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Contents January 1943

The Present Status of Wound Therapy

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OUT of the death of every war comes the promise of new life, of new freedom from suffering, as surgery drinks in wisdom at the blood rich founts of Mars. From the Spanish Revolution sprang a new, closed-drainage treatment for wounds, so striking in the statistics of its accomplishment that no thinking surgeon could deny it. With necessity as a bulwark for his judgment, Dr. J. Trueta, of Barcelona, clipped away the dead tissue from the wounds of his soldiers, washed them with saline, packed them with gauze, wrapped them thoroughly in plaster of paris, left them alone; and they healed. He used no strong antiseptics, no drainage tubes, no fresh dressings; he did not wash the germ laden pus away; it soaked into the casts and stunk till the air was foul with it; but his patients recovered. The series he reported numbered 1073, the mortality was 6.

This was startling, but was it new? Dr. Trueta said *no*. He had taken much of his principles and practice from Winnett Orr, American surgeon of the first world war. Twenty-five years ago Dr. Orr wrapped up broken bones and tissues in the same way. He reported results which, if fewer, were quite as remarkable. But working in the same fields with him were men of greater renown, with a technique that was good, and more conventional. Thus the Winnett Orr treatment was overshadowed by the Carrell-Dakin technique.

Through the interlude of peace a few persistent spirits, including its originator, kept the Winnett Orr method alive. As an interne, 12 years ago, I had the privilege of working under Dr. Fraser Gurd at the Montreal General Hospital. For six months I watched and aided in treating the compound fracture cases of Dr. Gurd and his associates by the "closed method," while in the adjoining ward I served in the same capacity, advocates of the "open method"—open drains, open splints, frequent dressings, and irrigations. Almost as a rule, the cases treated by closed drainage healed without infection. Free of the prejudices and surgical conventionalism that too often come with the years, I wondered that anyone could ever demur between the two methods.

Yet, had war not again offered its vast proving ground to Dr. Trueta, closed drainage might have died out, unestablished, as it did once before. Because the method was not original with Winnett Orr. Had not the peace after the Franco-Prussian war of 1870 been rather long, the work of Ollier might not have been lost.

Ollier, whose name lives in the Ollier-Thiersh graft, was better known for his plastic surgery than as the originator of *l'occlusion inamovible*. When his colleague, M. Guérin advocated infrequent dressings, because Pasteur had shown that the air was infected, and the infected air got to the wound at each dressing, Ollier protested. Not only the air bore infection, he said. A surgeon might perform his operation on a mountain top and infection would follow. Infrequent dressings also kept meddlesome fingers away. He drew attention to the elevation of temperature that frequently followed dressings. And moreover, the wound must be immobilized as well, he said, with a silicate type of plaster he described.*

*C'est a ce point de vue que je dois insister sur un autre avantage que la Commission a reconnu au pansement ouaté, je veux parler de l'immobilization de la plaie.

Before Ollier was English surgeon Joseph Gamgel, in 1853, who treated compound fractures and diseases of joints with a starched apparatus. And no doubt, if we went back to Hippocrates, we would find the treatment appearing again and again on the way, because it is based tightly on the fundamentals of surgery—cleanliness, rest (for the part as well as the patient), and drainage.

Principles of the Closed Treatment

The term, *closed treatment* is an unfortunate one, connoting, as it does, something opposed to drainage. We prefer to call the method *closed drainage*, since the cardinal principle of drainage is adhered to at least as thoroughly as in any other mode of treatment.

Theories have been made to explain the success of closed drainage. That it is due to bacteriophage has been discredited. That the calcium carbonate of the plaster cast has a direct therapeutic affect, akin to the work of maggots which give off calcium carbonate, is fanciful.

There is no need of such theories. In the first world war Ronald Hare showed how clean wounds of battle became contaminated, grossly contaminated, and more grossly contaminated, as they were subjected to the successive dressings of the stretcher bearers, the field ambulance station, the casualty clearing station, on their way back to hospital. Recent work showing the multiplicity of streptococcal strains present wherever there is organic matter gives added significance to his findings. Obviously, each exposure is an opportunity for further contamination. If bacteria can escape to the outside during a dressing, just as surely those outside can get in. Every drain, particularly every rubber drain, is a two-way street.

The plaster cast is an important instrument in the infrequent dressing technique. Anxiety for the patient's welfare is such a worthy motive, and peeking under the corner of the dressing so easy in a gauze wrapped wound! The need for plaster shears to get even close to the area definitely discourages this urge. But the great function of the plaster is in carrying out surgery's greatest therapy, rest. If it be necessary for the patient, surely rest is just as necessary for the part. Bones will not heal without it; union of soft tissue is sorely delayed. The unpadded cast, according to Trueta, gives rest which is infinitesmal in its effect. Not only are gross movements prevented. But that delicate line of leucocytic infiltration and congestion in all the tissues around the wound, that first body defense against systemic absorption, is protected against even the most minute trauma which might break it down.

It is hardly necessary to add that a plaster cast with a fenestration through which to dress the wound is worse than no cast at all. The window produces oedema, and the circulatory stagnation gives organisms a perfect culture medium.

That the closed drainage technique is the most inexpensive form of treatment and can be more readily carried out than any other under the difficult conditions of war are not of prime importance to the civilian surgeon. That the patient is more comfortable, happier, less apprehensive than when subjected to frequent dressings and irrigations—this is important to every surgeon.

Technique of Closed Drainage

The operative procedure must be carried out with meticulous detail. No local preliminary preparation of any kind is done in the ward. As soon as

the general condition of the patient permits he goes to the operating room. Here the surgeon takes the preparation upon himself. The skin about the wound is washed and if necessary scrubbed with soap and water. Tincture of green soap is convenient but not essential. All asked of any soap is that it cleanse. When followed by antiseptic tinctures, the weak germicidal action of green soap is not worth consideration. But its irritant action on the raw tissues is. More devitalizing than strong tincture of iodine, it should *never* touch the open wound.

Ether follows the soap, to dissolve the fats, and then alcohol for dehydration. Leaving the final painting with the skin antiseptic, and the draping to his assistant, the surgeon scrubs again.

The wound is now irrigated with normal saline, temperature 100-105 degrees F. This should be set up in a jar at such a height as to give good force to the flow through the glass nozzle. The wound may be cleansed with a quart of saline, it may need a gallon or more, depending on its extent. The saline jet should explore every crevice and cranny. Only when convinced he has used twice the saline necessary is the surgeon ready for his forceps and scissors.

Excision of the wound begins with the skin. If caused by a clean, sharp instrument which neither bruised nor shredded its edges, the skin wound may be left alone. Muscle tissue is easily hurt, and most susceptible to infection. It must be clipped back to the point where it oozes bright blood against the scissors.

Essential suturing of muscles, tendons, nerves and, rarely, blood vessels, is best carried out with a woven silk that has been boiled. Haemostatis must be thorough. The wound is treated with a sulfonamide preparation and packed with gauze. Like the saline, this must extend into every crevice, and should be packed with goodly pressure. The principle of the drainage is that it takes place not through the gauze, but between gauze and tissue. Thus there is a direct path from every portion of the wound to the surface. Formerly I used BIPP because it did not adhere to the tissues, and with it was no danger of discharges being dammed back. Not wishing to burden too greatly the tissues with drugs, and because recent work indicates that the use of oils in a wound tends to increase fibrosis and delay healing, I have changed to a plain gauze, impregnated with sulfonamide.

The Sulfonamides

In local use sulfanilamide has one advantage over its newer relations—its greater solubility and more rapid absorption into the tissues. Within five hours it shows a light blood concentration; within 12 hours, an adequate concentration. At 24 hours this is reaching a maximum, showing approximately 1 mg. per 100 c.c. of blood for every gram left in the wound. At 60 hours the concentration is almost gone. But sulfanilamide's lethal effect on the staphlococcus is slight, its toxicity relatively high, and its local effect on the tissues seems to be that of a very mild irritant.

Sulfathiozole is equally effective with sulfanilamide against the streptococcus and a potent weapon against the staphlococcus. Its toxicity is low, its irritant effect on the tissues, nil. Its absorption is slow, and spread over a longer period, an effective blood concentration not showing till the seventh day.

