARD
STEAMSHIP "ENGLAND"
APRIL 17th. 1866
aged 38 years

ERECTED BY HIS COMRADES AND FELLOW MASONS
Chas. J. Gossip
John B. Garvie
Frank F. Garvie

On the 17th. there were two deaths on the Island and fourteen sick—two dangerously. There were no deaths on board the hulk, but fourteen lay sick-

two dangerously. A commission was sent to Dr. Gossip, who was the senior physician, as Health Officer and Magistrate, in place of Dr. Slayter, and he entered upon the performance of his duties. Dr. Wickwire, residing in the City, was appointed assistant health officer and during the continuance in quarantine of the Health Officer, boarded every vessel arriving in port, as she was brought to below Meaghers Beach, and performed the other necessary duties of the office.

The purification of the England was immediately commenced and completed. The woods around the encampment were searched, and a quantity of bedding, clothing and other material belonging to the ship was burned. A Mr. Valentine, one of the saloon passngers, a wealthy merchant of Dublin, and the only cabin passenger embarked at Queenstown, was seized with a fit of apoplexy while ascending the quarter deck, fell back on the main deck and was taken up dead. He was buried on the afternoon of the 18th. just before the steamer sailed. A thorough inspection was made on that evening of all the emigrants, previous to taking them on board, and none but the perfectly healthy were permitted to embark. There were no new cases of cholera, but eight remained sick on board the Pyramus, of whom four had gangrene in their feet. Dr. Weeks of Dartmouth, on this day volunteered his services should more professional aid be required, and Dr. McLaren offered his services on board the England, should medical assistance be necessary.

The steamship England sailed on the evening of the 18th. for New York, with 875 steerage and 16 saloon passengers, and crew, including the master, of 116 persons. When the Health Officer left the ship, the passengers assembled on the deck, and expressed their satisfaction of the treatment they had received by cheering vociferously. The Medical men on the Island, and the community generally, a few days afterwards, were highly gratified by the news of her arrival at New York without a case of sickness or death having occurred during the passage.

There were on board the Pyramus—sick 7, well 4— on the Island—12 sick, well 29, dead 3. Some of the relatives of those who were sick preferred remaining with them to going on in the England. A young man Edward Holt, of respectable family in England, but who had wilfully embarked in the steamship as assistant steward, whose conduct had been excellent, volunteered to stay on the Island, and was of much assistance from this time during the whole period of the encampment.

There were still some cases of ship fever, and the disagreeable business of burying the dead continued. On the evening of the 22nd. of April there were thirteen sick on the Island, and one dying. In the Pyramus 7 sick. There had been two deaths on shore and three on the Pyramus. On the 23rd. of April, Dr. Gossip, who had previously been much exposed to the severe weather, was attacked by cholera, but recovered. This was the last new case. All the passengers were removed from the hulk to the shore on this day, preparatory to her being fumigated. The working party were engaged in carrying out the vacant tents and burning the clothing and bedding belonging to deceased passengers. The dead had all been interred. There was one death on the Island this day—but from this date to the 30th. there were no new cases and no more deaths. The Rev. Mr. McIsaac left the Island on the 29th. The Pyramus having been thoroughly cleansed and fumigated, returned to her moorings off the Dockyard. On the 30th. Catherine Howley, who had recovered from a severe attack of the cholera, but had incautiously exposed herself in the rain and got wet, died.

This was the last death and burial. The remainder of the passengers embarked on the 17th. day of May on board the steamer Louisa Moore, which had been sent by the Agents to take them away, and arrived safe and well at New York in a few days thereafter. They assembled at the encampment at the last moment, and visited the common grave of their relatives and friends, a few of them sorrowing audibly and with tears in their eyes at the afflictive dispensation which had separated them in a strange land, and refusing to be comforted. The rest of the sick, some four or five , were sent to the City Hospital; they were cases of gangrene, and amputations were necessary; they will all it is hoped, recover, but are still under treatment.

The foregoing narrative is not written merely to portray scenes of horror, or examples of devotion and self sacrifice in the cause of humanity—Let these pass for what they may be worth—Their impression probably, in a community constituted as that of Halifax is, may be small. We are hardly yet arrived at that stage of nationality when the general appreciation of heroism rises above mere selfish consideration, or when it commands its just or proper share of public admiration. We are a little people, and our ideas are somewhat contracted on all such matters. In other countries professional skill and daring command applause and gratitude. Great warriors, great statesmen, great poets, great orators, find a sure path to the pinnacle of fame, cheered on by applauding millions. Nova Scotians abroad have earned distinction by meretorious achievement, at no greater hazard than fell to the lot of those who risked their lives on board of the England or the Pyramus. Some of them contending against an open foe have fallen nobly—as Dr. Slayter fell contending against the insidious and invisible pestilence. Others live to enjoy the honours and rewards of gallant deeds, their Sovereigns approbation and the nations gratitude. We are a small people, however, and we may not presume to be generous beyond our pretentions. Our gratitude has therefore to be manifested in a smaller way, to those who placed themselves in the gap, and under God preserved this community from an infliction which may be paralleled but is not surpassed by the horrors or war, or the miseries of famine. The Legislature, recognizing their devotion, moved by the Honourable, the Provincial Secretary, voted 500 pounds to Dr. Slayter's widow, and Dr. Gossip, the senior physician at quarantine, has succeeded his respected friend as Health Officer; she and the brothers Garvie have received at the hands of the Mayor—The Corporation having a noble feeling on the subject—an acknowledgment of their meretorious services in the public presentation to each of a gold watch. What more? Will the Community in general understand, as the people of other countries do, the proper and delicate mode of proving to them that their worth is appreciated, that they are deemed to be valuable citizens; that as we have men who on emergency can be depended on, we will strive to retain them, and to make their position useful, pleasant and comfortable.

Apart from considerations such as these, there are others of a more serious import connected with the present safety. One emigrant ship has brought pestilence to our shores, and has departed, leaving sad mementos of her presence in the graves of several of our people, our respected Health Officer, and many of the passengers. The summer is opening upon us. There is cholera in France, in Germany and England, and in New York. We may expect arrivals like those of the England during the warm weather and towards the fall of the year. The first visitation of cholera in Halifax was most fatal in September and October, and there is no doubt now that it was introduced from abroad. A

relaxation of sanitary vigilance might subject us at any time to the ravages of disease. Should it again come it is to be hoped we shall be better prepared than when the England arrived in our harbour. The Government have given their attention to the establishment of a better quarantine station; and have been careful to provide for a strict inspection of all ships arriving from abroad, that is, from the neighbourhood States and from Europe and the West Indies but the avenues of approach by land ought also to be guarded. Passengers may escape from infected ships, and may visit us overland from any suspected place. One of the passengers from the England is reported to have died of cholera in Portland. A surveillance not harrassing but judicious, ought to be established at the frontier of the province. During the last summer the prevalence of diarrhoea and the modified cholera, was indicative to the Faculty that something more serious might at any time be expected to result. Iz has been proved also that our climate does not totally exempt from the deadly influence of yellow fever, and of late years the authorities have been called upon on more than one occasion, to take sanitary precautions against the spread of small-pox. There is a strong necessity laid upon us this summer, to be more than usually cautious and watchful of the introduction of epidemic of contagion. We need have no fear, however, with a strict examination by sea and land, and a continued attention to the cleansing of the City, of being subjected to a visitation the most fearful of any with which the Ruler of the Universe in these latter times has for his wise purpose thought fit to afflict the nations of the Earth.

NOTES

1. It is not intended here to cast any reflection on the Ship's officers for permitting this state of things to continue. The circumstances were evidently beyond their control. It was occasioned by the intensity of the disease, which had paralyzed all exertions and had begotten an absorbing selfishness, so that no one would help his neighbour.

2. On the 13th. Dr. Slayter, in a communication to the City, gave a short account of the labour of the previous night. He wrote: "Last night until one o'clock, Gossip, Garvie and myself, had to attend to the sick in the hulk of the ship as nurses, remove about 15 dead bodies, put some of them into coffins, and clean two decks of the ship. There are two priests on board, one Irish and the other French, and they have acted decidedly. Their presence among the flock, encouraging them, has done a great deal to check the panic—their cheerful spirit and courage is the admiration of all on board. Most distressing cases have occurred here—five poor little children were left orphans of one family, and when they clung to their dead mother and begged of her not to leave them alone, it moved the stoutest heart in the crowd. At one place you would see brothers and sisters, husbands and wives striving feebly to help each other—at another, little children lying sick with no earthly relative or friend to help them. Gossip, Garvie and F. Garvie, I believe, have not had one hour's rest since coming down."

3. The Rev. Mr. Rowe, the other minister before alluded to, was repeatedly and strongly urged to visit Dr. Slayter, and to offer his spiritual consolation, and refused.

4. A few days before this, Frank Garvie while walking in the woods was seized with premonitory symptoms of cholera, and fell. A passer by saw him and communicated the intelligence, and the Doctors hastened to the spot.

They removed him as soon as the nature of the attack would permit, and he recovered. The reaction from over excitement and incessant labour, may have something to do with these late seizures.

5. The Pilot who brought the England into the Harbour, and who, it was strongly asserted, did not go on board the ship, but followed in her wake—although there is some doubt of this fact—died of the cholera at Portugese Cove, where he resided. Several members of his family took the disease also, and two of his children died from its effect.

