

# The Nova Scotia Medical Bulletin

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

OCTOBER 1946

*Editorial Board, Medical Society of Nova Scotia*

DR. MARGARET E. B. GOSSE, Halifax, N. S.  
Editor-in-Chief

DR. H. L. SCAMMELL, Halifax, N. S. DR. C. M. BETHUNE, Halifax, N. S.  
and the Secretaries of Local Societies.

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.

It is to be distinctly understood that the Editors of this Journal do not necessarily subscribe to the views of its contributors.

1. Manuscripts should be typewritten, on one side only of the paper and double spaced.
2. Should proof be sent to a contributor, corrections must be clearly marked and no additional matter added.
3. Orders for reprints should accompany the proofs.
4. Communications should be sent to the Secretary, Dr. H. G. Grant, Dalhousie Public Health Clinic, Morris Street, Halifax, N. S.
5. Please mention the BULLETIN when replying to advertisements.

## Contents October, 1946

### SCIENTIFIC:

Health Services for the Canadian People—R. P. Vivian, McGill University	321
Teaching Venereal Disease to Medical Students—B. D. B. Layton, M. D.	327
The 102nd. Annual Meeting of the American Psychiatric Association— R. O. Jones, M. D.	333
Review—Wm. J. Morse	337
Abstracts from Current Literature—E. David Sherman, M. D.	340
Registration 21st., Dalhousie Medical School Refresher Course	344
Society Meetings	346
Correspondence	347

# Health Services for the Canadian People\*

R. P. VIVIAN

Chairman, Dept. of Health and Social Medicine, McGill University

CANADA is a country of tremendous area with a comparatively small population of diverse races, habits and customs. Our communities are frequently separated by great distances, and possess local problems of a social and economic nature. The establishment of good health services throughout this vast Dominion presents a very difficult and important problem. It is a problem, however, which I believe can be solved.

One might well ask why good services are not generally available at present. The answer can be found by viewing the insufficient number of adequately trained and competent personnel required, the absence of suitably distributed facilities of appropriate nature, and the lack of a method for providing ample and sustained financial support.

In recent years, we have heard a great deal concerning the establishment of health services. The subject has become a matter of general discussion, frequently by those who seem to lack a knowledge or understanding of the problem. I am sure that everyone in Canada is desirous of seeing a good service established upon a sound basis. This organization is one which should be prepared to give an authoritative opinion and to assist in helping to solve the problem.

People everywhere are concerned about illness and its cost. They are looking to government for assistance with the problem. The present day trend is towards the payment of the cost of health services in whole, or in part, from tax-collected funds. This trend could be dangerous, or it could make possible the most glorious period in Canadian medical history.

One of the dangers in a period like the present, when progress in social thought and development is enormously accelerated, is the hasty adoption of insufficiently considered plans, with all their implications. The danger is real as regards both service and cost. As an illustration I refer to the reportedly unhappy experience in New Zealand with its system of health insurance. Articles now appearing, which I have not seen denied, are stating that the service, as it exists, is far from complete in character or extent, that the cost is bearing very heavily upon the tax-payers, and that the reputation of the health service has been seriously impaired. The very heavy drain upon the government treasury is making it obligatory that the whole principle of health insurance be re-examined. In using this illustration, I do not wish to belittle in any way the attempt of New Zealand to find an answer to one of the most pressing and perplexing medical problems of the day.

In Canada we have been considering for some time what could be done about a national program of health services. The difficulties are great. The high standard of medical practice must be maintained. The needs and desires of people in various parts of our country must be given full consideration. A suitable method of paying for the service must be provided. The need is also great, and is perfectly obvious to anyone who has taken the trouble to examine the statistics. In my opinion, a good program can be established.

\*Address given at Canadian Conference on Social Work, June 25th-28th, 1946, Halifax, N. S.

It will require, however, the full support of the medical and allied professions, the conscious desire of the people, and financial participation by government. It must be a program that takes into full account what is meant by the term Health Service.

Health Service is an inclusive term. It means literally all the services that are required for the cure, alleviation and prevention of disease, and for the restoration and preservation of health. A complete health service can be divided into prevention, treatment, and supportive services. In the past, attention has largely been directed to the cure and alleviation of disease. This was natural as it represented the life-saving service for the afflicted, requested by the public, and for which they were prepared to pay. Advances in medical science have enabled us to attain a better knowledge of disease. Pathological processes have become more accurately understood. Many therapeutic substances and procedures have been satisfactorily developed. Through our better understanding of disease, we have acquired a limited knowledge of its prevention. We have been concentrating, however, upon what we could do for disease as an entity in man, but man is not an individual set apart. He belongs to a family, or a group, or a community. His health is of concern, not only to himself, but also to those dependent upon, or associated with him at work, or in his home. The attainment of cure or alleviation of disease, the restoration or preservation of health depend, therefore, upon the fullest consideration being given to all the conditions that affect health. The conditions which lie beyond the scope of a strictly medical service are social ones relating to the people of the community. A complete health program can only be constructed if we utilize the knowledge to be gained from the social sciences. In this connection, those in social welfare work can play a most important part.