In experimental work, in vitro, sulfathiozole seems to be only a few hours

behind sulfanilamide in its local effect. This would seem to indicate that a high blood concentration is not necessarily concurrent with local germ destruction. Because of its irritant effect, the soluble sodium salt of sulfathiozole, used for parental injection, is not recommended for local application. Novocaine in the tissues seems to inhibit theabsorption of both drugs. In an infected wound their absorption is so much slower that more dependence must be put on general administration.

Locally, we like to use a small amount of sulfanilamide, for its early effect, and a large amount of sulfathiozole. Where all parts of the wound are accessible, the powders alone are used. To get into distant crevices and muscle planes we use the saline suspension. I have employed up to twenty grams in extensive wounds, and up to thirty-five grams of the mixed drugs in the peritoneal cavity without signs of toxicity developing. In all severe wounds local administration is supplemented by general. When sulfathiozole is not well tolerated orally, sulfadiazine may be used. It seems to cause no gastric irritation, but its germicidal potency is somewhat less than sulfathiozole. As a guide to oral dosage, a blood concentration of 4-8 mg. per 100 c.c. is considered necessary. In cases where infection has developed, it is important to maintain an adequate concentration for at least a week after the temperature is normal.

Excision Versus Debridement

It has been stated, with some empiricism, that a wound more than three hours old should not be excised; that already bacteria are becoming active, that local infiltration rings are being formed, and that excision will break down defenses and spread the invaders. The three hour limit is a good rule of thumb, but the surgeon will want to weigh the case before him, the general condition of the patient, his age both in years and sclerosis, and the appearance of the wound, as he explores it. If he feels that excision is dangerous, he will fall back on a simple debridement, and laying the wound open, saucerizing and packing it.

Primary Suture

Where there is no tissue loss and tissue trauma is slight, where extensive fibrosis or scarring may cause disability, as in wounds of the ventral surface of the wrist, or where the cosmetic result is important, we usually employ a primary suture. Up to the point of introducing the packing the technique is exactly the same as with closed drainage. No rubber drains are used and the dressing is sealed, in plaster wherever feasible. If the surgeon feels that he cannot trust the sutured wound, without drains and locked in plaster, then he should not use sutures at all. Any serious infection in the wound following operative care will always manifest itself by a systemic reaction, by a neighbouring adenitis and by swelling of the part (appearing as a tightening of the plaster).

Subject to the same qualifications, we sometimes use a primary suture on compound fracture cases, with internal fixation on the bone fragments. Justification for this procedure is based on three points: (*a*) Experimental work indicates that bone is more resistant to irritation and infection than was once thought, and is usually infected secondarily to adjoining muscle whose resistance is shown to be very low. (*b*) It is very difficult to obtain satisfactory reduction of certain fractures by traction and manipulation without

contaminating the wound. (*c*) In a mounting series of carefully chosen cases we have had no cause to regret the procedure.

The third degree external rotation fracture of the tibia and fibula with wound on the medial side, directly over the bone and without muscle laceration is the injury we have commonly treated in this way. Since it causes no local tissue reaction, vitallium is the metal of choice for plating.

The Plaster Cast

The plaster cast must be applied without padding or over a very light stockingette. The former is preferable. Sheet wadding should not be used because there is danger of its causing circulatory obstruction as it becomes packed and rolled beneath the plaster. Dressings over the wound are no more than sufficient to absorb the immediate discharge. If the patient reaches the operating room before the injured part has begun to swell a plaster that is moulded carefully and intimately to the skin will cause no arterial occlusion and little venous obstruction. If oedema is already present, it will be necessary to watch the exposed parts closely for evidence of circulatory interference.

If the cast be smoothly applied, there is no danger of pressure sores. The moulded plaster is more easily put on than the roller bandage. It must extend far enough beyond the area of injury to give complete immobilization:—a wound of the shoulder or upper arm needs a cast covering arm and chest; for wounds of the lower leg the cast should extend to the perineum, and so on.

The stench that arises within two weeks of the cast's application will interfere with the patient's welfare only if it spoils his appetite, but it may cause distress to others in the ward. We have had no experience with the several deoderants described but best reported perhaps is lactose, sprinkled generously over the dressing before the cast is applied.

The elective removal of the cast should be not earlier than two weeks after its application, nor later than six weeks. When a fracture is present, time should be allowed for early callus formation before making the change. In smaller wounds, when rapid healing has taken place, it may be found advisable to carry on with open treatment. Otherwise, the skin is cleansed, the wound repacked (it will take only about a third of the packing it did at the first treatment) and a fresh cast applied.

The closed drainage treatment finds its best use in wounds of the extremities. It should never be used when because of age or disease, the surgeon is doubtful of the circulation of the part.

The Shocked Patient

Neither war nor the laboratories of peace have yet revealed the nature of surgical shock. Every casualty is its victim. If he be young, he will suffer less from it, but no matter what his age, it may kill him. The histamine-adrenalin theory explains only a part of the shock picture. Experimentally it cannot be produced with histamine, nor does adrenalin relieve it. Its clearest objective sign is a low blood pressure. This, reasons Dr. John Fraser, must be due to one of three factors, a change in the heart, in the capillaries, or to haemorrhage. Since the heart seems to function normally in shock, and haemorrhage is not a necessary accompaniment, the trouble must lie in the capillaries.

Certainly there is an increased capillary permeability, with a loss of blood serum into the tissues, and a circulatory stagnation. This can be demonstrated by the increase in the specific gravity of the blood and the increased cell count, signs which are apparent even before the blood pressure has begun to fall. Stagnation of the blood produces faulty tissue oxygenation of the tissues. Excessive carbon dioxide collects, up goes the hydrogen ion concentration. The result is acidosis. So called secondary shock appears to be caused by a similar train of events, the result of toxic absorption.

Somewhere in the vasomotor system a breakdown takes place. More than this is not known. Hence, in our ignorance,we turn to symptomatic treatment.

The patient is nervous. There is derangement of both his higher and lower centres. Reassurance will help the higher; rest and quiet will help both.

He is cold, from exposure, from vaso-motor failings and from blood stagnation. The treatment is heat—hot water bottles and hot drinks.

Pain intensifies shock. Morphia relieves it. But it should be borne in mind that many shock victims are not in pain. With shock is a lowering of pain sensibility. Since morphia may further depress the blood pressure, it should not be given unless definitely indicated. If needed, it may best be administered intravenously, because the capillary stagnation makes for slow absorption from the subcutaneous tissues.

Any local treatment that tends to increase the depression should be postponed. Only in major trauma to the chest and abdomen is operation justified in the presence of shock. Every form of anaesthesia is depressing. When it will serve, spinal is preferred. Local infiltration is less shocking than the inhalation anaesthetics, and when the surgeon feels that he must operate before shock has completely passed off he need balance the general dangers of the mask against the local, devitalizing effect of the novocaine.

A healthy heart will respond well to stimulation and by increasing its force help to fill sagging vessels, but if there is doubt about the state of the myocardium stimulants are better omitted. Acting directly on the heart alone, coramine is one of the best. Drugs which produce stimulation by vaso-constriction are contraindicated. If the prime factor in shock is capillary stagnation, it is sound reasoning that a drug, such as adrenalin, which produces arteriole constriction must further interfere with blood flow.

Most direct and prompt means of correcting a falling blood pressure is to fill up the vascular system with blood or a substitute. In severe shock this is the most essential treatment. But as always the surgeon must temper his therapeutic urge with clinical sense. Brittle, arterio-sclerotic vessels do not take kindly to sudden surges against their walls. Saving the elderly patient from shock is of little avail if he die with a ventricular dilatation or apoplexy.

Haemorrhage

In uncomplicated haemorrhage body defenses attempt to correct fluid losses by osmotic action through the capillaries. With shock this capillary action is lost and a relatively slight haemorrhage may produce more serious consequences. The custom of well meaning, over ardent first aid workers of putting above every minor cut a tourniquet which does not interfere with the arteries of the part but sets up a profuse venous congestion and haemorrhage is sometimes responsible for severe blood loss in minor injuries.

In major cases where the clinical picture is confused, the haemocytometer, showing a decreased count in anaemia or an increased count in shock, may establish the diagnosis.