6. Some of the passengers, not more than ten, with the connivance it is supposed, of a resident on McNabs Island, escaped from the ship, the day after she arrived.

*Medical Economics

DR. S. CAMERON MACEWEN

THE Members of the British Columbia Medical Association have been informed through the courtesy of the BULLETIN and by the Executive-Secretary of the Council of the College, as to the operations and services of the Medical Services Association.

Previous to your last meeting, the plan was under consideration and a great deal of work was done by the Committee on Economics of the Council, to try and bring into operation a plan which would be acceptable to the doctors of the province. The present set-up was approved at your last Annual Meeting and your plan became effective on November 1st, 1940. Details have been incorporated into a booklet which has been widely circularized, and each doctor has had a chance to study it at his leisure. I might mention a few outstanding principles:

1. CORPORATE STRUCTURE

The M-S-A is incorporated under the "Societies Act" and brings together along industrial lines those interested in medical care by prepayment—employees, employers and doctors. There are three classes of members—employee members, employer members and professional members. The employee members elect two directors, employer members and professional members each elect one director. This representative board of directors is elected by the membership at large and serves without pay. The M-S-A is a non-profit service organization and all dues collected are used or held for providing services to its beneficiary members and their dependents. No more than 10 per cent of the dues may be used for administrative expenses.

2. SERVICES

Medical and surgical care include services rendered by any doctor of medicine in the Province in the home, the doctor's office or the hospital, consultations, special medical services, such as X-ray, diagnostic aids, and laboratory examinations and the services of specialists. $35.00 is paid the doctor for obstetrical services when the mother has been enrolled for 10 months, including pre-natal, confinement and post-natal care.

3. REPORTS

A fundamental principle adhered to in the development of the M-S-A has been that the paper-work to be required of physicians should be kept at a minimum. There are only two reports for the doctors:

(a) *Physician's First Report*—which is the statement to be sent by the doctor notifying the M-S-A that a subscriber has requested services. This report should be sent immediately on the day that the doctor's services are first requested. Authorization for expensive procedures including major surgery is required and provision is made in this report for such requests from the office of the Association or the Director of Medical Services or in the case of districts outside the lower mainland from the following Assistant Medical Directors, who have all agreed to serve, at least for the present, without remuneration:

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*Address by Dr. S. Cameron MacEwen, at the Session on Medical Economics, Annual Meeting of the B. C. Medical Association, September 16-18, 1941.

Reprinted from *The Bulletin of the Vancouver Medical Association, October, 1941.*

Dr. J. S. Daly, West Kootenay; Dr. C. H. Hankinson, Prince Rupert; Dr. W. J. Knox, Kelowna; Dr. E. J. Lyon, Prince George (Central Interior); Dr. Thomas McPherson, Victoria; Dr. T. J Sullivan, East Kootenay; Dr. Gordon James, Britannia Beach.

(b) *Doctor's Final Report and Account*—which is the itemized bill for services rendered and should be sent on completion of the case.

4. Payment to Doctors

Payments are made to the doctors, not to the subscriber, and are at the rate of 75 per cent of the Schedule of Minimum Fees of the College of Physicians and Surgeons.

For the period of operation the estimates of cost have been adequate to discharge the obligations of the M-S-A for medical, surgical and hospital care and to set aside a reserve for contingencies of 12 per cent of the dues.

The Fee-For-Service method of payment has not occasioned any difficulty and our experience shows that it can be controlled. However, our experience has been too short to warrant any definite conclusions.

Continuity of the plan is assured. In a plan of this kind it is necessary that the members have assurance that contracts will be fulfilled. This plan has that assurance in that the plan is underwritten by the medical profession of British Columbia. Thus, the subscribers are protected and we have no reason to regret our undertaking. In fact, we are accumlating very valuable experience which may be of great help to us in the future.

5. Professional Membership

Practically all doctors in active practice in British Columbia have signed applications for professional membership. At this date 540 doctors have become professional members. We urge the few remaining doctors who have overlooked sending in their applications to do so. Doctors will readily understand that each employee inquires immediately whether the service of his or her doctor would be available. It is necessary to publish for the information of prospective members a list of doctors who have signified their willingness to provide services under the M-S-A.

6. Growth

The growth of the M-S-A has not been rapid but in comparison with similar plans in other places, we have made good progress. M-S-A's 600* subscribers compares with the 600 which was the enrolment of the Associated Medical Service Incorporated of Toronto for six months. This plan after three and a half years of operation now has 24,000 subscribers, and we understand that it is growing at the rate of 800 a month. The California Physicians' Service and the Michigan Medical Service have had similar experience. The latest information we have is that the enrolment is 23,000 and 197,000 respectively. (There are 190,000 subscribers in the surgical plan, and approximately 7,000 subscribers in the complete medical and surgical plan in Michigan.)

Experience has shown that with a new development of this kind, progress is slow at the start but after a fair number of groups have been enrolled the plans gather momentum. The known value of a plan and the "mouth to mouth" recommendation of its participating members increase the volume. We find that the best prospects are those who have talked to an employee or employer member or their own doctor.

*Now increased to 900 subscribers.

Our growth has been very similar to the physician establishing his practice. We have grown rapidly enough to warrant our continuance, and like the young physician, we have had ample opportunity to deal very thoroughly with a number of problems, many of which are new to us and require careful handling. Such gradual growth is always more stable than a mushroom process and in the end will result in a solid structure. The plan is gradually being extended to the whole Province.

7. The Future

The increased payroll deductions and higher living costs leave little for the payment of medical care and may result in the neglect of health. On the other hand, during and after a war, a greater interest is taken in health matters and it is well that we have a means provided whereby our services are placed within the reach of those who are in need of them.

There is no doubt that our plan requires an employer contribution, because generally employees cannot be induced to pay more than $2.00 a month for family care. Since we entered the field of payroll deduction, in addition to deductions from wages for *Workmen's Compensation, Group Life, Group Sickness and Accident, Community Chest* and in some cases *Pension Plans*, there have been *War Savings, War Services, National Defence Tax of 5 and 7 per cent* and *Unemployment Insurance* deductions. With the strained labour situation, each employer has his own problems, yet there is a definite interest in employee welfare plans. The employers realize that while Unemployment Insurance, pensions and group insurance fill a need, the disaster of disabling sickness still finds the wage-earner unprepared. The fear of ill-health and worry over doctors' and hospital bills impair efficiency.

Most imployers are receptive but we have not overcome the feeling of high cost that is abroad. Comparisons are made with contract practice and plans with salaried doctors. While the difference in services is appreciated, the spread in costs is too much to overcome. *Many of these contracts and appointments are on a basis equivalent to poor relief costs and are an embarrassment.* It is futile to attempt to replace these contracts while they are in existence.

Meanwhile, it has been suggested that leadership in the promotion of the M-S-A should come from the family doctor. People are greatly influenced by what their doctor tells them. I feel that the doctor does a favor to his employer friend when he brings this plan to his attention. Healthy employees are more efficient employees and while it is difficult to demonstrate this advantage in dollars and cents, we all know it to be a fact.

In any group plan the responsibility for selection of the plan must be assumed by those in a position to do so and since our plan requires the employer to pay part of the contribution, it is necessary that the employers be thoroughly sold on the advantages of preventive services. It is the experience of the life insurance companies that when the employer is sold on a group plan, contributes part of the cost and recommends the plan to his employees, 75 per cent of the selling job is accomplished. No one is in a better position than the employer's family doctor to recommend and point out to him the advantages of a comprehensive medical service.

8. Limited Service

It has been suggested, from time to time, that we recommend services be cut, or in other words, that we offer partial benefits for a price that employees

think they can afford. Any such partial service would have to be capable of a clear definition. The only service that fills this requirement is one which would start with "cutting" or surgical care only. There is no doubt that it would be popular for the following reasons:

(a) The total subscription rate might be about half the cost of medical and surgical care, and even when hospital benefits are added, would be low.

(b) Surgical benefits are spectacular and appeal to the imagination.

(c) Surgical bills are always relatively large, and subscribers tend to think of the large fees charged for abdominal surgical cases.

(d) Insurance company activity has popularized the surgical benefit in hospitalization expense policies.

(e) Surgical cases involve hospitalization and absence from gainful employment; consequently are always catastrophic from the ecomonic point of view.

Insurance companies offer this type of care with hospital group plans to employers with 50 or more employees and if we offered a surgical plan we would be in direct competition with them. The Calfornia Physicians' Service is now offering a Surgical Plan and the Michigan Medical Service has enrolled most of its subscribers under this type of plan. While experience elsewhere has shown that a Surgical Plan is necessary, if the general subscribing public is to be interested, we have not felt justified at this time in recommending a Surgical plan for the sake of gaining members.

9. Hospital Service Plan

The M-S-A has been approached by the Provincial Inspector of Hospitals, who is carrying on negotiations with the hospital representatives and group plans with a view of co-ordinating existing plans for hospital care, and possibly provide a means whereby further interested groups may obtain the benefits of prepaid hospital care. Some of the suscribers to the M-S-A desire hospital care and as the M-S-A has been the only means by which they can obtain it on a group basis, hospital care to a certain extent has been added to medical and surgical care. It has always been the policy of the M-S-A not to offer hospital care in areas where hospital service plans are in operation, and that when an acceptable agency is set up, it would withdraw from hospital care and would co-operate with the hospital organization insofar as it may be permitted to do so.