We have seen for some time a growing interest in social welfare that belies the traditional statement of man's inhumanity to man. Social welfare is now officially recognized as a responsibility of government through legislation and the allocation of tax funds for this service. Its true role, however, is frequently misunderstood. It should not be merely the doling out of charity under another name from the taxpayer's pocket. It should be the means of attaining further advances in the progress of society as a whole. It can aid substantially in the program for man's betterment, in which a positive state of health is of paramount importance. A good health service must include the supportive services to be found and developed in the field of social welfare.

To-day your program committee has arranged for papers to be presented on the various aspects of a health service: Public Health, Medical Care, Social Welfare, Medical Economics. I have been asked to speak particularly upon the subject of Medical Economics. The economics of a health service, however, cannot be dealt with unless we take into consideration the proper relationship which should exist between the variety of services which make up the whole program, and allow for the fullest possible development of each part. Concentration upon any one aspect would not only unbalance the program in a costly manner, but could lead to serious failure in achieving the objective of improved health. All the attention cannot be given to medical care—the curative service, as the cost would be fantastic. The "back log" of ailments which now require correction would consume our whole effort, leaving no provision for the prevention of future ailments or for the stimulation of a posi-

tive state of well-being. All our efforts directed to hygiene and preventive medicine at less cost would ultimately prove to be of greater benefit to future generations, but would overlook many of the urgent medical care problems requiring solution now. The program must contain both treatment and preventive measures.

The practice of medicine has reached such an advanced stage that no one person can be expected to possess a thorough knowledge of its many fields. Specialization has become necessary and has proved its value. The construction of a sound health service will require specialization. This means continued recognition of our present specialties and the development of new ones as needed. The role of one of the important contributors to the well-being of mankind needs to be clarified and augmented. I refer to the general practitioner—the family medical adviser. It requires special attributes and special knowledge to deal capably with the complexities of family practice. It also requires further assistance.

In the past the family doctor has been so busily engaged in treating his sick patients that he has had little opportunity to extend his interest in the prevention of disease beyond the few immunizing procedures of proven value for some of the acute communicable diseases. An adjustment of our method of medical practice would make it possible for the family doctor to be of inestimable value in aiding his patients in further developments of hygiene and preventive medicine, that go far beyond what he is now able to do for the relatively few who present themselves for guidance. The necessary advances for the prevention of illness and the improvement of health can only come about through the family physician and those trained to assist him. One of these is the community nurse, who provides the vital link between the physician and the family, through her visits to the home. The other is the social worker. Many of the problems of health can only be solved by the assistance of a competent, well-trained social worker. It is these three who will carry the major burden in a good health service. Their work will need to be co-ordinated. The training of each must be such that co-ordination can be achieved.

Specialization is required in social work. It is also being undertaken. May I plead that specialization be undertaken only by those whose special attributes and training fit them for the task, and that it should be truly in their own field. There is real danger that some medical social workers may destroy their primary usefulness by basing their specialties upon certain branches of medicine of which they presume a medical knowledge which they cannot hope to possess without a full medical training.

It is undoubtedly trite to say that a chain is only as strong as its weakest link, but an adequate health service can only be constructed on a chain basis. The vital links are those in closest continuous contact with the individual and his family, the family physician, the community nurse, the social worker. The co-ordination and application of their efforts constitute the keystone of an arch for the support of the health of the Canadian people. It can be an arch of triumph. It will require careful planning.

All planning should start at the level at which the program is to be applied. Too much attention has been given to the creation of the superstructure of health programs, and too little to their workability at the level of the individual. From sound planning of the foundation, the ultimate structure can be safely built. The strength of the practice of medicine lies in its access to special

services that are beyond the field of the general practitioner. The strength of a complete health service will likewise be found in access to a variety of specialists and appropriate facilities. Our program must, therefore, contain not only co-ordinated services, applicable to the individual and his family, compatible with local circumstances, but also co-ordinated specialist services beyond the local community. The planning of the program will determine its approximate cost and how that cost can be met.

It is completely futile to say that an all-inclusive service, given on a basis of need can be obtained at a flat rate, because the rate itself cannot be determined in advance. The cost of a basic Public Health program can be determined. Portions of Public Welfare programs can be settled. The cost of an unlimited medical care service can only become known after a specified period of time has elapsed and the bills added up. We can base a defined or limited program of medical care on a flat rate by actuarial experience. The cost of this is frequently too high to be attractive to the average individual. Limited insurance plans or partial coverage serve a very useful purpose. They are much needed and provide a way for people to protect themselves against a portion of the cost of illness, but they cannot be expected to extend their coverage beyond those hazards which can be forecast. It is unlikely that they can be utilized by even a majority of our population, let alone by those who need the most protection. Present programs in Canada, supported by tax funds, are very much in the same category. Uniformity of service and economy of operation make municipal doctor plans satisfactory to the people concerned for the limited service that they provide. An all inclusive service is required, but I do not believe it can be satisfactorily obtained upon the basis of the presently proposed social insurance principle.