Transfusion

The ideal replacement for blood, whether it be spilled on the ground or into the capillaries, is more fresh, whole blood. Citrated blood, if given immediately after collection, seems to be practically as good. As it stands it rapidly loses its leucocytes and platelets. Kept more than a few days the red cells' fragility is increased. Potassium escapes from cells to plasma and after ten days is present in such quantities as to cause a severe reaction. The use of the vacuolitre bottle greatly facilitates the collection and preservation of citrated blood.

Blood serum or plasma has been used with success in the treatment of shock where there is no cell loss. Collected in large quantities and mixed, either loses its specificity and may be given to any blood group. In Canadian laboratories and service hospitals greater success and fewer reactions have been met with the serum. In American institutions the reverse is true. The 6% solution of gum arabic in saline, used in the first years of the war, for want of something better, had not changed since World War I when it caused severe reactions.

The military surgeon will continue his search for an ideal transfusion substance. To the surgeon in normal civilian practice, whole blood, fresh or citrated, will remain the choice for some time to come. In severe shock cases, where life may be measured in minutes, he will use blood serum, if available, and 50 to 100 c.c. of 50% glucose if it is not. Normal saline he will reserve for the milder shock cases because, in the more severe cases it will pour out of the capillaries almost as fast as it is run into the veins.

Summed up, the treatment of shock is in greatest part the treatment of the fallen blood pressure. Wagensteen has said that a systolic blood pressure of less than ninety calls for a grave prognosis; that a pressure remaining below seventy for several hours usually means death. Such a clinical yardstick is useful as long as we remember that it is just as elastic as the human being who is measured. As the blood pressure rises, the patient recovers. The treatment has been symptomatic, but its basis is firm in clinical observation and experience.

General Treatment

Beyond the routine use of the sulphonamides there has been little recent development in general treatment. The use of anti-gas gangrene serum combined with the anti-tetanic serum as a prophylactic is probably of little value in the 4000 unit doses now being used. But the sulfonamides at least discourage the growth of the B. Welchi group.

Of the vitamins, only C and K are of specific value; vitamin K where its deficiency may lead to secondary haemorrhage; vitamin C because it helps in the maturation of the early fibroblasts to granulation and fibrous tissue. Because some of us have come to lay too great stress on the carbohydrates in immediate post operative and post traumatic diets, recent experimental work on nitrogen is important. In extensive wounds either recent or suppurating,

there is marked nitrogen loss. Nitrogen is essential to general well being and to good wound repair. Nitrogen is present only in protein foods.

Even if the end of the present conflict comes in answer to our most sanguine prayer, we may be sure that the surgery of wounds will emerge a greater, more learned art than before.

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Quinidine Sulphate*

K. A. MacKenzie, M.D.

IN 1912 a Dutch merchant consulted Dr. Wenchebach, the distinguished Viennese, physician for a distressing heart condition which was manifested by attacks of irregular heart action causing discomfort and anxiety. The condition was recognized as auricular fibrillation. On being told that there was no known remedy, the merchant expressed great surprise that such an eminent heart specialist should know so little about the heart. He then announced that he had discovered a remedy himself. While taking the usual treatment for recurring attacks of malaria, he had observed that the irregularity had frequently disappeared after the usual dose of quinine. The next day he returned and showed his physician that he had a regular pulse. Dr. Wenchebach, greatly impressed by this observation began to use the drug in similar cases and in 1914 was able to publish results which indicated that, in some instances, at least, a normal rhythm was established by the use of quinine.

Another Viennese physician, Frey, became interested and studied the pharmacological action of several cinchona derivatives. He soon came to the conclusion that quinidine sulphate, a derivative of quinine, was more effective than quinine and in 1918 reported ten cases treated, with restoration of normal rhythm in six, that is, sixty per cent. These two papers created a wave of interest in the drug and led to careful clinical and experimental studies by physicians in different countries.

In London, Sir Thomas Lewis, with great enthusiasm and with the assistance of a group of investigators carried out experiments on animals and made important clinical studies on patients. He added much to our knowledge of the action of the drug and his conclusions regarding the mechanism of the drug on vagal conduction, circus movement and the refractory phase of the heart, while highly technical, are of great interest to physiologists and clinicians. In 1921, he published his observations in the *British Medical Journal.* He showed that quinidine abolished the abnormal rhythm in six out of thirteen cases, but that some of these recurred. He clearly pointed out certain dangers, one of which was embolism and indicated that the drug should be used with great caution in carefully selected cases.

In the past twenty years the drug has been used by many clinicians and much has been written in medical journals and text books. We are now able to assess the value of the drug with some confidence and use it in carefully selected cases.

My first venture with quinidine was in 1922 shortly after reading Dr. Lewis' paper. A patient in the Victoria General Hospital had auricular fibrillation and seemed to be a suitable case. He was given quinidine according to instructions, three grains twice a day to test for idiosyncracy, followed by six grains three times a day. Within forty-eight hours the pulse suddenly became regular and the patient stated that he was conscious of improvement. The normal rhythm was noted at 5 p.m. During the night the patient died suddenly and so quietly that the nurses were unaware of the exact time of

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* Read at the Annual meeting of the Medical Society of Nova Scotia, July 1942.

death. A post mortem examination revealed that he had a large embolus blocking the main middle cerebral artery.

In the next three years I prescribed quinidine for six patients taking all precautions in my selection. In three the arrhythmia was abolished and in three unchanged. One of these patients had several attacks of fibrillation restored to normal each time with quinidine. No ill effects were observed. My seventh patient suffering from long standing mitral disease suddenly developed fibrillation. Quinidine restored the normal rhythm in twenty-four hours, but unfortunately she had an embolism producing a hemiplegia which partly recovered. She lived for many years with a residual hemiplegia but with no recurrence of the arrhythmia. Two patients with embolism out of eight was very disturbing and for some years I did not again use the drug. I saw many suitable cases but when the danger of embolism was explained, the patient made the decision to carry on with the irregular heart.

In 1933, my houseman noticed that his heart was irregular and a cardiogram confirmed the diagnosis of auricular fibrillation. He had some subjective symptoms but examination revealed no evidence of organic heart disease. We discussed the use of quinidine and, for a time decided not to use it. As the arrhythmia persisted he became tired of waiting for a spontaneous cure and with a full knowledge of the risk involved decided to take the drug. In less than forty-eight hours the rhythm suddenly became normal and has remained so ever since. A few years later a complete report was submitted to an insurance company and he was accepted as a good insurance risk.

During the past year, three patients have been treated with satisfactory results. Case 1, age 48. Heart enlarged. Trace of albumen. Quinidine restored the rhythm after the dose had been gradually increased to thirty grains daily. Case 2, age 24. Fibrillation came on soon after the extraction of a tooth. No organic disease could be demonstrated. Rhythm was restored on thirty grains daily. It first became flutter and later normal. Case 3, age 53. Hypertension only. Rhythm was restored after the dose had been gradually increased to sixty grains daily. There were no ill effects.

While quinidine is given with some fear and with great caution in the selection of cases of fibrillation and flutter it may be used without such fear in two other common conditions, extrasystoles and paroxysmal tachycardia.

Extrasystoles. This common irregularity does not, as a rule, call for any treatment. When they thrust themselves unpleasantly on consciousness, disturbing sleep and producing an anxiety state, relief is sought and treatment indicated. Bromides and other simple sedatives are usually effective. When these measures fail, quinidine gives striking and satisfactory results. Five grains three times a day is a reasonable dose and may be given for long periods. A smaller dose may be sufficient to prevent recurrence.

Paroxysmal tachycardia. This disturbance may at times be very alarming and threaten life. Usually the attacks end spontaneously. Attacks may last for a few minutes or persist for several days when heart failure may supervene. Cases. Mrs. G., age 42. Many previous attacks. This attack had been going on for five days and there was evidence of heart failure. Physician and friends felt that the end was near. Quinidine ended the attacks in two days, recovery was complete and she has remained in good health except for short and harmless attacks. Mr. H., age 40. Attack had been present for five days and death seemed imminent. Quinidine ended the attack in two days and he was able to resume work as a farmer.

Summary

Quinidine is a useful therapeutic agent in selected cases of auricular fibrillation and flutter and a safe remedy for frequent and annoying extrasystoles and serious attacks of paroxysmal tachycardia.

Idiosyncracy is probably rare but should be kept in mind. I have not seen the toxic effects which have been described.