The proposal is tentative and will not include any provision for medical care. All of us will be glad to see the benefits of prepaid hospital care made available and we welcome these negotiations and trust that they may reach a speedy conclusion. Pending any formal arrangements being made, the M-S-A contracts with suscribers must of course continue without change.

10. Financial Assistance

Apart from the 10 per cent for administration expense and registration fees, organization expense has been met from advances. As the plan grows this organization expense will be liquidated as is customary from registration fees. These advances are authorized by the Council of the College. The expense has been kept at a minimum.

11. Other Medical Service Plans

The other Associations operating approved plans similar to the Medical Services Association and participating in the 25 per cent discount are:

B. C. Telephone Employees' Sick Benefit Association.
B. C. Electric Railway Company Office Employees' Medical Aid Society.
Vancouver School Teachers' Medical Services Association.

These Associations continue to enjoy the confidence placed in them under which they undertake to pay the doctor directly and under which all doctors are included.

Other Associations are and may attempt to discount doctors' bills. These other plans have not been approved for various reasons. We wish to repeat our warning to all doctors not to accept any attempted discounting of accounts by such Associations. The doctor may with propriety accept the payment tendered on account and bill his patient for the balance. With these lay associations, their obligation is to their member and they are not obliged to pay the doctor under their contracts.

I hardly need remind you that approval by the Committee on Economics signifies that the Committee is satisfied that dues collected from beneficiary members are used for the purpose of paying for services and that an Association to which approval is given is not operated for profit.

SUMMARY

Out of the above, our chief problems are:

(1) *Enrolment of New Groups*

Up to the present a certain percentage of all employees must be enrolled before being admitted to the M-S-A. It is true that a great many would join if individual applications were accepted but this would involve careful examination to prevent a large percentage of poor risks and would increase the overhead in the matter of collections.

Mr. McLellan has done splendid work in enrolling the present membership, but it is impossible for him to do all that should be done.

I feel that some method should be worked out that would interest both employers and employees in the plan.

It has been proposed that the doctors be given a form which they will be asked to complete, giving the names of employers to whom they are well known, and to whom they would be willing to send a letter, the draft of which will be enclosed. The letters will be prepared for the doctor's signature, mailed and followed up by the M-S-A. The doctors obtain no personal advantage by doing this and they should have no hesitancy in informing the employer that they are paid on a scale comparable to the Workmen's Compensation Board.

(2) *Reports*

First Reports have been coming in well but it seems that the doctors get tired before the Second Report and Account is due, or possibly they do not want their money.

(3) *Authorization*

When the membership is small in numbers and therefore the receipts are not large, it is vital that expenses should be kept at a minimum. This particularly applies to the above mentioned. We cannot give a luxury service, but aim to give a complete service. In many cases the rule laid down for these services has not been observed. Often, perhaps, it has been because the doctor considered the service essential. In no case, so far, has the service been refused, chiefly, because it seemed unfair to the member and also because I felt that some doctors did not understand the implications of their thoughtlessness.

It is very easy to obtain authorization—through the office or by application to the Director of Medical Services or Assistant Directors of Medical Services, as previously listed, and I will have to insist that this rule be lived up to much more than in the past.

(4) *Lay Organizations*

Several societies and particularly some casualty companies have capitalized on our publicity. These societies offer quite a different type of service with the inference that it covers the same benefits—first visits, etc.

More than that they arbitrarily make deduction of 25 per cent on doctors' accounts.

There are only four plans to which the medical profession has agreed to accept the 25 per cent discount. These are, M-S-A, B. C. Telephone, B. C. Electric Office Workers' Association and the Vancouver School Teachers. I would particularly like suggestions as to the best means to combat this arrogant assumption of unauthorized rates. As one doctor expressed it to me, "I do not want to stick my neck out by refusing to accept their cheque for the diminished amount unless I am sure all doctors will do the same."

(5) *Statistics*

I am unable to give the time to this work that should be given. There are many things I would like to do which would increase the value of the experiment. All forms should be coded—the machinery is there— but it would take a considerable amount of time. Until the time comes when a "full time" Director of Medical Services is on the job some of these things will have to remain undone. Most of them can be attended to later but it would simplify matters if they could be done as we go along.

To the Medical Profession, I wish to extend thanks for the Co-operation it has given us, and I may say that we have had no complaints from the doctors in almost a year of operations and also not a single complaint from any insured member.

Thanks to the BULLETIN for its courtesy in publishing all the material given to the Editor, particularly to the Committee on Economics of the Council for the very considerable time given, both in the formative stages and in the frequent meetings since operations were begun. To Dr. M. W. Thomas, Executive Secretary of the College, who has acted as representative of the doctors on the Board and who has given freely of his time, and much appreciated advice. To those doctors who have made it possible to carry on by their generous subscriptions. To our very efficient office staff, Mr. A. L. McLellan and Miss Myers.

"The Congress of the American College of Surgeons"

Boston, Nov. 3, 4, 5, 6 and 7

ON November 20th ultimo, we were again favored with a visit of our good friend, Dr H. G. Grant, who presented a paper on "Health" at our regular meeting of our Western Nova Scotia Medical Society, at the Grand Hotel, Yarmouth. At the end of the meeting, he again approached us and, as usual, asked us "some material" for the MEDICAL BULLETIN. Just back from the Clinical Congress of the American College of Surgeons, we suggested our "impressions" of the Congress, and here we are.

We shall endeavor to be brief and give you this time "practical suggestions," particularly what applies to the general practitioner. But before we go into minor details, it is most fitting that we should give you our impression as to the magnitude of the Congress—and its mighty force in moulding public opinion with regard to certain problems of Health such as Cancer, Tetanus, Surgical Problems of Modern Warfare, etc. In the presence of 3000 members and guests, President Evart Graham of St. Louis made reference to the present war situation. He remarked that it was almost incredible that the Germany of 50 years ago should have degenerated into its present position of denial of the true value of intellectual enterprise, asserting that under Nazism, humanitarian principles will be ended, charity hospitals will be gone, crippled children will no longer be bothered with by the surgeon."

"Let anyone picture to himself the consequences, if this conception (as given by Berhart Rust, Nazi Minister of Education) should dominate the world. In medicine, no more humanitarian principles! Gone the Charity Hospitals! No more bother about crippled children! It's their own misfortune if the poor are sick and the children crippled. They are the weaklings. They will be counted out, as in the boxing ring."

"What of the effect of the glorification of such brutality upon the doctor himself and especially upon the surgeon? Is such a philosophy compatible with the kind of surgical practice with which you and I are familiar? Certainly not. Why carry out all the troublesome details to make an operation as safe as possible? If the patient is strong, he will recover anyway, and why worry if the weak does not survive!"

You can readily understand, dear reader, what potent influence these words exercised upon the mind of all the members of the Congress. They were strong words, refuting a philosophy which is based on uncertain ground, on a civilization which cannot endure.

Another important feature which impressed us with a certain degree of force, is the interest of all the members of the medical profession taken in scientific problems. During the week of November 3rd, Boston was a busy centre of intellectual activity. There were no great and elaborate demonstrations for golfing, for banqueting, for dancing, but a constant pour of physicians seeking professional advice and enlightenment in the hospitals and the lecture rooms. Hardly was there enough space to accommodate them all, and the one who would get up too late in the morning (and that is, after 7.30 a.m.) was

simply out of luck, for the choice of his tickets for the lecture rooms. Every day meant a big asset to the one who was there to learn, and eager to study: Hospital Clinics in the mornings at different hospitals of the city; Film Exhibitions sharply at 12 p.m. at Salle Moderne, Statler Hotel; "Panel Discussions" in the afternoon at the "Statler", and Public Meetings on general medical surgical problems in the evenings at the Copley-Plaza, the whole day's programme being executed to the letter and with the greatest courtesy to all the members of the Medical Profession.

We shall go on with a brief resume of some of the "Panel Discussions" in the next issue of the BULLETIN.

J. EMILE LEBLANC
West Pubnico

Editor's Column

THE BULLETIN has made its contribution for 1941. The Editors are glad to have been able to carry on in spite of many handicaps, the chief of which, as you have so often heard, is lack of material. The BULLETIN is published for its readers among the medical men of Nova Scotia. It can exist only by the contributions of that same group! What fires of exhortation have burned out under the glacial content of your pens without liquefying a single drop to trace your thoughts and experiences into articles for publication! The BULLETIN must have this material. Will not each one of you try to send us something in 1942!

Numerous changes have occurred in our medical world in the past year. The many good friends and colleagues in the services are greatly missed. Their withdrawal from civil practice to the more urgent needs of active service has left gaps most difficult or impossible to fill. To them all, at home or abroad we wish the best of health and good luck in 1942!

The epidemic diseases which at the start of 1941 were causing such havoc throughout the Province were finally and laboriously brought under control and the recrudesence feared for the last quarter of the year failed to materialize. Much very fine work has been done in the realm of public health. Much remains.

The threat or promise of controlled medicine, so startlingly dropped in our laps at the annual convention in Kentville gave us much cause for thought and conjecture over a period of weeks, followed by the inevitable relapse into apathy. What do *you* really think of a change in the method of medical practice? Would you accept *any*? Would you accept state medicine if administered and remunerated in fairness and justice according to your lights? Would you accept a panel, or some form of insurance such as the associated services in operation in Ontario?

Think seriously of these things and try, if you can, to make a personal decision. Discuss it at your local society meetings and try to get a decision by the group along with definite opinions as to what scheme might be successfully operated in your district. You will have to take a stand for or against this matter in the near future! Don't be democratic—be prepared!