The operating principle of social insurance is to fix an amount of money as part of the cost of any program and supplement the balance from general taxation. In as much as the total cost of medical care services cannot be determined in advance, the supplement could well turn out to be most of the financial nutrition of the program and would undoubtedly be considered as attrition by the taxpayers. Service given upon demand and without adequate control would be ineffectual, expensive and open to serious abuse. This is vitally important from the standpoint of the individual, both as a recipient of the service and as a contributor to the tax fund. It is equally important to those in charge of government treasuries in carrying out their responsibilities to the people they were elected to serve.

There is great need for a suitable health service for the Canadian people. It must be one that will provide the maximum possible in every area for every individual, at the minimum cost commensurate with the service. It must be paid for in such a manner as to ensure a more equitable distribution of the cost of illness while retaining the incentive of the individual to attain and maintain a positive state of well-being. The only way of which I know that it can be obtained in Canada is to co-ordinate the services required and support those services by money obtained from taxation for this purpose. I use the term support advisedly.

Public Health services are a responsibility of government. It is incumbent upon governments to fully develop a state program in hygiene and preventive medicine and to provide the money required by taxation. This is a matter for Provincial administration, with Dominion co-ordination to ensure uniform-

ity and equality of service. Every province in the Dominion of Canada is able to finance a good public health program out of present revenues. The cost is approximately \$1.25 to \$1.50 per person per year, without those services undertaken in the medical care field. These are grants-in-aid to public general hospitals, tuberculosis sanatoria and hospitals for the mentally ill where the province does not provide its own treatment. The cost to the provinces in fulfilling their statutory obligation for the mental patient is very high. It might be considered that this spending is more properly part of a public assistance than a health program. The problem, however, is essentially a health one, and the difficulties of administration require that it be undertaken by Departments of Health.

Public Welfare now stands on the same footing as Public Health, a responsibility of government. Many of the gaps which need to be filled in both the preventive and treatment services could be undertaken by Departments of Public Welfare. The requirement is the establishment of a uniform system of Public Welfare administration, on the unit basis, co-ordinated with the unit system of Public Health administration, and the reasonable support of treasury funds. Public Health and Public Welfare programs are undertaken in the interest of the community or the state. They are basic and fundamental; they should be recognized as such and paid for completely by taxes. To a large extent these services are carried out by salaried personnel employed by government. I do not believe that treatment services in Canada could be satisfactorily undertaken by such a method.

Medical attention, broadly speaking, in time of sickness is largely an individual problem. A portion of this cost, if not the whole, should be met by the person receiving this service. The maintenance of an individual's health cannot be achieved without his full co-operation. This depends upon the retention of the incentive to be well or to recover from illness as quickly as possible. A medical care program, in Canada, fully paid from tax sources, would I believe, tend to destroy this incentive. The effect could be an overwhelming burden of doubtful value, to be carried by the service at a staggering cost to the taxpayer. I do believe, however, that tax funds must be obtained to assist in the establishment and maintenance of a good program in curative medicine. The cost of a fully developed treatment service is beyond the paying capacity of the average individual when sickness requires that he use such service. On the other hand, it is grossly unfair to expect the responsible person to pay exorbitant taxes for the treatment of those who refuse to assume reasonable responsibility for their own health.

The answer to this very difficult question would appear to lie in the application of a procedure of which we have some knowledge, that is subsidy. By subsidy I mean the predetermined utilization of tax-collected funds obtained by the Dominion and/or Provincial Governments to pay a part of the cost of medical care. The balance to be paid by the individual and/or the local municipality. I firmly believe that careful subsidy of a medical care program is not only sound in principle, but is probably the only satisfactory way a good service can be obtained in Canada. It could provide for:—

1. The establishment and maintenance of services in the outlying districts, which cannot support any service of their own.

2. A more equal distribution of diagnostic, consultant, and treatment services by specialists.
3. The establishment of hospitals of various kinds, so badly needed at present.
4. A visiting-nurse service.
5. The payment of that portion of the cost of all these services, including those of the general practitioner, which is beyond the reasonable paying capabilities of the individual. This can be determined in advance.

The creation of a good health service for the Canadian people is perfectly possible upon a sound basis. It will take leadership and co-operation to do it. If such a program is to be tax supported and the needed controls maintained, there must be participation by the three levels of government in Canada. This means that each government in raising their allotted portion of the cost must retain the means by which to do so. A clear allocation of the taxing fields is, therefore, required. The leadership, to a large extent, should come from organizations representing those who are most familiar with the need and who are prepared to help to meet it. I trust that this organization may be counted upon to do its utmost in helping to provide the best possible "Health Services for the Canadian people."

---

**The Twentieth Annual Spring Graduate Course in Ophthalmology and Otolaryngology will be held at the Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Virginia, April seventh to the twelfth, nineteen hundred and forty-seven.**

# Teaching Venereal Disease to Medical Students

B. D. B. LAYTON, M.D.

Chief, Division of V.D. Control

Department of National Health and Welfare

AS a direct consequence of two recent conferences of public health officers' attention has been focused upon the subject of the average practising physician's knowledge of venereal disease.

It is not a coincidence that this matter has come under intensive consideration at this time, nor is it a transient reaction on the part of what might be termed a few enthusiastic individuals in this field.

To the contrary, this may be regarded as the culmination of a number of years of observation by civilian public health officers, combined with the more concentrated experience of venereal disease control officers in the Armed Forces, working in constant association with general-duty medical officers, whose role, in the Army, paralleled that of the civilian general practitioner.