Embolism is a real danger. It is due to the dislodgment of a thrombus when a sluggish auricle suddenly resumes function and may occur when the rhythm becomes normal from any cause such as digitalis or even when it occurs spontaneously. Embolism is a fairly frequent complication of mitral stenosis. A decision to use the drug in cases of fibrillation and flutter should be made only after careful consideration and never in the presence of congestive heart failure. The patient should be in hospital and share responsibility for this possible and unfortunate complication.

In extrasystoles and paroxysmal tachycardia the danger of embolism is not present and the drug may be used without fear. It is useful both as a curative and preventive measure.

Dosage. Three grains twice a day may be given as a test for idiosyncracy. If no toxic effects are noted, five grains may be given three times a day and increased until the desired effect is obtained. Sixty grains daily has been frequently given and in rare cases as much as two hundred grains have been given. The oral method is satisfactory and is the method of choice. It has been given intravenously.

War Time Experiences on Land and Ocean

FLORENCE J. MURRAY, M.D.,C.M.

INTENSE nationalism and more and more anti-foreign propaganda were evident throughout the Japanese empire for more than a year before the attack on the Allies was made. We in Korea were not much affected during this time except for some unpleasant experiences in country travel and more than the usual supervision by the police.

In October 1940 the western governments advised their nationals to return to their own countries, and a large majority did so. Most missions and business firms kept on a skeleton staff to remain as long as possible and salvage what they could.

Three out of five of our household sold what they could not take of their possessions and returned to Canada, Miss Beulah Bourns, my colleague in the nursing department of the hospital, and I moved what remained of our shattered home into two or three back rooms which would be warmer in the cold weather, coal being rationed, got a pup and a kitten, and proceeded to make the place as homelike as we could.

Our other stations were all closed and, apart from a few Russians and Germans, the only other white people in the city were two men of our mission whose families had evacuated. They lived in a house not far away but in another compound across a street and behind a hill from us.

In July, 1941, we went to Whachinpo Beach, a foreign summer resort, to see what was happening to the foreign property there. Two days later all foreign assets were frozen and we had to return to see about our affairs and make the required reports to the government. Getting back was not so easy for troops were moving north to the Siberian border and all civilian traffic was restricted. Luggage could not be checked and several people had to walk for days carrying their hand baggage. We were fortunate in getting on the train, though at Wonsan two of our number were taken to the police station and finally put back on the train with orders to get out of there quick. One, who wished to go in the opposite direction, was obliged to accompany us and next day, as I tried to see her off on the train for her proper destination, a Japanese guard with rifle and bayonet threatened the group of women of which I was one with his weapon. I took the hint and went home but we heard afterward that our friend reached her home on the other side of the country without further incident.

We found that the mission schools and hospitals were exempt from the provisions of the Freezing Act. We had made provision for emergency and had cash enough on hand for our personal needs for several months. Even after the freezing we were allowed to draw a certain amount from the banks each month for living expenses and by the time war was declared and this became impossible, we had drawn most of what we had in the banks.

In preparation for eventualities I had resigned from being superintendent of the hospital and since several months the institution was in the hands of a Board the majority of whom were Koreans and a Korean superintendent. This left me in charge of the department of Obstetrics and Gynecology.

People who came to see us were now regarded with suspicion and visitors became noticeably fewer. Many, however, continued to come and they and

the hospital staff of seven Korean doctors and two internes urged us to remain in the country. They thought that women were not likely to be imprisoned even in the case of war and they offered, if our funds were cut off, to pool their salaries and give us a share.

In October, 1941, the two men secured permission to go to Manchuria to try to make an arrangement with the army who were taking over some of our property there. It took them a month to get permission to leave the city, to travel on the train, to leave Korea, to enter Manchuria, and they also had to surrender their residence permits. Once in Manchuria they had to go to the capital to get permission to leave Manchuria again, to enter Korea, to travel, and the residence permit had to be secured again. This took so long that we thought they had been arrested and we would not be seeing them again. Finally they arrived and after that all foreigners, including Russians and Germans, were forbidden to travel at all.

On Dec. 8, Dec. 7 in the western hemisphere, the gendarmes, military police, who wear swords, came to our houses to tell us that there was war between our country and theirs and for our protection we would have to be interned. They were quite polite and told us not to be afraid for they would protect us. We knew we would have nothing to fear from the Koreans but were not so sure of the Japanese. We were forbidden to write letters or to go anywhere but to the hospital where we were told to carry on as usual.

That night three gendarmes took up their residence in the men's house where Mr. Scott was strictly guarded night and day, never being left alone for an instant, while Mr. Fraser (E. J. O. Fraser, Arts, Dal. '11) was taken to the gendarmerie. The telephone and radio in the Scott house were sealed up but we were allowed to use ours. The telephone was a private one connecting the hospital and our two houses only. As short wave radios have never been permitted in Japan, we could get only the news the authorities wished all to hear. News from Manila, the British station in Shanghai, and from Vladivostock had all along been drowned out by jamming the wave lengths, and after Dec. 8th the Shanghai station went off the air altogether and was used henceforth for Japanese propaganda. Sometimes we could hear the French station in Shanghai giving news in English but this was censored by the Japanese and not very different from what we read in the Japanese newpapers or heard over the radio in Korean. The newspapers were not very happy reading. The kindest reference to Hong Kong was "the accursed British colony," the treachery of the cowardly British in destroying rubber trees in Malaya was deeply deplored by the Japanese commander there, and the dastardly deeds of the British and Americans who were said to have sheltered their own troops behind native women in the first lines, and native troops in the second, was fully described as said to have been carried out in Hong Kong, Malaya, and the Phillipines.

In spite of these infamies of our countrymen, our cook continued with us and the man who did the gardening and marketing for both houses stayed on the job. The poor fellow was kept busy carrying Mr. Fraser's meals to him. This was a great concession as most people while under investigation have to eat the prison fare which is rather bad. The unfortunate servant took a beating one day because he did not give sufficient information about us and the people who used to come to visit us.

Mr. Scott's secretary was also arrested and beaten in prison for having sent Mr. Scott a present of sugar, discovered when the Scott house was searched.

As far as we know those two were the only ones who suffered on account of their relationships with us.

The gendarmes were polite enough when they searched our house. They apologized for giving us the trouble of showing them around. Our radio happened to be out of order at the time and this made them suspicious that it was a short wave set we were tampering with to destroy the evidence.

While Mr. Fraser was still locked up three gendarmes took me to the gendarmerie. They told me it was only for questioning and that I would soon be back but the people in the hospital did not expect to see me again and I knew the word of those gentlemen was not always to be trusted. Besides the gendarmes two fully armed soldiers guarded me. After some hours of questioning, they accompanied me home to look over all the photographs I had taken in Korea. We had expected this and they found nothing to cause suspicion. Our cameras were then sealed up but left with us.

On Christmas day we were given the special privilege of going to Mr Scott's for dinner. We were admitted by the gendarmes all three of whom guarded us while we ate. Word had come that Mr. Fraser was to be released by Christmas time and when he did not come, we were anxious about him. Those under investigation in Japanese police stations or gendameries are often tortured. That is the system, not at all something specially designed for enemy aliens, and one is not very happy while one's friends are in such places. Mr. Scott knew that his friend was being well treated and he passed on that information to us in one of the prayers in the little Christmas service we were allowed to have after dinner. No names were mentioned and even the prayers had to be interpreted into Japanese but we understood and went away with hearts considerably lighter than when we had gone.

Mr. Fraser was released free of suspicion on Dec. 30, the guards left the house, and we were allowed to go back and forth after that. From that time on we were under the police who paid frequent visits but did not quarter themselves upon us.

Fuel, rice, flour, sugar, matches, cotton goods, and some other articles were rationed. Butter and coffee were off the market absolutely. Sometimes we could get margerine but it was usually so bad it could not be eaten. Peanut and bean oils had to be used for shortening in cooking when they were to be obtained. Korean friends sent us many gifts of food, and since they could not invite us to their homes, sometimes they sent whole dinners all ready prepared. Korean food is excellent but the kindness that prompted the gifts was appreciated quite as much as the food.

Mr. Fraser had a small radio that had not been sealed up. As he could get Shanghai better than we could, we used to go over there at night, wrap the radio set in a big comforter to keep the sound from being heard outside, and with one ear cocked for anybody coming, and the other close to the radio, listen to the news.