The task of indexing all past volumnes of the BULLETIN, conceived and so relentlessly pursued by your Editor in-Chief, has, we hope, added much to the usefulness and permanence of your journal. Some idea of the magnitude of the undertaking will be conveyed to you as you turn the pages. We are very grateful indeed to Mrs. Cooke for carrying through the outline and detail of this work and trust it meets with your approval.

The BULLETIN mourns with you the loss of the many good friends called by death in the past year. Some, cut off at the threshold of their careers gave to those about them the very utmost of their talents throughout the few years alloted them. Others, a long and useful life behind them, worn perhaps and tired by the cares and labors of their years, passed on to well deserved rest and peace. We wish them back but they might say to us:

Good friend had you the gift of giving
Eternity of earthly living
Pray God my strength sufficient be
To spurn such weary boon of thee!

We share the grevious loss with their families and to them we extend our sincere sympathy.

In the world at large strife and tumult continue while confusion multiplies. The friends of yesterday are the enemies of today; the black-guards of the past are the knights in shining armour of the present; the enigmatic as unpredictable as ever. No one can see into the future and none fortell the closest turn of fate. Let us forgive the bad leadership for which we were responsible in the past and give thanks for men like Churchill and Roosevelt. Pray God they be spared for the fulfilment of their destinies.

So yet another year decants its last drop into the beaker of history. There all its strange and powerful reagents must simmer and effervesce until Time, the filterer, can clarify the liquid in the glass and give to us a formula with which to synthetize a new and better world for humankind.

May we suggest that among all your new year resolutions you adopt this one to keep inviolate:

> *Whereas* all that is material is vain and reality falls into the mists of conjecture; *whereas* truth is false, and light, revealing nothing, blinds the eyes—*be it therefore resolved* in 1942 to pursue the practice of medicine to the good of our fellow man, to that alleviation of suffering and distress than which no surer pattern has ever been evolved for good and useful living.

The Editors wish you all a Happy New Year!

J. W. R.

The Editor
THE NOVA SCOTIA MEDICAL BULLETIN
Halifax, N. S.

Dear Sir:

Health Insurance is in the air. In fact it has been hovering for so long one is reminded of that popular song, "I'm forever blowing bubbles." With the knowledge, however, that the Federal Government plans to introduce legislation at the next session of Parliament making Health Insurance compulsory through-out Canada, or at least an enabling Act allowing the Provincial Governments to do the same in their respective districts, it is most essential that the medical profession of Canada consolidate its opinion and commit itself either for or against.

With that in mind I propose to take the National Health Insurance Act of 1911, point out its strength and its weaknesses and see whether it could be applied to Canada.

Health Insurance was introduced into England in 1911 by Mr. Lloyd George. It insured workers of a small income group against the cost of medical care; it provided cash benefits during illness and convalescence as well as maternal benefits. Fundamentally it is a good thing and there is no denying it. The principle of insurance against the cost of sickness and loss of time due to illness is sound and cannot be refuted. But in all insurance schemes the

benefits must be paid for by the premiums. In England the premiums set down are nine pence a week, in our language eighteen cents a week, or nine dollars a year to provide medical care; cash benefits of fifteen shillings ($3.75) a week for twenty-six weeks, and for a benefit of half that amount for those cases taking more time for recovery. Now here perhaps I should pause and present you with a mass of statistics proving that the premiums instead of being eighteen cents a week should be 23.84 cents and so on. But I am not going to do that. With all due respect to the statisticians, and they are a most useful body, there are certain things on which we may express ourselves without going too deeply into statistical background. To us the question here in Canada, or to bring it closer home, in Nova Scotia, "Can any Government honestly promise to provide good and sufficient medical care, with cash benefits of approximately $3.75 a week for twenty-six weeks, and further with cash benefits for half that amount in a small percentage of cases, for nine dollars a year? To me the answer is obvious! The premium is too low. I shall not attempt to give the exact figure, for after all there is a certain amount of arithmetic mixed up with this question. But this statement will hold, to provide good and sufficient medical care in Canada, together with cash benefits corresponding more or less to those in England would require a premium of at least twice that at present pertaining in the Old Country.

How do the doctors fare in England? They receive nine shillings per insured person per year, and they are allowed to treat as many as twenty-five hundred individuals. How would a similar arrangement be received in Canada? Can you imagine, Mr. Editor, some of your friends, well trained general practitioners, being placed at the beck and call of the public, day and night, for two dollars a year? I have in mind the country practitioners in Nova Scotia, especially those in northern Cape Breton, or along the eastern shore of Halifax County, or in many other places equally as difficult in winter and spring. The fact that under the National Health Act of 1911 doctors are allowed to take care of twenty-five hundred patients proves that the amount paid per individual per year to the doctor is too low. It is true that some physicians work much faster than others, but no doctor can properly care for twenty-five hundred persons. Here, again, it is difficult to give an exact figure, but fifteen hundred should be about the limit—the fee should be set on that basis. The doctor has had an expensive education and many of them are on graduation in debt. He needs money for books, for equipment; he should have time for leisure, for reading and for post-graduate study, he should be enabled to save enough during the active part of his life to tide him along in the latter part when his earnings are necessarily smaller. If such a system is put into effect in Canada, the average income of doctors for taking care of fifteen hundred persons should be at least between forty-five hundred and five thousand dollars. If the incomes are set lower than this the result is easy to foresee. The medical profession will lose interest, the standard of practice will be lowered, and the Government will not accomplish the benefit of the enactment.

There are several other points in Health Insurance which could properly be discussed here, some being included in the National system while others are not.

Should cash benefits be included in a system of Health Insurance? Those who have practised amongst people of low incomes will not hesitate to subscribe to the value of a certain amount of money coming into the family during the

illness and convalescence of the bread winner. The curse of cash benefits is excessive certification by dishonest physicians. If we subscribe to the principle of cash benefits I cannot see where it makes any difference whether the system is included in one of Health Insurance or whether it is a thing apart. The difficulty would remain the same. With the appointment of medical referees approved by the Medical Societies, and with a system of finance whereby excessive payment of funds for cash benefits would make that much less for medical care, cash benefits could, I feel, be safely included in a system of Health Insurance.

In England every insured woman receives a benefit of forty shillings on the delivery of a child. When the husband and wife are both insured, the benefit is eighty shillings. This is an excellent arrangement and could well be adopted here. It is a living example of the practical English way of doing things. In Canada we are rather prone to what we call "education"—the issuing of pamphlets, talks over the radio, lectures and home visits by public health nurses. These things are all to the good, but the payment of a sum of money to a woman of the low income class who has brought forth a child, is, to my mind, a very practical supplement to our methods of combating maternal and infant mortality.

There are a few serious deficiencies in the National system. Our brothers, the dentists, are not included in the general scheme! Are we in Canada to blindly follow this? Assuredly not! True, there is now a considerable amount of dentistry carried out in connexion with the British scheme, but it is an additional thing and was not originally included. Just how many dentists are needed, how many patients each dentist should be allowed, and how much remuneration the dentist should receive, it is not my place to say. But the dentists are a part of medicine, and they are essential to the good health of our country, so if our friends in Ottawa are really going to step out and pass a law with the avowed object of improving the health of Canada—they must include the dentists.

And what of the nurses, who have also been passed over in the National scheme. I think of the many times I have attended the "graduating exercises for nurses," and of the eulogies to Florence Nightingale and those who from that time have followed her—Mr. Editor, if my memory serves me rightly you yourself have been responsible for some of those great outbursts of oratory to which I have listened. Were we sincere in our speeches? Did we really mean what we said? Does the medical profession truly feel that nursing is essential? Why, of course, it does! So this is another item the Government at Ottawa must include in the legislation!

And now perhaps I come to the most important item of the lot—the medical care of the indigent. No Health Insurance Act in force in any country includes the care of the poor. Those who defend the Health Insurance scheme of England and other European countries, that were, maintain that the poor of necessity cannot be included in a Health Insurance scheme—because the poor cannot pay the premiums. What weak logic! To think that we, the physicians of Nova Scotia, cared "a tinker's damn"—if there is such a thing —what name the scheme be given. Practically all the schemes now in force are incorrectly named. They do not insure the health of the people, for preventive measures are included in none of them. They insure against the cost of sickness, and yet most of the schemes are known as Health Insurance. So we are not going to be buffaloed by a name—the care of the indigent must

be included. I do not for a moment maintain the physician should receive the same amount per capita for taking care of the indigent, as for those who are paying the premiums, but he should receive something. We have cared for the poor from time immemorial and we have done it willingly. It is part of our job. But of late the load is becoming too heavy. Previous to the war, in many parts of Nova Scotia, it was quite common for over fifty per cent of a doctor's practice to be amongst those who could not pay. Some plan should be worked out, comparable perhaps to that now in effect in Ontario, whereby the doctor receives from forty to sixty per cent of his usual fee for taking care of the poor. This is a point we must insist on. We can rest assured that the fee set by this Government, or any other Government, will be none too generous for caring for the insured. So why should we care for the poor for nothing? It is just as reasonable that the grocer provide free food, the coal merchant fuel, or the lawyer free advice—it costs the doctor gasoline, medicine, bandages, etc., and precious time.