The unanimous and considered opinion of those who have had this opportunity to study the matter is that, as a general group, medical doctors, recent graduates and graduates of some years' standing, are not sufficiently well-informed on venereal disease diagnosis, treatment and control to carry out their day to day responsibilities in a manner which will, as far as they are concerned, properly fulfil their duties.

That this situation does exist was specifically brought to attention at the Second Federal-Provincial Conference of V.D. Control Directors held in April of this year and attended by Directors of Venereal Disease Control Divisions of all provincial Health Departments, as well as representatives of the three Armed Services. Similarly, the Dominion Council of Health, at its 49th meeting in May, 1946, agreed that, in the field of venereal disease control, the general practitioner plays a most important part and recommended that under-graduates in medicine should receive more adequate instruction in the subject.

That our present teaching of venereal disease is inadequate might well be illustrated by the following observation involving one simple item in the general practitioners field. Ignoring entirely the incompleteness of reporting by physicians, concerning which much could be said, one outstanding feature of our experience in the notification of venereal disease has been the consistent disregard by medical men in one province for the employment of accepted terminology to differentiate the stages of syphilis. To illustrate, figures compiled by the Dominion Bureau of Statistics show that other than with minor modifications the incidence of all types of syphilis is relatively constant throughout Canada. An inspection of the reported cases of syphilis shows that in Canada in 1945 there were reported 5,695 cases of primary and secondary syphilis and 15,278 cases of syphilis—all types, i.e., 37% of the total were primary and secondary cases. In the province mentioned there were reported during the same period 31 cases of primary and secondary syphilis and 664 cases of syphilis—all types, i.e., 5% of the total were reported as primary and secondary cases.

For the first six months of 1946 a similar situation persists. For Canada,



as a whole, the proportion of primary and secondary syphilis was 39%. For the province mentioned, out of 343 cases of all types syphilis, only 16 were reported as primary or secondary, again, approximately 5%. This is the only province which shows a percentage as low as this, the others differing slightly amongst themselves but within the same magnitude.

One has every reason to believe that the standards of the teaching institution in this province are of the highest, yet surely there is something wrong with the method of instruction when the physicians report only 5% of their cases of syphilis as in the primary and secondary stages while we have every reason to suspect that the true proportion is in the neighbourhood of 35% to 40%.

Admittedly, this is an isolated example, but it does serve to illustrate rather emphatically one inadequacy in a comparatively simple phase of the general picture of venereal disease knowledge. From discussions with other interested individuals it would appear that this lack of knowledge encompasses, in varying degree, the whole subject of venereal disease in so far as the general practitioner is concerned.

What, specifically, are the deficiencies most evident in our present method of instruction? Considering venereal disease teaching from a general viewpoint, possibly, the most outstanding feature is the lack of correlation of the teaching of the different aspects of the subject. While admittedly it is necessary that the bacteriology of syphilis be taught at one time, pathology at another, skin manifestations in the dermatology clinic, other complications in general surgery, or gynaecology, or by the neurologist and cardiologist, little effort seems to be made to correlate these various laboratory and clinical features of venereal disease at any one time in the student's course.

In consequence, the student's knowledge is inco-ordinated and incomplete. He has acquired a little knowledge about a number of things relating to syphilis but the general picture is obscured by the multiplicity of detail.

This is not mentioned in an effort to detract from the value of the instruction "per se" as it is given to the student by the teaching faculty at the medical school. It is all very important and essential training which the student must receive, but it is felt that, in spite of the high standard of the instruction, there are many loose ends left in far too haphazard a state.

Another shortcoming which has been mentioned is that venereal disease instruction has not been given the prominence it merits in the teaching curriculum. I do not think it is possible to offer any comparative figures regarding the amount of time the general practitioner spends in the treatment and control of venereal disease patients. But it may provide some indication to point out that, in one province, the medical officers of health, according to a survey carried out, are occupied from ten to twelve per cent of their time in venereal disease control activities, while in another, it was estimated by the Chief Medical Officer of Health that his field workers devoted as much as twenty-five per cent of their time to V.D. control. These are, admittedly, rough figures and are not applicable to the general practitioner, but they do indicate that a significant part of a physician's practice may be intimately, or indirectly associated with venereal disease and its consequences. It would, therefore, seem reasonable to urge that training in venereal disease should receive the same prominence as other subjects on the curriculum and that the standard of training should parallel that in other specialized fields.

Considering further the method of instruction, it has been suggested that the teaching of venereal disease and its complications is approached, in many instances, in the wrong direction, emphasis being placed upon late manifestations and complications rather than the early case. Obviously an effort should be made to correct this misrepresentation of the important aspect of the V.D. problem—the control of the early infectious case.

Another point I would refer to deals with teaching in V.D. clinics. Here is an excellent opportunity for the student to acquire first hand knowledge and experience in the diagnosis and management of V. D. cases and contacts, including the study of the background of each patient, the environmental and psychological factors involved in the acquisition of venereal disease.

From my personal experience and that related by others, it is apparent that the full value of instruction in clinics is not being utilized. The physical set-up of the clinic is, in many instances, most unsatisfactory for teaching purposes, and the clinic physicians are usually far too busy to spend much time with the students. Those that do, all too frequently present an irregular and disjointed discussion which has little constructive value.