Toward the end of May we were told to get ready to be in Tokyo by the first of June as we were to be exchanged for Japanese and repatriated.

We had arranged for the hospital to take over two of the vacant residences, one of which was in use as a medical annex and the other as a maternity department. Now we packed all our furniture and belongings in a couple of rooms and gave the hospital permission to use the house as a dormitory for

nurses. If the authorities granted permission for this, our buildings and property are in good hands for the duration.

At six o'clock in the morning of June first, 1942, accompanied by the police, we set out on foot for the railway station carrying our hand luggage. All we were permitted to take with us was what we could personally carry, no written or printed matter and no photographs, and one thousand yen in Japanese money which is quite worthless outside Japan. Our baggage was examined by both gendarmes and police before we left. It was again examined by similar gentlemen and also by the customs in Kobe and again in Yokohama. Any one who tried to get by with a few of his family photographs or other contraband speedily had them taken from him.

We were allowed to travel second class on the trains but were not permitted sleepers and the travelling was at night so we could not see anything of the country. Crossing the strait we were kept in the third class quarters below decks with the portholes covered. The police carried our cameras.

On the train we met with other foreigners making ninety-nine in the party. We had had no news of these until now and found that all had been interned, some had been in custody for a few weeks, four had been imprisoned for several months, and three had been very cruelly treated. None but Miss Bourns and myself had been allowed to continue our work. Now all British and Americans were out of Korea, except two old men who had been there for years, had Oriental wives and families, and threatened to commit suicide if sent away.

In Kobe, Japan, we were marched through the streets carrying some of our luggage, the biggest pieces being taken on a truck, to a building used as barracks for soldiers and naval cadets. Here the Canadians and Americans were interned for two weeks, twelve in a room fifteen by eighteen feet. The chief difficulty was to keep clean. We had brooms to sweep out our rooms but no buckets for water to scrub the floors. The food consisted mostly of raw fish and cabbage and none of us got any fatter on the diet. Most of us had brought some food with us and we were certainly glad we did. We were also allowed to buy fruit and anything else we could get at a store next door but that was not much.

The chief pastime was lining up and being counted. We were also allowed to walk in the yard for a few minutes after meals two or three times a day before being ordered back to our rooms. We were counted in our rooms in the morning and again at nine in the evening when lights had to be out. Singing was permitted for half an hour in the evening. We were allowed to go, ten at a time, to the baths for a hot bath, Japanese style, once a week, and twice we were taken for a walk around the city.

The diplomats and the English and Australians were interned in other places, some being in hotels, while we saw some of the prisoners of war from Guam, Wake Island, and the Phillipines crowded together in their quarters as we walked the streets. We all waved but that was the only communication possible.

On the evening of June 16 we were marched through the main streets of Kobe for the populace to gaze upon but that piece of propaganda proved a sort of boomerang. No one gloated or sneered or even smiled. There were very few people in the streets though the event had been advertised in the daily papers and most of those we saw seemed quite disspirited. We further noted that there was very little in the store windows and few customers in the shops.

After another night sitting up in the train we boarded the *Asama Maru* at Yokohama and sailed up Tokyo Bay. In the absence of news or information of any sort, rumors were frequent, including one that we were not going home at all but were to be interned right there on the ship for the duration.

However, on the eighth day up came the anchor and we found ourselves moving.

Our ship was marked for purposes of identification with immense white crosses on funnels, bows, stern, and sides. These were lighted up at nights and the ship's lights blazed every night.

There were about six hundred passengers from Japan, Korea, and Manchuria. The people from Manchuria had had a worse time than those in Korea. Some we knew had been imprisoned months before war broke out, had been sentenced to be deported, and the day before they were to leave, the war came, and they were rearrested and interned. Others had been tortured. Many had had their possessions "bought" by the police or soldiers at one or two per cent of the cost. In all three places the Canadians had been treated with more leniency than others.

At Hong Kong we stood away off shore behind the island and the Americans who were being repatriated came off in launches. They were received by fully armed soldiers and gendarmes and they certainly looked like refugees. What luggage they had was in bags, baskets, or anything they could get, and some of them had little but what they stood up in. Even that in some cases was made out of the chintz covers of the furniture in the houses where they were interned. They were thin and tanned and some of them looked so weak it seemed a great effort for them to drag along the bits of luggage they had. Several of them had lost from twenty-five to forty pounds in weight and they all said the British were having it worse than they, and they had been hungry all the time.

The thing that made me "maddest" at Hong Kong was to see the cocky little Japanese buzzing about with such an air of importance and proprietorship in good British boats.

At Saigon in French Indo-China we went up the river for several miles but not quite in sight of the city. As soon as the anchor was dropped sampans came off from the shore with bananas, plantains, cocoanuts, oranges, eggs, and whiskey. In a few minutes Japanese money was going over the side on the ends of long cords and the other things were coming up.

People who had been interned in French Indo-China and Thailand were taken on here and these folk had all the baggage they wanted to take, as had some from Japan. Trunks and even a piano came on board. These folk reported that they suffered no inconvenience beyond restriction of liberty. They told us too that not long before an allied submarine had come up the river and sunk several French gun boats.

The next stop was off Singapore where we lay for four days. At each port we saw plenty of Japanese gun boats and one day off Malaya about seventy aircraft came over head to impress us. Nobody even went to the side of the ship to look.

Tokyo time is being observed all over the "co-prosperity sphere" and our watches were never adjusted all the way to Singapore. By that time we were having breakfast before daylight and going to bed at dark. When finally

watches were set back, it was an hour each day till we got on to something like sun time again.

The Italian liner *Conte Verde* from Shanghai with passengers from China joined us off Singapore. She was marked like our ship and the two went on together. The Italian commander and officers were very pleasant to their passengers and they had music and entertainments. They were also promised communication with the other ship, for many families were divided and people did not know if some of their families were on the other ship or left behind in the Orient. The Japanese officers were seldom seen and obviously avoided any contact with the passengers. The Japanese commander also refused to allow any communication between the ships.

From Singapore we sailed south, entering the Indian Ocean through the straits between Sumatra and Java. In many places we were quite close to land and were surprised to see so few signs of life. No houses or villages could we see and there was scarcely even a fishing boat all the way from Formosa to Java. By the terms of our safe conduct we had to avoid the usual ocean shipping lanes and saw only one or two ships far off on the horizon all the ten weeks we were at sea.

The food, though not very good, was so much better than we had been getting in the internment camp that it seemed wonderful in contrast. Unfortunately, of the nine hundred or more passengers now on board the *Asama*, many were in third class or in special quarters fitted up to take extra people and these were not very comfortably situated. They were also penalized by having third class food which was pretty poor and none too plentiful.

There was also a scarcity of water which was available for only half an hour twice daily. In cabins with a dozen people ablutions had to be hasty. Laundry was also a problem. Most of us managed to do some washing in our cabins and wore our clothes without ironing.

The greatest excitement of the trip was on entering the harbor at Lourenço Marques, Portugese East Africa, where we saw for the first time on the trip a busy port and, Oh, Joy the good old Union Jack and the Stars and Stripes at the mast heads instead of the Rising Sun. Officers and crews came on deck and cheered us, arms up in the V for victory, while their sirens gave it in the Morse code. The passengers cheered but the ship did not reply to the salute.

Our cameras were returned to us as we entered African waters.

That afternoon we docked and the second thrill of the day occurred when Swedish officers came ashore with mail from home, the first most of us had had in eight months.

Early next morning we lined up for the last time on the *Asama* and as we marched down one gangway the Japanese filed up the other.

Once aboard the Swedish liner *Gripsholm*, we were asked to stay on deck for a few hours till the cabins could be cleaned out. The stewards served dinner on deck, buffet style, and the shouts that went up when the folk from the Far East saw white bread, butter, fresh vegetables, and roast fowl, brought smiles of gratification to the faces of the stewards.

And then line-ups began again. We lined up for cabins, to hand in our passports, to get landing tickets, to get deck chairs, to get money advanced on loan from our governments, for nobody had a cent but Japanese money, to be vaccinated, and to receive questionnaires to fill in, to be finger printed, and several more. A line-up of fifteen hundred people takes time. It also took time

to get the cabins assigned and after standing in line till midnight I slept the first night on the floor in the second class lounge. At midnight on the second night I got my cabin but some one else equally weary was in my berth.