Just where does the specialist fit into the pattern of Health Insurance? In the National system he is not a part of the plan. The English have given the insured general practitioner service; if the specialist is needed, this must be done through the paid doctor and the patient pays an additional fee. We undoubtedly owe much to British medicine. But that is no reason why we should blindly copy their scheme of insurance. The specialist should be included in the Canadian scheme. The same type of practice as now prevails should continue. The bulk of the work must be done by well trained general practitioners, and he (the G.P.) should have the privilege of calling in the specialist when necessary.

Where does preventive medicine come into the picture? In all schemes of Health Insurance it has been left out—a thing apart—something for the public health officer to worry about, or the public health nurse, or the sanitary inspector. Of course this is all wrong. There should be no sharp line of demarcation between cure and prevention. The physician working under a scheme of Health Insurance should carry out the commonly accepted preventive measure as part of his job; prenatal care, post-natal care, care of the infant up to one year of age, vaccination against small-pox and immunization against diphtheria, and so on. He should do these things and the Government in making up the tariff should realize that he must be paid for doing them. In Newfoundland the Government, for a number of years, has been paying physicians for practising prevention, and the plan is working well. The doctors receive a fee from the Department of Health and Welfare for removing diseased tonsils, for vaccination against small-pox and for administering toxoid. In this one respect both the doctors of that country and the Government are quite satisfied.

There is only one more detail I will deal with, and that is death or funeral benefits. If the Federal Government is sincere in enacting a Health Insurance Act, it should have clearly in mind certain objectives; the protection of the health of the lower income classes, the provision of medical care, supplying the family with funds when the bread winner is ill, maternal benefits and whatever else they feel is for the welfare of the group concerned. They should also insure the family against the unexpected, and as a rule exorbitant charges incidental to death. The costs of burial, especially to the class we are talking about, are altogether too high. It is not so bad in Canada as it is in the United States where the undertaking business has developed into a racket, but it is

bad enough. It may be the fault of the people—or perhaps the morticians are to blame. That matters little. Our job is to correct it, and that can be done by including a funeral benefit in the plan. If the Act includes a stated sum paid to the family to be used for funeral expenses, the undertakers will soon get in line and do a job for the price set down. This will do away with the present Canadian spirit of "keeping up with the Jones," such as expensive caskets, just to show the neighbours that poor John has been sent into the hereafter with proper style, irrespective of his ultimate destination. The funeral benefit has worked in other countries, and it will work in Canada.

The question is asked,—Can the National system be applied to Canada? One can answer that without any doubt. The answer is no. The National system is based on the fact that in England due to industry the population is dense enough in most parts to make it possible to pay the physicians. In Canada this is not so. The National system could be applied, for instance, to many parts of Ontario and Quebec. It could be, as a matter of fact it is, in effect in the Isle of Cape Breton, but there are many parts of Canada where a system of State Medicine would have to be introduced. I am thinking now of the sparsely settled parts of our country, the northerly parts of Saskatchewan and Alberta, and many other places. This, however, would make little difference. There is no reason why the Federal Government should attempt to apply a plaster to the whole country. In Great Britain they found they were forced to adopt the system of State Medicine or subsidized medicine in the Highlands and Islands of Scotland. It has worked excellently since 1913. Some similar system could be adopted here in parts where the population could not support a physician.

I started this letter, Mr. Editor, on an aeroplane between Washington and New York. The altitude varied from four thousand feet upwards, so if parts of this discourse are rather rocky and incoherent, you will have to excuse it on the grounds of anoxaemia. And now to see if I can finish it or to see if we can get anywhere.

The Canadian Medical Association is the official body representing the doctors of Canada. It has grown in strength from year to year until to-day its membership includes a majority of the physicians of Canada. Since the beginning of the war it has been recognized by the Federal Government as the Medical Profession of Canada. It is the only body, and the proper body, to advise the physicians in Canada on the question of Health Insurance. The Canadian Medical Association has done good work in the past, but the work to be done in the next few months with the Federal Government advising them and forcing them to see the folly or wisdom of certain features of Health Insurance will be the final test of wisdom and strength on the part of the Canadian Medical Association.

The Canadian Medical Association and its several divisions should immediately:

(1) *Formally approve or disapprove the principles of Health Insurance.* I know that this has already been done, in fact I was present at the meeting of Council when it was passed, but in the meantime most of the doctors have forgotten about it. To-day I am sure that at least one half of the members of the Canadian Medical Association do not know whether they are for or against Health Insurance. So the matter should be revived immediately and action taken again.

(2) Bring before the Federal Government the details which they—the

Canadian Medical Association—know are essential. Here I refer to things as the income group to which this law shall apply, the amount the premiums should be, the amount to be paid to the physicians, the type of practice to be followed, the place of dentistry, nursing and so on.

Having done these things the Canadian Medical Association should, and I know they will, fight to the last ditch to protect the rights of their profession. For the Canadian Medical Association will be fighting to preserve these traditions, in fact for the very soul of medicine, and that, Mr. Editor, is well worth fighting for.

This last advice I know sounds unduly pugnacious, but there is very good reason for it. The medical profession of England in 1911 were against Health Insurance: in fact they were thoroughly organized and had agreed amongst themselves not to practise under it. But their backs were broken by that clever politician, Mr. Lloyd George, and they accepted it whether they liked it or not, and the experience of the medical profession in other countries has been more or less the same.

So, if the Canadian Medical Association, after having duly considered the legislation which to date has been so well guarded, finds that it is not a wise or just; finds thatperhaps that, as in other countries, the medical profession is to be exploited for the purpose of vote getting or popularity—then again I repeat they must fight, and by that I mean fight! And if we do this, Mr. Editor, what then? We shall at least have the satisfaction of knowing that as a group we have done our best. And we can hope that the Act will be slightly better than it would have been if we had sat idle and done nothing.

Sincerely yours

H. G. GRANT

Dec. 8, 1941

Dear Doctor Schwartz:

I am interested in your reprint of Dr. Thebaut's article, in the November number of the BULLETIN, copied from *The Diplomate.*

I wonder if you have altered the spelling of the name of that *Journal.* It looks peculiar to me. I agree in great part with what Dr. Thebaut has to say in this article. Most medical doctors are far too careless in their pronunciation of medical words. It is not altogether their fault The majority of practis ng physicians in Canada are graduates of Canadian and American Schools. Many of their professors, lecturers and demonstrators, probably outstanding men in their profession, are far from sound in their pronunciation. English teachers, as a rule, are much more reliable in their use of words and pronunciation. The Canadian medical practitioner is in a difficult position. Many of his words are pronounced as in the English schools, many have been learned in American clinics and colleges, while some are purely Canadian, and are not any better on that account.

All linguists know that there is a definite American school of pronunciation to-day, just as there is a definite English method. It is of no use to deplore this. The two schools must grow and expand side by side. Most of us, even those who have studied in England, will accent the first syllable in "laboratory". Just try that out on your English colleagues.

I think that your author goes quite too far. By all means let us discourage the use of obvious mispronunciations and to remember that we are members of a learned profession. But, let us try to determine what really are mispronunciations.

Here is where any reformer in this field begins to tread on dangerous ground. Gone are the days when we can be dogmatic about pronunciation. Your author is dogmatic.

Moreover, if he always uses the pronunciations he urges he might be called pedantic. Let us examine a few of his pronunciations He says that the following words, "have only one correct form:'

"An' gina". But the Oxford Dictionary gives angi' na, and no other. Webster's Collegiate gives this as first choice and so do the Century and Gould's. So far from there being only one form for "umbili cus", both Webster and Gould give "umbil' icus" first place. As for "abdo' men" both Webster and the Century give authority for the use of "ab' domen" Webster also gives "pare' sis" first place. I could give you other instances and further proof that when your author says "yet the dictionaries agree on but one correct form," he has blundered.

I think the article will do a lot of good. Let us hope that it will induce some of us to buy a good pronouncing medical dictionary such as Dorlands. And let us hope that a uniform pronunciation may be adopted in our medical schools.

Yours truly

J. A. M. Hemmeon.

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184 College Street
Toronto 2, Nov. 17
1941

TO SECRETARIES OF DIVISIONS

Dear Doctor:

Re Gasoline Rationing

Will you please accept our thanks for the prompt and helpful manner in which you responded to our appeal for statistics dealing with gasoline consumption in your province. Due to the fact that all the Divisions replied, I was enabled on November 12th to present to the Oil Control Board a statistical statement, a copy of which is enclosed.

The Oil Controller's office assured me that the information which we had tabled, would be helpful in arriving at quantities which will be allowed the iedical profession; that we would be advised in due course what those quantities will be, and when rationing will begin.

It was my impression that the Board desires to be fair to the medical profession within the limits of their ability to do so.

Yours sincerely

T. C. Routley
General Secretary

Recapitulation of Canadian Medical Profession in Respect to the Business Use of Automobiles

Total Number of Doctors Registered	10,492
Inactive, or living outside Canada	401
City and Town Doctors	6,965
Rural Doctors	3,126
Cars Driven by City and Town Doctors	6,557
Cars Driven by Rural Doctors	3,020
Total Number of Cars Driven by Canadian Doctors	9,577
Average Mileage of City and Town Doctors' Cars	13,520
Average Mileage of Rural Doctors' Cars	14,735
Average City and Town Gas Gallonage per year	866
Average Rural Gas Gallonage per year	908
Average Mileage per gallon, City and Town	15.6
Average Mileage per gallon, Rural	16.1
City and Town Cars Use in a year (6557 x 866) gallons gas	5,678,362
Rural Cars Use in a year (3020 x 908) gallons gas	2,742,160
Total Gas Consumption per year, for all Doctors' Cars, in gallons	8,420,522

Submitted by

(Sgd.) T. C. Routley
General Secretary

Dated November 12, 1941

Case Report

CASE OF DACTYLOLYSIS SPONTANEA OR AINHUM

A negro seaman, Thomas Toby, age 51, was admitted to the Halifax Infirmary on June 11, 1941, complaining of pain in the left fifth toe. A week previously, while abandoning ship, he had struck the toe and since that time he had been greatly bothered by pain walking with a marked limp.