To be most effective, a planned course of instruction in the clinic should be presented to the student, and the teaching should be given by some one devoting his full time and consideration to it, not by the doctor administering treatments whose thoughts are restricted to or frequently interrupted by the stream of patients passing through. Obviously, it is most ineffectual to attempt to teach any subject under such adverse circumstances. In order that the facilities offered by the clinic may be fully utilized, an effort should be made to reproduce an environment most conducive to concentration and attention on the part of the student and eliminate all features which may distract the instructor.

Having examined briefly some existing defects in our general plan of V.D. training, we are led to the consideration of steps which will accomplish improvement of instruction of medical students in the field of venereal disease control. One would be over optimistic to consider that even a drastic revision of any training syllabus would be sufficient in itself to equip medical graduates with a knowledge which we feel it desirable for them to have. To the contrary, there will undoubtedly be necessary a number of revisions to any course of training to achieve ultimately a desired standard, and even then modifications will have to be made from time to time to keep abreast of the rapid advances in this particular field. However, if the course of training in venereal disease is to be improved, we should make a start at the earliest opportunity and with this in mind the following suggestions are offered.

First and foremost the co-ordination of teaching should be considered. To achieve this, a co-ordinating committee should be formed. The purpose of this committee would be to integrate the functions of each of the Departments in the Faculty of Medicine and point out where the greatest emphasis should be placed. All teaching should be correlated to the general scheme.

This committee should consist chiefly of the following members:

Dean of the Faculty

Heads of Departments (Medicine, Surgery, Obstetrics and Gynecology, Pediatrics, EENT., Preventive Medicine, Pathology, Bacteriology, etc.)

Director of Provincial V.D. Control Division.

An additional member of such a committee would be a member of the Medical Faculty who might ultimately act as the head of a separate department of Venereology or whatever such a department might be titled. It is felt desirable that eventually one individual should direct the complete course and supervise all teaching activities. Our aim should be directed toward a unified school of thought in syphilology with a view to the development of a department in the medical school which would accept the responsibility to direct a teaching policy and co-ordinate all teaching pertaining to the subject.

One final word regarding the co-ordinating committee. The presence on the committee of the Director of the Provincial V.D. Control Division is considered most essential. He is the only man who is in a position to assess the effectiveness of the teaching measures employed and his experience of observations combined with those of his field workers will prove a valuable guide in considering other modifications to be incorporated in the course.

To impress the student with the importance of this subject, V.D. training might well be initiated during the early clinical or even the pre-clinical years of his course. One's purpose would be to condition the undergraduate's mind through the succeeding years to the proper concept of venereal disease. As each of the different laboratory and clinical features of syphilis is dealt with, an effort should be made to develop in the student's mind the proper picture of a progressive disease entity rather than a disjointed symptomatic process.

To emphasize further this feature and to act as a guide, a plan or outline of the full course in syphilis which will be presented throughout the entire medical course might be given to the student upon entering medical school. With this could be incorporated a synopsis of lecture material which would permit supplementing as the lectures are delivered, and the addition of notes, excerpts of scientific articles and other useful information which will be accumulated.

In the final year of the medical course, it would seem most appropriate, to ensure the correlation of teaching which has been given throughout the earlier clinical years, to present a general review of the subject in the form of a symposium of venereal disease which would provide a well rounded picture of these conditions.

First a complete review of syphilis and gonorrhoea should be presented, each being dealt with as a distinct and complete entity, and the full course of each condition being considered in chronologic sequence. With this as a solid foundation the more specific aspects of venereal disease control should be discussed. Primarily the student should be impressed with the responsibility which automatically becomes his when a patient suffering with venereal disease presents himself for examination and treatment. He should be made to realize that his duties go beyond making a correct diagnosis and prescribing adequate and effective treatment. Obviously his first responsibility is to his patient, but having given proper attention to the existing condition he must consider the other aspects of the case, his responsibility to the public, first, to prevent the further spread of disease by the person from whom this patient acquired it and, second, to prevent his patient from transmitting the infection to other individuals.

There is also the responsibility of the physician to the Health Department of his community, his knowledge of legislation relating to health, and

venereal disease in particular, and his familiarity with the operation of the Division of Venereal Disease Control in his province. In a preliminary lecture on the subject of venereal disease control each of these points might be touched upon briefly, but they should be considered in detail in subsequent discussions.

Another lecture might deal with the responsibilities of patients and contacts, the disclosure of information leading to the identity of the contact, the technique of interviewing the patient to obtain the maximum of information and at the same time educating the patient to his responsibility to the community, his family and himself. The status of the infected contact in the community should be fully appreciated.

Along the same theme a great deal of valuable information could be conveyed to the student regarding the services provided by the Public Health authorities in so far as diagnostic and treatment facilities which are made available, case finding, contact investigation and so on. Education in venereal disease control is a very broad subject and knowledge concerning it would be of value to the physician not only that he may appreciate his responsibility in the dissemination of V.D. education but also that he may be familiar with current activities in this respect. Films, both of a technical nature and for the instruction of the lay public could advantageously be screened in conjunction with a lecture on education.