We were in Africa for five days and every moment we were not waiting in a line to do something else we spent on shore. It was winter south of the equator but the weather was quite like a September day in Nova Scotia. There is no grass in that part of Africa but the trees were green and many flowers in bloom.

Lourenço Marques is a Portugese city with wide clean streets, mosaic pavements, many trees, public gardens, and a fine museum where can be seen a great variety of the flora and fauna of Africa.

Imported articles mostly come from Portugal and are very expensive. Native products are incredibly cheap.

We visited the state hospital which consists of several buildings spread at considerable distances over a large area. The buildings are mostly two stories in height. The older ones were in poor condition and one for the care of Africans was decidedly primitive. The newer buildings were quite up to date and well equipped. The maternity wards compared favorably with any I have seen. In several wards natives and Portugese were both admitted.

Free treatment is available for the poor and Portugese are considered poor if they receive less than one hundred pounds a month. I did not find out the criterion of wealth and poverty in the case of Africans.

Steaming south from here we went far to the south of the Cape of Good Hope into cold and stormy waters. For about two weeks only during the whole of the trip were we in cool weather. All the rest of the time we were in tropical heat. Many people slept on the decks.

Crossing the South Atlantic, we entered early one morning the magnificent harbor of Rio de Janiero and found another busy port where we were thrilled to see the *Queen Elizabeth.*

Rio is surely one of the most beautiful cities of the world. The natural beauty of the place is unsurpassed by any city I have seem in nearly thirty countries. The man made part also is something of which the Brazilians need not be ashamed.

Two days out from Rio we saw a derelict, bows and stern gone, burned to the water's edge, tiny wisps of smoke still curling upwards, but not a sign of human life anywhere in sight.

The trip north was uneventful and on August twenty-fifth, 1942, we dropped anchor in New York harbor after ten weeks on the ocean during which we travelled eighteen thousand miles, most of the time getting farther away from our destination, crossed the equator twice, and touched at four continents.

That night we were put aboard a sealed train with guards from the Canadian navy, and next morning in Montreal sixty-nine repatriated Canadians were on their native soil, free to come and go as they pleased.

Minutes of the Semi-Annual Meeting of the Medical Society of Nova Scotia, 1942

THE semi-annual meeting of the Executive of The Medical Society of Nova Scotia was held at the Dalhousie Public Health Clinic, Halifax, N. S., on December 2, 1942, at 3.00 p.m.

Dr. W. A. Curry of Halifax presided. The following representatives of the Executive and members of Council of the Canadian Medical Association attended: Dr. C. Miller, Dr. J. P. McGrath, Dr. J. C. Wickwire, Dr. G. V. Burton, Dr. D. F. McInnis, Dr. C. F. Messenger, Dr. W. J. MacDonald, Dr. P. S. Cochrane, Dr. K. A. MacKenzie, Dr. H. K. MacDonald, Dr. A. R. Morton, Dr. W. L. Muir, Dr. J. R. Corston, Dr. D. M. MacRae, Dr. H. W. Schwartz, Dr. A. M. Marshall, Dr. W. G. Colwell and Dr. H. G. Grant. Dr. F. R. Little, one of the Society's representatives on the Provincial Medical Board was present by invitation.

The President called the meeting to order and the first item on the agenda was the next annual meeting. He explained that the Canadian Medical Association had called off the annual meeting following the request of the Honourable C. D. Howe, Minister of Munitions and Supplies, that conventions should be discontinued. The Canadian Medical Association are holding a business meeting only.

Dr. H. K. MacDonald advised that the Canadian Medical Association recommended the Divisions hold their annual meetings. Dr. Miller suggested that three counties contribute towards any expenses. It was unanimously agreed that the annual meeting be held.

The place of meeting was next considered and as the hotel situation in Halifax is still acute due to war conditions, it was decided the meeting would not be held there. The following letter dated November 21, 1942, from Mr. R. M. Ellis, Manager of the "Cornwallis Inn" was read:

> Replying to your letter of November 20th, as far as we know now, the Digby Pines will be open next year and we shall be very pleased to have your Association meet there for the Convention.

It was the consensus of opinion that the meeting should be held in Digby next year, and in the event of The Pines not being open, that the meeting be held at Kentville. As the annual meeting had not been held in Halifax for some-time and as it was held in 1939 in Digby, it was decided to ask the Halifax Branch of The Medical Society of Nova Scotia if they would act as hosts and take care of the extra expenses incidental to the annual meeting.

Regarding the scientific programme it was moved by Dr. H. K. Mac-Donald and seconded by Dr. Miller, that the President be empowered to appoint a committee of three to deal with these matters and to arrange with the local committee in and around Digby to carry out the details. Carried.

Dr. Grant advised that the Society decided at the last meeting to invite the Provincial Association of Medical Health Officers to contribute one paper each year. Dr. Burton suggested a more extensive programme and that the

meeting continue for one day longer. It was agreed that the annual dinner be a mixed one.

Regarding the annual golf tournament Dr. H. K. MacDonald moved that the feasibility of holding the golf tournament be left to the programme committee. This was seconded and carried.

Dr. Corston spoke on the newly formed Medical Procurement and Assignment Board Advisory Committee. "Since the last meeting your committee has been enlarged in its scope. Up to the time of our last annual meeting the so-called Divisional Advisory Committee was a subsidiary committee to the Central Medical Advisory Committee of the Canadian Medical Association. Since the annual meeting the central medical advisory committee of the Canadian Medical Association has been incorporated into a larger organization called the Medical Procurement and Assignment Board, which is a Government Board set up by the Dominion Government and patterned more or less on the arrangements they have in the United States. It is made up of medical heads of the Army, Navy and Air Forces, representatives from the Department of Pensions and National Health, the members of the C. M. A. Central Committee, and some others. The existing Divisional Medical Advisory Committees were asked to continue as a subsidiary committee to this new organization, and to add to their number the Chief Medical Officers of the three services in this district. The type of warfare is changing in this war and the 800 immediately required medical officers that we had in mind has been extended to 1,000. We have come pretty well up to what might be expected of us in Nova Scotia. It is generally admitted that we have not very many more men to put into the forces with the exception of the young graduates. It is expected that every able bodied medical graduate will of necessity become a medical officer. The further activities of the Board consist chiefly of a survey which is to be made of all the medical organizations in Canada, the results of which will probably be submitted to the Selective Service department of the Government at Ottawa. This survey has been agreed upon by the Board at Ottawa and our Divisional Advisory Committee will be asked to attend to it in this district. We will be assisted by a full time medical officer to do that work."

The next item was a discussion on the Alberta system of membership. Dr. Curry explained the fee system in Alberta and mentioned recent efforts in Prince Edward Island and New Brunswick to put the same system into effect in those two provinces.

Dr. Grant: "At the last annual meeting Dr. Archer told us about the one fee for licenses for the Medical Society in Alberta, and following that our Executive instructed the representatives to the Provincial Medical Board to bring it up at their meeting. The following is the letter from Dr. H. L. Scammell."

December 1, 1942

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

Dear Dr. Grant:

At a meeting of the Provincial Medical Board held November 10, 1942, your communication of July 22nd, addressed to the President, and relating to the adoption in Nova Scotia of "an annual fee for licenses for every practitioner in the province" was considered.

In accordance therewith the following motion was passed: "That this communication be referred again to the Secretary of the Medical Society of Nova Scotia with the

recommendation that each branch of the Society, through whatever means it may desire to adopt, secure the opinion of every medical man in the territory served by such branch Society as to their willingness or otherwise to participate in such a move. When by this means the whole of the province of Nova Scotia is individually canvassed the Board is willing to again consider the situation."

In connection with the above it was the desire of the Board that it be represented by the President and Secretary at any conference held by the Society or officers or representatives of the Society to determine the character of the statement to be placed before the branch Societies in connection with the above resolution.

Yours truly
(Sgd.) H. L. Scammell
Registrar

After considerable discussion it was moved by Dr. Corston that the President have power to appoint a committee, two of which would be the President and Secretary, to confer with the Provincial Medical Board on the above subject, and report back at the annual meeting. This was seconded by Dr. McGrath and carried.