Examination revealed a tender toe, slightly swollen, warm, and with no decreased mobility. The plantar crease was increased in depth and extended medially on to the dorsum, about three-quarters of the circumference being surrounded by this constriction. The skin at the base of the groove was moist and cracked

Inquiry into the history showed that pain in the left toe had been present over a period of five years, the onset of the pain being co-incident with the appearance of the furrow. In addition the right small toe had been amputated in 1925 for a similar condition and two other members of his family had suffered from the same malady.

Radiological examination demonstrated only some narrowing of the distal end of the proximal phalanx. The Kahn test gave a slight reaction with a positive Eagle test.

From the history and clinical findings a diagnosis of dactylolysis spontanea, or ainhum, was made and amputation recommended. This was carried out in two stages, with final amputation at the metatarpo-phalangeal joint. The convalescence was uneventful the patient being discharged walking, without pain, on July 14, 1941.

The Pathologist's report showed hyperkeratosis of the skin of the furrow, thickening of the subcutaneous tissue with simple chronic inflammatory change and osteoporosis of the underlying bone. These were in keeping with a diagnosis of dactylolysis spontanea or ainhum.

The findings of this case are in keeping with the description of Ainhum as given by Cecil.[1] Characteristically may be mentioned the negro race, the swollen painful fifth digit, the furrow at the digitoplantar fold and the familial tendency.

R. Begg (Interne)
(Service Dr. MacIntosh)
Halifax Infirmary

1. Cecil, R. L. *Textbook of Medicine*, W. B. Saunders & Co., Philadelphia, 5th Edition 1941, p. 533.

The Brain and Spinal Cord

THOMAS W. POOLE, M.D.
Lindsay, Ont.

They may talk of the brain and point with pride,
To its arching dome and its basis wied;
To its cortical cells and its ganglia deep,
And the treasures of thought its chambers keep,
To the wonders which eye and ear enthral,
But the spinal cord surpasses them all.

For the eye will close, and the brain will tire,
And our thout in its very source expire;
While the lordly brow with lowered crest,
With the downy pillow in needed rest;
But the sentinel cord its vigil keeps,
For "the spinal system never sleeps."

The brain may suffice for our waking hours,
When the mind controls its wayward powers.
'Tis by it we laugh and by it we weep;
It leaves us to die when it goes to sleep.
But the tireless cord with a ceaseless play
Is wakeful and active both night and day.

When the powers of life seem about to yield,
The brain is the first to resign the field;
But the spinal cord holds out to the last,
And it often conquers when hope is past,
Survives the weak maunderings of the brain,
And ushers us back to the world again.

Then here is a toast I would have you hail,
The spinal cord from the bulb to the tail.
You surely must honour the famous spot
Where Flourens located "the vital knot."
The cord! the cord! with its mysteries deep,
Which the pyramids guard and the ganglia keep,
The first to grow and the last to fail,
The spinal cord from the bulb to the tail.

From *The Canadian Lancet*, November, 1890, Vol. xxiii, No. 3.

Abstracts from Current Literature

A Five Year Survey of the Blood Sedimentation Test in Acute Appendicitis. Lesser, A., and Kaufman, L. R., Surg. Gynec. and Obst., 1941, 73:163.

The routine use of the blood sedimentation test has contributed to the more accurate differential diagnosis of the acute surgical abdomen, and particularly, of acute appendicitis. A consistently normal blood sedimentation rate in acute appendicitis has been corroborated in more than 90 per cent of cases in a survey by the authors covering a five year period.

A small percentage of cases show a slight elevation from absolute normal; this circumstance may be due to minor deviations from details of technique, as a result of routine ward usage, and in any extent does not affect or alter the significance of a low or minimal blood sedimentation rate in all cases of acute appendicitis.

Acute adnexal disease, the condition most commonly to be differentiated from acute appendicitis in acute abdominal cases routinely admitted to the surgical service of a large municipal hospital, has come to needless and frequently harmful operation much less frequently as a result of increasing awareness of the blood sedimentation test.

As previously observed, there is no relationship between leucocytosis and the blood sedimentation reaction. This survey of cases over a five year period substantiates the importance of the blood sedimentation test in the differential diagnosis of acute appendicitis, and warrants its continued use and clinical application.

Primary Hypochromic Anemia Terminating in Pernicious Anemia. Miller, E. B., and Damashek, W.: Arch. of Int. Med., 1941, 68:375.

Two cases of primary hypochromic anemia which terminated in pernicious anemia are reported. In the first case, in which the hypochromic anemia was associated with the Plummer-Vinson syndrome, (which is simply primary hypochromic anemia in association with dysphagia) pernicious anemia developed after several years of observation. In the second case, the administration of iron apparently unmasked underlying and coexistent pernicious anemia.

Castle and his co-workers have shown that the normal gastric juice contains a ferment other than pepsin or rennin, designated as the intrinsic factor, which in the presence of proteins and perhaps the vitamin B complex (extrinsic factor) produces a substance, known as the hemopoietic principle, capable of inducing a remission in patients with pernicious anemia. In a case of typical addisonian pernicious anemia there is an insufficient amount of this ferment. Castle and others further supported their theory with a demonstration of the presence of the intrinsic factor in cases of achlorhydria without anemia. Others also found the intrinsic factor present in the gastric juice in cases of simple achlorhydric anemia (idiopathic hypochromic anemia).

Meulengracht demonstrated that in the pig the intrinsic of Castle is produced in the pyloric region of the stomach and in the first portion of the duodenum. The submucous glands of the duodenum are similar histologically to the pyloric glands, and Meulengracht spoke of them altogether as the "pyloric gland organ." From this evidence it has been assumed that this similarity exists in man also and that in pernicious anemia there is a diffuse atrophic lesion of the stomach also involving the duodenum, which would account for the lack of intrinsic factor in the gastric juice of patients with such disease. Should the atrophic process begin in the proximal half of the stomach, where hydrochloric acid and pepsin are secreted, and then later involve the pylorus and duodenum, as suggested by Hurst, a simple explanation would exist for the cases in which primary hypochromic anemia precedes pernicious anemia. A predisposing tendency to atrophy of the stomach, with or without atrophy of the pyloric gland organ, could account for the familial relationship often seen in cases of simple achlorhydria, idiopathic hypochromic anemia and pernicious anemia. In cases of simple achlorhydria a combination of such factors as prolonged iron-poor diet, faulty intestinal absorption and diarrhea, with or without chronic hemorrhage, might finally result in the condition known as primary or idiopathic hypochromic anemia. Investigations have suggested that achlorhydria may interfere with the proper absorption or utilization of organic iron. Intestinal malabsorption has also been shown to exist in cases of achlorhydric anemia.

Several observers in fifteen cases of pernicious anemia found a characteristic lesion of the stomach, which was localized to the fundic portion of the stomach and did not affect the pyloric gland organ. Since the glands of the fundus produce chiefly hydrochloric acid, there is a morbid histologic basis for the achlorhydria in pernicious anemia but not for the absence of the intrinsic factor—if one assumes that the latter is produced in the pars pylorus. Magnus and Ungley suggested that the pathologic mechanism in cases of pernicious anemia may be similar to that involving the islets of Langerhans in cases of diabetes, in which the lesion is either functional or of an organic type not demonstrable by the histologic technics now available. Meulengracht suggested that the pyloric gland organ may be subject to the influence of a gastric hormone elaborated in the atrophic fundus.

The evidence gained from the literature seems to indicate that some persons possess a constitutional predisposition to gastric achlorhydria, which is often familial. This state need not be associated with anemia or other symptoms. During the stage of simple achlorhydria, hypochromic anemia may result, especially if another factor, such as dysphagia, inadequate diet, intestinal malabsorption or hemorrhage, is present. Occasionally, by an unknown mechanism, the intrinsic factor of Castle may become seriously diminished, with the result that pernicious anemia develops. In the first case reported in this paper, there appears to have been constitutional atrophic gastritis with gastric achlorhydria. During the period of emotion, dysphagia appeared, and because of this difficulty a diet greatly deficient in iron-containing foods was taken. As the result of these various factors, a chronic iron-deficiency state appeared. A few years later, probably as the result of either functional or organic involvement of the pyloric gland organ, the intrinsic factor probably became greatly diminished with the result that pernicious anemia developed.

In the second case, primary hypochromic anemia and pernicious anemia were apparently coexistent, although the iron deficiency state was sufficiently outstanding to result in the diagnosis of the first entity. When iron was given, the anemia became macrocytic and the underlying pernicious anemia was unmasked.

THE RELATION OF THE NASOPHARYNX TO ULCERATIVE COLITIS. Weiss, S., Slanger, A., and Goodfriend, S.; Jour. Lab. and Clin. Med., 1941, 26:1925.