A broad review of this type should also include the association of the moral, legal and welfare aspects with the general problem. While admittedly the activities of the physician will be confined to matters of a medical nature, he should at least be familiar with the moral and social implications in order that he may have a well balanced and fully rounded picture of the problem.

These various topics call for a comprehensive knowledge and familiarity with the subject and would be especially enhanced if delivered by an instructor whose day to day activities were intimately associated with the points under discussion. It would therefore seem logical that the lectures dealing with the public health aspects of venereal disease control might best be given by personnel of the Provincial Division of Venereal Disease Control. In most provinces there is a full-time V.D. Control Director while in the others a qualified medical officer of Health devotes a part of his time to this work. Consequently, personnel are available and I feel confident that in every province the V.D. Control Director would be eager to co-operate in delivering a series of lectures such as has been briefly reviewed. In addition to the lecture course small groups of students should have a conducted tour through the provincial V.D. Control Division, wherever this is feasible. To observe the various activities in such a Division is a valuable education in itself and would serve further to impress the responsibilities of the physician to the Health Department.

One brief additional word might be said about venereal disease treatment clinics. To derive the maximum benefit for teaching purposes there are two features which could stand much improvement. First, the delegation of one or more qualified physicians to devote full time to teaching while the students are present in the clinic, and this should include adequate preparation and the accumulation of clinical material for demonstration purposes, wherever possible. Second, the physical arrangement of the clinic. I shall not dwell upon this at any length but I think you will agree that even in some teaching hospitals, the V.D. clinics are a disgrace—teaching under existing circumstances

is impossible. The co-operation of the medical superintendents of such hospitals should be obtained by any means necessary to assure improvement at least to an acceptable level. Then possibly they may be utilized for teaching with some benefit.

In this discussion I have confined my remarks to generalities with regard to teaching venereal disease. Details are, of course, important but should be worked out by the co-ordinating committee. Each Department should appreciate and accept the responsibility for contributing its share in the over-all plan.

Also, I have not touched upon other than under-graduate teaching and training. In considering the subject we should not overlook the importance of further training in V.D. treatment and control for the Intern group, the arrangement of post-graduate training facilities, including refresher courses for the general practitioner in our teaching institutions, and of course the specialized branch of public health work, those graduates studying for the Diploma of Public Health.

One's chief concern at the present time, however, is the training of the under-graduate, and in concluding my remarks, I would like to summarize the points which I feel are of outstanding importance:

1. Co-ordination of teaching of venereal disease through the formation of a Co-ordinating Committee in the Medical Faculty. Ultimate objective—the establishment of a separate department to deal with instruction involving all aspects of venereal disease and its control.
2. A specific plan of syphilis teaching throughout the medical course with a final year symposium on venereal disease, presenting a complete review of the subject.
3. Greater emphasis on the teaching of syphilis as a progressive disease entity.
4. Greater emphasis on the public health aspects of venereal disease control, such instruction to be given by experienced Public Health personnel.
5. Improvement of venereal disease treatment clinics in order that their facilities for teaching may more effectively be utilized.

# The 102nd Annual Meeting of the American Psychiatric Association

Chicago, May 27-30, 1946

ROBERT O. JONES, M.D.

Associate Professor of Psychiatry, Dalhousie University

THE 102nd Annual Meeting of the American Psychiatric Association was held in Chicago, May 27-30, 1946. Convened in troublous times, in the midst of the railway strike, power dim-outs, the general unrest of black markets and the last days of O.P.A., the meeting was astoundingly stimulating and encouraging. Noteworthy were the reports of increased understanding of human behavior gained from the extensive experience of war with emerging therapeutic possibilities as a result. From the social angle the Conference was a huge success, giving the opportunity to renew old friendships with a group whose members have been scattered from the islands of the Pacific to the heart of Europe during the past five years. In all the above, however, one issue which received a great deal of discussion stands out from the rest in importance—the angle of medical care, economic security and, above all, the humanitarian care of a large section of our sick population. This issue concerns itself with the care and treatment afforded our mentally ill patients in our State and Provincial Hospitals. The following quotes largely from a most significant report filed by the Committee of Psychiatric Standards and Policies of the American Psychiatric Association—a report most forcibly presented by the Committee's chairman, M. A. Tarurmianz. The Canadian representative on the Committee was Dr. C. B. Farrar, Professor of Psychiatry at the University of Toronto.

The background of this report is obvious—all over the country there has been a wave of increasing interest in psychiatric problems. It has become commonly known and monotonously reiterated that more hospital beds are taken up for nervous and mental diseases in our country than all other diseases put together, that for every individual graduating from university four will spend some time in a mental hospital, that one out of twenty of our population have psychiatric treatment at some time in their lives, that schizophrenia is more prevalent than tuberculosis and is probably our greatest single cause of human suffering. Going along with this realization is an equally vivid one that our facilities for dealing with this problem are, to say the least, woefully inadequate, in some cases providing for the care of psychiatric patients under conditions in which few of us would keep a dog. Public recognition of this fact has emerged in such unfortunate newspaper publicity as that given the New Brunswick Provincial Hospital recently and the criticism and disclosures of the State Hospital system of Illinois in a widely circulated American magazine. While it may be true that in many instances there are abuses that need remedying, surely this could be done with less adverse publicity and destruction of public confidence in the institutions that do exist. The American Psychiatric report recognizes these abuses and suggests measures for the provision of adequate psychiatric services in our state hospitals. Highlighting this report are the following statements—"It is obvious that such services can be rendered