The next item was a letter read by Dr. Grant.

184 College Street
Toronto, September 2, 1942

TO THE SECRETARIES OF DIVISIONS

Dear Doctor:

May we direct your attention to the Supplement of the September, 1942, Journal, page 9, Section 58, "Sir Frederick Banting Memorial."

You will observe that, at the Jasper Meeting, the Ontario Division expressed the view that the collection of funds for this memorial should be undertaken immediately. After consideration of the matter, it was agreed that it should be referred to the Divisions for an expression of opinion.

Please let me have your views at your earliest convenience.

Thanking you, I am

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

The following letter was next read by Dr. Grant.

184 College Street
Toronto 2, Nov. 24, 1942

TO THE SECRETARIES OF DIVISIONS

Dear Doctor Grant:

At the annual meeting in Jasper Park last June, a lengthy discussion took place with regard to ways and means of increasing C. M. A. membership. The following resolution was passed:

> "That each of the Divisions be asked, in so far as possible, to make their Divisional Membership contingent upon C. M. A. membership as has been done in some of the Provinces; and that a covering letter be enclosed showing the arrangement whereby membership has been obtained in each Province and the results achieved by those Provinces having adopted a composite fee."

On August 10th, we wrote to each of the Divisions asking for information regarding their fee structure, what it covers, how it is collected, the total medical population of the Province and the total membership in the College, the Provincial Division and the C. M. A.

From the replies received, we have compiled a summary, a copy of which is enclosed herewith.

It is hoped that, in the Provinces where a composite fee has not yet been adopted, the matter will receive very careful consideration at an early date.

Yours sincerely

(Sgd.) T. C. Routley
General Secretary

It was decided that it was unnecessary to enforce this rule in the Nova Scotia Division. Each year there are only two or three members who belong to the Medical Society of Nova Scotia only.

Dr. Grant read the following letter.

184 College Street
Toronto 2, Nov. 25, 1942

TO SECRETARIES OF DIVISIONS

Dear Doctor:

The following recommendation was made by the Committee on Industrial Medicine in reporting to General Council at the Jasper Park meeting last June:

"That, instead of sections on Industrial Medicine in the Canadian Medical Association and in its various Divisions arrangements be made whereby at all suitable sessions of their meetings, at least one paper be presented discussing some aspect of the control of disability among wage earners."

In discussing this report at the recent meeting of the Executive Committee, it was duly moved, seconded and agreed—

That this recommendation be brought to the attention of the Divisions with the suggestion that, at their annual meetings, they endeavour to have at least one paper on Industrial Medicine.

This matter is brought to your attention for such action as your Division may see fit to take.

Yours sincerely

(Sgd.) T. C. Routley
General Secretary

It was agreed that the Executive approved of the action of the Canadian Medical Association in not having a section on Industrial Medicine, and that the letter be referred to the Programme Committee.

The following letter was next read.

184 College Street
Toronto 2, Nov. 14, 1942

TO THE SECRETARIES OF DIVISIONS

Dear Doctor:

At a combined meeting of the Sections of Dermatology and Radiology in Jasper Park last June, considerable discussion took place with regard to the advisability of providing free biopsy service in every Province of Canada. The discussion was summed up in the following resolution which was passed unanimously:—

"It is recommended to the Canadian Medical Association that the matter of a free biopsy service be studied; and in those Provinces where such a service does not exist, that a recommendation for its provisions be made to the Government concerned."

This matter is passed to the Divisions for such action as they may see fit to take.

Yours sincerely

(Sgd.) T. C. Routley
General Secretary

It was agreed that as we have free biopsy service, no action was necessary.

Dr. Grant read the following resolution from the Colchester-East Hants Medical Society.

Truro, N. S., Oct. 11, 1941

Dear Dr. Grant:

The following resolution was passed at the Colchester-East Hants Medical Society, September 24, 1941.

"*Be it resolved* that a Pension scheme be instituted under the C. M. A. for the benefit of all Medical Practitioners in Canada who desire to retire at the age of 65 years, or earlier if desired, due to physical disabilities rendering members unfit for practice.

"*And further* that the applicant for a pension must have been in active practice in Canada, in good standing, for at least ten years directly preceding his application and a regular contributor to the scheme.

Also that all applicants must be members of the C. M. A."

Yours truly

(Sgd.) D. S. McCurdy
Secretary
Colchester-East Hants Medical Society

It was moved and seconded by Dr. Cogswell and Dr. H. K. MacDonald that this be referred to the General Secretary, Dr. T. C. Routley, for his advice. Motion carried.

Dr. Schwartz, the Editor-in-chief of the BULLETIN, stated that the present editors were thinking of retiring and suggested that perhaps the secretary should be the editor-in-chief and have two associates with him.

Dr. H. K. MacDonald suggested that perhaps the present editorial board would continue for the duration, as it was fairly agreed that they were doing a good job.

Dr. Curry asked if they were willing to carry on until the annual meeting. Dr. Muir asked if it would be out of place to have a retired man as editor-in-chief.

It was agreed that Dr. Schwartz and Dr. Grant should call on Dr. M. D. Morrison and ask him if he would be willing to act as editor-in-chief for the NOVA SCOTIA MEDICAL BULLETIN.

Dr. MacKenzie stated that at the last annual meeting a Legislative Committee consisting of himself and Dr. Gosse had been appointed. One thing under consideration was to take proper steps to see if the three months' time limit in rendering bills to the Workmen's Compensation Board could be extended to the one year period. This procedure would involve a change in the Act. The proper procedure would be for our Committee to go before the Minister, Mr. Curry, first, and present our views and ask him if he would bring an amendment to the Act, but before doing so the Committee must have valid reasons for asking for that change.

Dr. Muir advised that at the annual meeting in Sydney a committee had been appointed to bring up the matter of fees. We have not had a schedule of fees for years, and in conjunction with Dr. Woodbury, who is chairman of a local committee on fees, we are acting together, and the matter will be brought up at the next annual meeting.

It was moved and seconded that the regular rate of ten cents a mile, one way, be paid to the out of town delegates who had attended the meeting. There being no further business the meeting adjourned at 5.20 p.m.

Correspondence

DEPARTMENT OF NATIONAL DEFENCE

THE DEPENDENTS' BOARD OF TRUSTEES

DEPENDENTS' ADVISORY COMMITTEE
at
302 Bank of Nova Scotia Bldg.
Halifax, N. S., Dec. 29, 1942

DR. H. G. GRANT
Secretary, Nova Scotia Medical Society
Dalhousie Clinic

Dear Sir:

The Dependents' Board of Trustees, a Government Board, created by Order-in-Council, (P.C. 18), in January, 1942, provides special assistance to dependents of men serving in the Canadian Navy, Army or Air Force. The Board has its Headquarters in Ottawa and is represented throughout the Dominion by Regional Committees. The object of the Committee is to consider applications for supplementary financial assistance in cases where, occasioned by illness, calamity, etc., the monthly allowance is not adequate. Each case is decided on an individual basis, the family circumstances being taken into consideration. As the local Regional Board finds that most of the cases coming before it are those in which doctors' and hospital bills are involved, it would suggest that the Nova Scotia Medical Society be informed as to the existence of the Board and its powers, and particularly of the fact that all medical bills before being passed by the Board, must be assessed by the Department of Pensions and National Health, according to its schedule of fees. In order to assist the assessment and prompt payment of the bills they should be carefully itemized. Also the Government requests that all bills passed by the Dependents' Board of Trustees must be in full for services rendered to the dependent. We would also like to point out that only bills incurred after enlistment are taken into consideration. For your information we enclose a Circular describing in detail the functions of the Dependents' Board of Trustees. We would be very pleased if you could inform the members of the Nova Scotia Medical Society of this information, either by Circular or otherwise.

Yours very truly

R. A. MAJOR
Chairman
DEPENDENTS' ADVISORY COMMITTEE
Per: Claire Fulton, Secretary

CF/M
Encl.

DEPARTMENT OF NATIONAL DEFENCE

THE DEPENDENTS' BOARD OF TRUSTEES

RECORDS BUILDING
Ottawa, Ont., August, 1942

The Department of National Defence is keenly interested in the welfare of families of men in the Armed Forces of the Dominion. This folder is to let you know something of the arrangements made by the Department to assist dependents—please read it carefully and keep it for future reference.