Nonspecific ulcerative colitis is a chronic disease of unknown etiology, characterized by exacerbations and remissions, with symptomatology of bloody diarrhea and loss of weight, with proctoscopic findings of an edematous, granular, easily bleeding mucosa with ulcerations, either punctate or serpiginous; with blood findings of a secondary anemia, X-ray findings of the colon showing loss of haustrations and narrowing of the lumen. In these cases bacteriologic studies do not reveal any amoeba histolytica, B. dysenteriae, or diplostreptococci.

The authors and others noted that exacerbations in ulcerative colitis were preceded very frequently by upper respiratory infections. They began to study cultures taken from the nose, throat, and rectosigmoid mucosa of ulcerative colitis cases, and collected a series of fifteen cases between 1934 and 1938.

The ages of these patients varied from 13 to 45 years, with typical histories of from five weeks' to eleven years' duration. Most of these patients had been under medical care before coming under observation of the authors. The symptomatology included abdominal cramps, bloody diarrhea, loss of weight, weakness, and anemia. The proctoscopic findings showed granular mucosa, freely bleeding and ulcerated. Bacteriologic studies of the nose and throat revealed staphylococcus albus, 6 cases; hemolytic streptococcus, 4 cases; streptococci nonhemolytic, 2 cases; streptococci viridans, 1 case; staphylococci hemolyticus, 1 case; micrococcus catarrhalis, 1 case. Bacteriologic studies of the mucosa of the rectosigmoid revealed B. coli, 9 cases; staphylococcus albus, 5 cases; streptococci nonhemolytic, 3 cases; B. coli hemolyticus, 2 cases; streptococci hemolyticus, 1 case.

All patients except one were treated with a combined vaccine; this patient was given only a vaccine prepared from smears taken from the rectosigmoid. Vaccine from the nose and throat was added in this latter case, and after three injections of the combined vaccine, the bowel movements became formed and blood disappeared from the stools. These fifteen patients have been well for a period ranging from nineteen months to four years.

Vaccines were prepared only from those organisms which were present simultaneously in the nose, throat, and rectosigmoid cultures. These vaccines were standardized to contain 1,000,000,000 organisms per cubic centimeter. Three dilutions were used, namely, 1:1, 1:10, and 1:100. The authors injected these vaccines three times a week in increasing doses from 0.1 c.c. to 1 c.c. for a total of 15 or more injections. Each week the three dilutions were used; the 1:100 the first day, the 1:10 the next injection, and the 1:1 dilution the last injection of that week. Each injection was increased by 0.1 c.c. each week.

What relation these various organisms from the nose, throat, and recto-sigmoid, as indicated in these studies, bear to the etiology of nonspecific ulcerative colitis the authors are not prepared to state. Whether by giving these various vaccines they are preventing upper respiratory infections, and in that way preventing exacerbations, is not known. However, this seems to be the possible explanation of the rationale of this treatment. The authors express the hope that others will utilize this treatment until such time as the specific etiology of nonspecific ulcerative colitis will be definitely established. They are of the opinion, as Paulson believes, that in those particular cases of ulcerative colitis, where amoeba, B. dysenteriae, and diplostreptococci of Bargen are found, the resulting ulcerative colitis is secondary to these organisms.

THE "PRESSURE THEORY" OF ECLAMPSIA. Davis, J. A., and Snook, L. O.: Surg. Gyn. and Obst., 1941, 73:336.

Eclampsia has with reason been called the "disease of theories." Among these many theories there is one which, it seems, has not been given adequate consideration. This idea, first clearly stated by King in 1887, is that the primary derangement in eclampsia is a mechanical one of pressure on the abdominal viscera consequent upon the filling of the abdominal cavity by the rapidly enlarging uterus. Either in whole or in part this concept appears in medical literature; it has never been disproved. Recent experimental work, especially that of Goldblatt, has added cogency to this old theory and necessitates its reappraisal.

The term "eclampsia" as used in this article by the authors includes syndromes referred to as low reserve kidney, pre-eclampsia, and eclampsia.

The writers compiled selected briefs from the literature from 1767 to the present time which demonstrates that the pressure theory has been current for many years and has been advocated by men prominent in the annals of medicine.

In 1939 Goldblatt and his associates considered the possibility of their studies on renal ischemia and hypertension as being pertinent to the problem of eclampsia. They stated that as this condition occurs only at a time when the uterus is greatly enlarged, it is at least possible that the mass may press on the aorta or both renal vessels to produce renal ischemia. They suggested postural treatment of eclampsia to relieve this pressure.

From an anatomical standpoint, the renal veins and arteries, the inferior vena cava, the kidneys and urinary tract, and the aorta are in a position to be compromised between the pregnant uterus and the posterior abdominal wall. This is true particularly of the left renal vein which lies between the aorta behind and the superior mesenteric artery and the muscle of Treitz in front. In pregnancy, many investigators have demonstrated pressure of the enlarged uterus upon the right ureter and its relation to hydronephrosis and urinary tract infection. The predominance of right ureteral involvement is attributed to the usual right obliquity of the pregnant uterus and the protection afforded by the sigmoid colon on the left. The lordosis of pregnancy would make these visceral structures more vulnerable to pressure. The analogous lordotic albuminuria in children is consistent with this idea. In quadrupeds, in which the hydrostatic pressure of the gravid uterus and of the intestines is exerted against the anterior abdominal wall, toxemia is said to be rare.

The abdominal cavity is of limited size and distensibility. The addition of the rapidly enlarging uterus to the contents of this cavity during pregnancy should produce a compression of the other viscera or a distention of the abdominal cavity. That the distention occurs is obvious. That a compression of the other viscera may occur is a possibility. That hypersensitive toxemias are more common in primiparas, in whom the abdominal cavity and abdominal wall resists distention to a greater degree than in multiparas, is consistent with a pressure element being important in the genesis of these disorders. In addition, the toxemias are much more common in twin pregnancies and in polyhydramnios, in which conditions the increase in the uterine mass would be more likely to exert compression. The clinical observations that the hypertensive toxemias almost uniformly occur in the latter part of pregnancy, that they are relieved by delivery, and that they are improved by rest in bed and sedation are consistent with the theory of mechanical origin.

Ischemia of the kidneys, with resultant hypertension, has been produced experimentally and observed clinically to originate by several mechanisms. Some of these are:

1. Pressure on the renal artery and/or vein by various types of clamps.
2. Pressure on the kidney by the oncometer and celloidin pack.
3. Obstruction to the outflow of urine.
4. Urinary-tract infection.
5. Limitation of the blood flow to the kidneys by the pressure of tumors.
6. Pressure on the aorta and inferior vena cava by various methods.

Of interest is the work of Dill and Erickson who produced eclamptic-like syndromes in pregnant animals by constriction of the renal artery. Also of note is the reduction of an experimental hypertension by the release of constricted vessels or by the establishment of an improved blood supply to the kidney. Theoretically, all the above mechanisms could be duplicated by the pressure of the gravid uterus and an improved blood supply to the kidney would result through such release of pressure by delivery.

Thus, the old "pressure theory" as interpreted to-day would be that renal ischemia, produced by direct and indirect pressure of the gravid uterus, causes widespread arteriolar constriction from which follows the altered physiology characteristic of the hypertensive toxemias of the late months of pregnancy.

E. David Sherman, M.D.
Sydney, N. S.

Society Meetings

VALLEY MEDICAL SOCIETY

THE semi-annual meeting of the Valley Medical Society was held at the Queen Hotel, Annapolis Royal on November 12, 1941.

Dr. I. R. Sutherland presided. Present were Doctors A. B. Campbell, M. R. Elliott, Gordon R. Mahaney, L. B. W. Braine, C. S. Bezanson, H. E. Killam, W. A. Curry, H. G. Grant, C. K. Fuller, R. A. Moreash, A. F. Weir and L. R. Morse.

The minutes of the last meeting were read and approved. It was decided that the election of the place for the annual meeting be left in the hands of the President and the Secretary.

Dr. H. G. Grant, Secretary of the Medical Society of Nova Scotia, was the first speaker. He said that the Federal Government of Canada was going to introduce a health insurance scheme of some kind either this fall or next fall. He discussed some phases of the National Health Act of England. A request was made for a hundred per cent membership of the Valley Medical Society in the Canadian Medical Association. This would strengthen the hand of the Canadian Medical Association in any dealings it might have with the Federal Government in formulating a scheme for health insurance for Canada.

Dr. Sutherland appointed Doctors Campbell, Elliott and Kelley to contact any non-members of the Canadian Medical Association in an endeavour to have them become members. A list of the non-members is to be sent to these three men by Dr. Grant through the secretary.

Dr. W. A. Curry of Halifax was the next speaker. He spoke on intestinal obstruction and made use of lantern slides during his talk. Intestinal obstruction was divided into high obstruction and low. The signs and symptoms noted in each were given. In obstruction associated with strangulation of the bowel, surgical interference cannot be started too soon. He described the Miller-Abbott tube in detail. The anaesthetic of choice was spinal. In treatment he advocated besides surgery, the use of the tube, chemotherapy and continuous intravenous saline. In investigation the X-ray can be used to advantage and a rectal examination should be made.

A vote of thanks was extended to Dr. Curry for coming and giving us this much appreciated talk.

Dr. Elliott, the next speaker, gave an interesting case report of spontaneous subarachnoid haemorrhage. A man, age 55 years, while hunting, became confused, had loss of memory and convulsions. He had severe pain in his eyes. The spinal fluid, showing decomposition products of blood, was the important factor in the diagnosis.