to people only through a competent staff. A true medical and psychiatric service can be rendered to the patients of our hospitals through competent personnel which cannot be obtained in any state without consideration of salaries of such a personnel. In the majority of our hospitals the most skilful psychiatrists are relegated to administrative responsibilities while the person to person treatment of our patients is passed on to the younger and less experienced staff members." "Every recognized psychiatric hospital should be so well planned that the medical man and the public will accept them, thus public trust and confidence in the medical profession will be established. Such services can be rendered to the people only through a separation of the acutely and subacutely ill, as well as convalescent cases, from the chronic."

*"The cost of such care should be considered on the same basis the cost of the care of physically acutely ill in an approved general hospital. It is also deemed essential to include the cost of such services in the policies of the "Blue Cross" and other hospital insurance plans."*

"There should be a new integration of state mental hospitals with General Hospitals and Medical Schools."

"The Medical Schools should supply men from their staffs to do teaching in state hospitals. This teaching could be in the nature of seminars, discussion of case reports, bedside teaching and lectures. The senior men in the State Hospitals should receive appointments on the teaching staffs of our Medical Schools."

The report goes on to point out that there are many men in the country to-day wanting training in psychiatry but not being interested in the State Hospitals "in spite of the fact that there are many lucrative vacancies on State Hospital staffs." If such men were given appointments on a new basis—for example, they could spend half a day at a State Hospital, and at least a half a day two or three times weekly in the outpatient Clinic of a General Hospital, as well as some time on the wards of a General Hospital, in addition to receiving regular instruction and supervision by men on the staff of a Medical School—then, we could develop a new type and standard of psychiatric education in the country."

The Committee feels that every psychiatric hospital administrator will concur in these ideas. It adds—"It will be necessary for the organized medical profession through its many channels, to induce the public as a whole to become cognizant of the importance of this program and to prepare its representatives to think seriously how to make this program a reality."

The concluding paragraphs are particularly stressed—"The public will not consider psychiatry as a legitimate scientific branch of medicine, as long as mental patients are treated in institutions at a cost of a minimum sixty-five cents per capita per diem and a maximum cost of two dollars per capita per diem.

The Committee believes the American Psychiatric Association should become more realistic and demand that every state mental hospital consider a minimum of five dollars per capita per diem necessary for the care and treatment of acute, subacute and convalescent cases, and two dollars and fifty cents per capita per diem for the care of various types of chronic cases."

Attached is a statement of the requirements of a state mental hospital with a capacity of 1000 patients.

This report should have special significance to the profession and the people of Nova Scotia. At a time when we are thinking of reconstruction and expansion of our social services, and when there is considerable interest shown by the public in the care of our psychiatrically ill, we should consider how we measure up. We have an extremely well run, moderately well equipped Provincial Hospital with a patient load of about 400 patients, the majority of whom are acutely ill and need a great deal of medical and psychiatric attention. This hospital is staffed with two full time and one-half time physicians—well trained, extremely hard working and conscientious, but by the very mathematics of the thing, completely unable to give treatment services in many cases. In addition we have our County Asylums, with a population of over 1700 psychiatrically sick adults. The care given in these places varies tremendously, in the words of the Davidson report (1944)—“At its lowest, the type of care provided sinks to a level that no enlightened community should tolerate for any of its citizens. Even at its best, the care provided in these county asylums is little more than custodial.”

In Nova Scotia then we have 2000 or more psychiatric patients in institutions—we have three trained psychiatrists working with this group. We have not one well trained occupational therapist, physiotherapist or psychiatric social worker for this whole group. These 2000 people were once and, in some cases still are, the patients of the readers of this BULLETIN—This report of the American Psychiatric Association is certainly not some specialist's concern without reference to the real problems of the medical profession of Nova Scotia.

#### REQUIREMENTS FOR RE-ORGANIZATION OF "X" STATE MENTAL HOSPITALS WITH A CAPACITY OF 1000 PATIENTS EACH

1945-1955

##### FIRST GROUP

###### Receiving Ward

Cap. 30 Patients

- 1—Psychiatrist
- 8—Graduate Nurses
- 5—Attendants.