1. WHAT IS THE DEPENDENTS' BOARD OF TRUSTEES (D.B.T.)?

The D.B.T. is a Government Board created by Order-in-Council (P.C. 18) in January, 1942, to operate under authority of the Minister of National Defence. The D.B.T. has its headquarters in Ottawa and is represented throughout the Dominion by Regional Committees (known as Dependents' Advisory Committees), the addresses of which are shown on this folder.

2. WHAT IS THE PURPOSE OF THE D.B.T.?

To provide special assistance to dependents of men serving in the Canadian Navy, Army or Air Force.

3. WHAT KIND OF ASSISTANCE?

(a) Financial—over and above what is already received under the existing Marriage or Dependents' Allowance regulations;

(b) Non-financial—the Regional Committee can offer advice, and can arrange for assistance to be given, in all types of problems, through the various organizations in your own community.

4. WHO ARE ELIGIBLE FOR FINANCIAL ASSISTANCE?

Dependents of members of the Canadian Armed Forces below the rank of Warrant Officer Class I who are in receipt of Marriage or Dependents' Allowance and who are in special or urgent need.

5. HOW ARE APPLICATIONS MADE?

(a) By dependents—direct to the nearest Dependents' Advisory Committee.

(b) By members of the Forces—through their Paymasters (Navy or Army) or Accounting Officers (R.C.A.F.)

6. HOW ARE APPLICATIONS DEALT WITH?

Each separate application is carefully investigated for the Regional Committee by a qualified person. Financial assistance may be given only in cases of special hardship or to meet emergency needs that cannot be met in full by the dependent or members of her household.

7. FOR WHAT PURPOSES MAY GRANTS BE MADE?

To assist in meeting:—

Expenses due to sickness, (Hospital, Doctor's, Dentist's or Optician's bills, X-rays, Surgical appliances, etc.);
Funeral Expenses;

Special Educational costs;

Losses due to calamities;

Living expenses of large families (more than 4 children) and in other cases of unusual financial difficulties at the discretion of the D.B.T.

Grants made by the D.B.T. are not loans; they are not repayable and they do not affect regular Pay and Allowance cheques. The D.B.T. does not offer "charity": its object is to help dependents in cases of special hardship or emergency.

If you are in need of help or advice or if you know of dependents in need —consult the nearest Regional Committee.

Note.—Dependents who receive Assigned Pay *only* are *not* eligible.

THE DEPENDENTS' BOARD OF TRUSTEES

August, 1942

Regional Dependents Advisory Committees

Headquarters

City	Address
Charlottetown	145 Great George St.
Saint John	80 Prince William St.
Moncton	(Sub-Committee of Saint John) City Hall.
Halifax	302 Bank of Nova Scotia Bldg., Hollis and Prince Sts.
Quebec	18 Henri Belanger Bldg., 88 Cote de la Montagne.
Montreal	2nd Floor, Jones-Heward Bldg., 249 St. James St. West.
Kingston	38 Clarence St.
Ottawa	Room 3, 145½ Sparks St.
Toronto	421 Brock Bldg., 200 Bay St.
Hamilton	210 Imperial Bldg., 25 Hughson St. S.
Peterborough	City Hall.
London	511 Huron & Erie Mtge. Corp. Bldg., Dundas St.
Windsor	310 Canada Bldg., 274 Ouelette Ave.
Sudbury	258 Pine St.
Port Arthur	Room 105, Customs Bldg.
Winnipeg	502 Confederation Life Bldg., 457 Main St.
Regina	105 Darke Block, 2125-11th Ave.
Saskatoon	273-2nd Avenue South.
Calgary	21 Renfrew Bldg., 120 7th Ave. W.
Edmonton	709 Tegler Bldg., 10189-101st St.
Vancouver	435 Federal Bldg., Hastings St.
Victoria	Weiler Bldg., 920 Gordon St.

Applications or enquiries should be directed to the nearest Regional Committee. Do not send applications direct to Ottawa; this causes delay, since the Board returns them, in every case, to the Regional Committee for investigation and report.

PLEASE DO NOT DESTROY THIS—KEEP FOR REFERENCE

Personal Interest Notes

THE marriage took place on December 18th at the home of Dr. L. M. Silver, Halifax, of Ruth Joyce McGrath, daughter of Mrs. H. McGrath and the late Mr. McGrath of Sherbrooke, and Dr. Gordon Louis Silver, son of Dr. and Mrs. L. M. Silver. The groom graduated from the Dalhousie Medical School in 1935, and since then has been practising in Sherbrooke, N. S.

Dr. Royden Simpson Gass, son of Mr. and Mrs. Fred Gass, New Glasgow, N. S., director of the Division of Tuberculosis Control in Tennessee, is in charge of the Middle Tennessee Tuberculosis Hospital which was dedicated on December 21st. The new hospital will provide 65 beds and will house state headquarters for the Division of Tuberculosis Control as well as tuberculosis medical service. Dr. Gass graduated from the Dalhousie Medical School in 1925.

The BULLETIN extends congratulations to Dr. and Mrs. J. R. Cameron of Middle Musquodoboit on the birth of a daughter, Constance Diane, on January 4th.

The marriage took place on December 15th at Halifax of Ethel Pauline Gates, daughter of Mrs. A. Gates, Harmony, Kings County and Dr. Crossman Harley Young, son of Mr. and Mrs. Borden Young of Blandford, Lunenburg County, N. S. Dr. Young graduated from the Dalhousie Medical School in May, 1942, and is at present practising with Drs. Hebb and Brennan of Dartmouth.

Colonel J. G. D. Campbell, Medical Officer of Camp Borden, spent the Christmas holidays in Halifax, and he and Mrs. Campbell left on a visit to Montreal and Toronto before returning to Camp Borden.

The marriage took place at Halifax on December 28th of Margaret Augusta Mack, eldest daughter of Dr. and Mrs. F. G. Mack, and Dr. Henry Brown Ross, son of Mr. and Mrs. H. A. Ross, all of Halifax. Dr. Ross graduated from the Dalhousie Medical School in May, 1942, and is at present resident physician at the Victoria General Hospital and will shortly join the medical service of the R.C.N.V.R.

The BULLETIN extends congratulations to Colonel G. R. Forbes who was recently appointed district medical officer for Military District No. 6, and promoted from Lieutenant-Colonel to Colonel.

PHYSICIAN WANTED

There is an urgent need for a physician at Louisbourg, Cape Breton. Anyone interested will kindly apply to Allister MacDonald, Secretary of the Louisbourg Board of Trade.

Society Meetings

CAPE BRETON MEDICAL SOCIETY

Through the kindness of Col. Bob Sutherland, the Cape Breton Medical Society met December 10th, at the Military Hospital in Sydney. Dr. Eric Macdonald was in the chair. About 45 members and guests were present. After routine business was dealt with the scientific program was presented by members of the hospital staff.

Major Stevens discussed gun shot wounds involving fractures and soft tissues. The different types were illustrated by X-rays and the presentation of patients. His results were shown to be excellent.

Captain Kahsler spoke on Virus Pneumonia showing numerous X-ray films of the condition, as well as ones taken during convalescence.

Captain George Murphy read a detailed report on a case of Mononucleosis which presented some unusual features.

All papers were freely discussed.

After refreshments were served by the staff, the members reluctantly retired, voting Colonel Sutherland and his staff excellent hosts and the meeting one of the best the Society has held.

Obituary

THE death occurred at Saskatoon, Saskatchewan, on January 10th of Dr. Robert James Macdonald, a native of Hopewell, Pictou County, N. S. Dr. Macdonald was born in 1867, received his B.A. from Dalhousie in 1889, and graduated from the University of New York in 1894. He practised for some years in New Glasgow and Westville, and moved to Saskatoon about thirty years ago. He was a specialist in nervous diseases. He is survived by his wife, a daughter of the late Walter McDonald of Glendyer Mills, Inverness County, N. S., are two sons, Walter E. Macdonald of Halifax and Dr. John R. Macdonald of Prince Rupert, B. C.

The BULLETIN extends sincere sympathy to Dr. H. B. Atlee of Halifax on the death of his mother, Mrs. Sarah Margaret Atlee, wife of A. E. Atlee of Annapolis Royal, who died on December 27th, at the age of seventy-two.