Dr. Kelley and Dr. Morse cited somewhat similar cases.

Dr. C. K. Fuller of Yarmouth was the last speaker. His subject was eye, ear, nose and throat errors. He stressed the difference between glaucoma and iritis and the treatment of each. A phone message one night told him a man was having another attack of gall stones. This patient had glaucoma and the pressure inside the eye was so great (the man having intense pain) that the

eye ruptured. The dangers of blowing your nose in case of the common cold were stressed. This practice, especially when done with the lot of force, has a tendency to force the discharge into the sinuses. His experience was that the use of sulphanilamide in treating middle ear disease and mastoiditis was dangerous. He cited a case.

On motion the meeting adjourned.

Dinner was then served in the Queen Hotel dining room.

R. A. MOREASH
Secretary-Treasurer
Valley Medical Society

Personal Interest Notes

DR. ROBERT MURRAY MacDONALD, son of Dr. E. M. MacDonald of Sydney, who graduated from the University of Edinburgh in 1939, and since than an interne at the Western General and the Royal Hospital for Sick Children at Edinburgh, and who spent the last year at the Royal Infirmary at Leicester, returned to Canada in October, 1941, and is now Surgeon Lieutenant in the R.C.N.V.R.

Colonel J. G. D. Campbell, O.C., Camp Borden Military Hospital, was home in Halifax on leave for the Christmas holidays.

Dr. Clarence L. Gosse, (Dal. '39) of Cleveland, Ohio, spent the Christmas holidays with his father, Dr. N. H. Gosse and Mrs. Gosse, in Halifax. Dr. Gosse is a fellow in surgery of the Crile Clinic in Cleveland.

Dr. and Mrs. L. B. W. Braine of Annapolis Royal spent Christmas with their daughter, Mrs. Charles Clark and Mr. Clark of Tatamagouche.

Congratulations to Dr. and Mrs. W. E. Pollett (Hope Hatfield) on the birth of a son on December 19th, 1941, at 18 Royal Circus, Edinburgh, Scotland. Dr. Pollett, formerly practised in New Germany.

Dr. and Mrs. J. H. L. Simpson of Springhill spent the New Year holidays in Halifax.

Dr. and Mrs. W. G. Colwell of Halifax enjoyed a ten day's visit in Montreal and Ottawa early in December.

Dr. and Mrs. G. G. Lehv of Halifax spent two weeks in New York during the Christmas holiday season.

Congratulations to Dr. and Mrs. D. K. Murray of Liverpool on the birth of a son on December 21st.

Obituary

The death of Dr. Charles Ashton Webster occurred at his home in Yarmouth on November 22nd, at the age of seventy-seven. Dr. Webster was born in Yarmouth on June 1, 1864, son of the late Dr. John L. R. Webster and Helen O. Geddes. He received his early education in Yarmouth, attended the Halifax Medical College and graduated from College of Physicians and Surgeons of New York in 1886, and took post-graduate work in New York and London. He succeeded to his father's practice in Yarmouth as the fourth physician in a direct line of Webster doctors. In 1917 he was one of the first in Nova Scotia to become a Fellow of the American College of Surgeons. In 1936 he was honoured by the Medical Society of Nova Scotia for having been in continuous practice for over fifty years. He was also a senior member of the Canadian Medical Association. A year ago he was forced to withdraw from active practice because of ill health.

Dr. Webster was keenly interested in the affairs of the community and was an active member of the United Church, the Yarmouth Board of Trade, the Public Library, a director in three agricultural societies, a member of two historical societies and various hospital societies.

He is survived by his wife, the former Mary Page Murray of Yarmouth, four sons, Dr. John Alexander, now practising in Yarmouth, Geddes, a defence industry engineer in Montreal, Robert and David, students at Dalhousie University and two daughters, Elizabeth and Helen in Halifax; three brothers, Kenneth of Milton, Mass., J. Lindsay and James, both in British Columbia, and one sister, Mrs. H. O. Tremayne of Toronto.

The funeral service was held on November 25th from the Memorial Chapel in Mountain Cemetery. All town doctors, including those at the air station and training centre, acted as honorary pall bearers.

Dr. Robert Faulkner O'Brien of Halifax died at the Victoria General Hospital pavilion on November 29, in his seventy-fourth year. Dr. O'Brien, who retired from active practice about ten years, suffered injuries in an accident on November 27, from the effects of which he failed to recover.

Dr. O'Brien was born at Noel, Hants County, a son of the late Osmond O'Brien, widely known Nova Scotia shipbuilder. He was the last surviving member of his family. He received his early education at Pictou Academy, and later entered Dalhousie University where he received his B.Sc. degree in 1893, and graduated from Jefferson Medical College in 1895. During his long career Dr. O'Brien had practised at Windsor, Maitland and Elmsdale before coming to Halifax where he continued his practice for many years up to the time of his retirement ten years ago.

Dr. O'Brien is survived by two sons, Major H. D. O'Brien R.C.A.M.C., now on overseas service, and Robert of Saint John, and one daughter, Anna, Mrs. E. D. Blair of Toronto.

Funeral service was held from the home of his son, Dr. H. D. O'Brien, on December 2nd, conducted by Rev. Dr. J. A. MacKeigan of St. Andrew's United Church, of which Church Dr. O'Brien was a faithful member. Interment was at Camp Hill cemetery.

Dr. Donald John Macdonald died suddenly at his home in Halifax on December 19th at the age of 68. Dr. Macdonald was born in Whycocomagh in 1873, graduated from McGill University in 1897 and then set up a practice in Sydney. It was in 1916 when he joined the Army Medical Corps that he first came to Halifax, where he served as Major at the Halifax Military Hospital during 1916-17 and at Camp Hill Hospital 1917-18. At the conclusion of the war he set up practice in Halifax. He is survived by his wife, the former Marion Longworth of Truro, on son, Major R. Ian Macdonald, now overseas, and one daughter, Sheila, Mrs. C. F. MacKenzie of Halifax, and five grandchildren.

Dr. Avery Fillis Buckley, retired Halifax physician, died at the home of his son, Louis, in Kitchener, Ontario, on December 21st, at the age of 85. Dr. Buckley received his education at Mount Allison University and Dalhousie Medical School from which he graduated in 1898, took a post-graduate course in London, England, and practised in Halifax, up until the time of his retirement about ten years ago, for nearly fifty years. After his retirement he resided with his daughter, Mrs. R. K. Elliot of Dartmouth and later with his son in Kitchener. Dr. Buckley was for a number of years on the staff of the Victoria General Hospital. Dr. Buckley also took an interest in painting and won some recognition as an artist. He is survived by two daughters, Mrs J. A. Irvine, Calgary, and Mrs. R. K Elliott, Dartmouth and four sons, Roy, Calgary; Louis, Kitchener, Ontario; Orland, Harrow, Ontario; and Wilfred of Kingston. Dr. O. R. Stone of Bridgetown is a son-in-law of Dr. Buckley.

Dr. William Alfred Lawson, died suddenly at his home in Dartmouth, on January 11th, at the age of 66. Dr. Lawson, a native of Wallace, attended Pictou Academy and taught school at Wallace and Tatamagouche for a few years. He studied medicine at Dalhousie University and graduated in 1903. Later he took special classes in diseases of the eye, ear, nose and throat in Chicago. He practised at Harcourt, N.B., Dorchester, N.B., Port Greville, Advocate and Dartmouth. In Dartmouth Dr. Lawson was well known. For the past few years he was interested in shipbuilding and made an intensive study of sea-going craft. He is survived by his wife, one daughter, Margaret, and one son, Wilfred, at home.

Dr. Donald Thomas MacPhail died suddenly at his home at Purdy Station, N.Y., on December 16th, at the age of 70. Dr. MacPhail was a native of Whycocomagh and secured his early education at Sydney Academy and Dalhousie University. He obtained his medical degree in Philadelphia in 1896, and after post-graduate work in London and Berlin, established himself in New York as a general practitioner. During the first world war he was a captain in the U.S.Medical Corps, and an examining surgeon of the U.S. Public Health Service. After the war he became known as an eye, ear and throat specialist. Dr. MacPhail's wife predeceased him in 1927, and surviving are a daughter, two brothers and two sisters.

The BULLETIN extends sympathy to Dr. and Mrs. J. J. Cameron of Antigonish on the death of their son, Dr. Owen John Cameron, which occurred on January 9th following a sudden attack of heart disease. Dr. Cameron was

born in Antigonish 46 years ago. He graduated from St. Francis Xavier University in 1914 at the age of eighteen. In the same year he began the study of medicine at Harvard, where he made a brilliant course, graduating with honours at the age of twenty-two. He was the youngest graduate in the faculty of medicine at Harvard up to that time and was recognized as possessing special aptitude in the field of surgery. This aptitude received further recognition when following graduation he served for eighteen months on the staff of Rhode Island Hospital in Providence. In the last half-year of his service he was selected to replace the chief surgeon, then absent on leave. Eventually, Dr. Cameron returned to Nova Scotia, locating in Glace Bay for a time, and then entered general practice in Antigonish. Besides his parents he is survived by two sisters and a brother.

The BULLETIN extends sympathy to Dr. H. A. Payzant of Dartmouth on the death of his wife, Eugenie Fer Payzant, which occurred at her home January 9th, after a brief illness.