###### Ward for Acutely Ill

Cap. 60 Patients

- 2—Psychiatrists
- 15—Graduate Nurses
- 10—Trained Attendants
- 2—Physio-hydro-therapists
- 2—O. T. Aides
- 2—Recreational Aides

###### Convalescent Ward

Cap. 100 Patients

- 2—Psychiatrists
- 10—Graduate Nurses
- 14—Trained Attendants
- 4—O.T. Aides
- 2—Recreational Aides

###### Re-education Ward

Cap. 150 Patients

- 2—Psychiatrists
- 6—Graduate Nurses
- 20—Trained Attendants
- 2—Physio-hydro-therapists
- 2—O.T. Aides
- 2—Recreational Aides

##### The Monthly Cost of Medical, Nursing and Allied Services for the Above Four Services—340 Patients

7—Psychiatrists.....	\$ 3,500.00
39—Graduate Nurses.....	6,240.00
49—Trained Attendants.....	4,900.00
4—Physio-hydro-therapists.....	800.00
8—O.T. Aides.....	1,200.00
6—Recreational Aides.....	900.00
Total.....	\$17,540.00



## SECOND GROUP

## Continuous Treatment Ward

Cap. 300 Patients

- 2—Psychiatrists
- 8—Graduate Nurses
- 50—Trained Attendants
- 2—Physio-hydro-therapists
- 6—O.T. Aides
- 3—Recreational Aides

## Senile and Arteriosclerosis Ward

Cap. 200 Patients

- 1—Psychiatrist
- 4—Graduate Nurses
- 25—Trained Attendants
- 2—O.T. Aides

## Medical and Surgical Ward

Cap. 60 Patients

- 1—Psychiatrists
- 10—Graduate Nurses
- 10—Trained Attendants

## Children's Ward

Cap. 30 Patients

- 1—Psychiatrist
- 3—Graduate Nurses
- 4—Trained Attendants
- 1—O.T. Aide
- 1—Physio-hydro-therapist

## Ward for Alcoholics

Cap. 50 Patients

- 2—Psychiatrists
- 6—Graduate Nurses
- 7—Trained Attendants
- 2—Physio-hydro-therapists
- 1—O.T. Aide
- 1—Recreational Aide

## T.B. Ward

Cap. 40 Patients

- 1—Psychiatrist
- 8—Graduate Nurses
- 7—Trained Attendants
- 2—O.T. Aides

The Monthly Cost of Medical, Nursing  
and Allied Services for the Above  
Services—680 Patients

8—Psychiatrists .....	\$ 3,200.00
39—Graduate Nurses .....	6,240.00
103—Trained Attendants .....	10,300.00
4—Physio-hydro-therapists .....	800.00
13—O.T. Aides .....	1,950.00
8—Recreational Aides .....	1,200.00
Total .....	\$23,690.00

# Review

WM. I. MORSE

ARTIFICIAL PNEUMOTHORAX IN PULMONARY TUBERCULOSIS, Including Its Relationship to the Broader Aspects of Collapse Therapy—by T. N. Rafferty, Formerly Resident Physician, William H. Maybury Sanatorium, Northville, Mich. 178 pgs. illust. Grune & Stratton, New York (Publishers), 1945.

This up to date book of fine quality represents a valiant attempt to analyze the very confusing literature on this subject, combined with valuable experience. A creditable effort has been made to set down much needed criteria and standards of adequate pneumothorax. The medically ideal use of pneumothorax can only be realized when combined with adequate sanatorium care; and expert surgical consultation and treatment must always be available. The programme laid down is the medically ideal, and it is realized that these facilities are not always available.

The principle of primary thoracoplasty is supported, with the following indications:

- (1) Where the extent of disease requires permanent collapse—e.g. extensive fibrocavernous disease, large apical cavity.
- (2) Where the chance of serious pleural infection with pneumothorax is prohibitive.
- (3) Where interference with bronchial drainage renders pneumothorax dangerous because of possible atelectasis and sequelae.

Major collapse therapy (phrenic not included) is felt to be indicated as follows:

- (1) Extensive cavernous disease.
- (2) Cavity and positive sputum not promptly controlled by bed rest.
- (3) Progression of disease in spite of sanatorium care.
- (4) Predominantly exudative disease that does not regress after a liberal period of bed rest, or bed rest with phrenic.

Tracheo-bronchial tuberculosis, the importance of which is now recognized, and which occurs in 11% of cases, is discussed. Clinical and roentgenographic indications for bronchoscopy are given. The local treatment of tracheo-bronchial lesions by bronchoscopic aspiration and cauterization with 30% silver nitrate is advocated; as well as alternating periods of high humidity and the use of carbon dioxide inhalations to decrease sputum viscosity. Regarding the management of associated parenchymal disease, it is noted that pneumothorax is frequently complicated by atelectasis, tuberculous empyema and anaerobic infection, with a mortality in one series of 42.5%. Thoracoplasty in one small series showed 12% unchanged, worse or dead, and 72% arrested. To minimize complications, pneumothorax is not used if tracheo-bronchial disease is advanced or in the acute phase. A longer than usual trial of bed rest with local treatment may make pneumothorax permissible if the bronchial lesion has responded well. Pulmonary resection is indicated if

bronchial stenosis is marked or pulmonary suppuration more than minimal, providing there is no active contra-lateral parenchymal disease, or bronchial disease showing progression or ulceration.

Lobectomy may also be indicated for tuberculous bronchiectasis, lower lobe cavities, and after failure of a properly performed thoracoplasty to control parenchymal disease.

In the management of pneumothorax, two points are stressed in order to obtain a selective collapse:

- (1) Early pneumonolysis for adhesions.
- (2) Frequent small refills in the first few months.

Positive pressure pneumothorax has many complications and is rarely indicated. Eleven per cent of cases in which pneumothorax is planned, are carried to completion and effective.

If pneumothorax is not controlling parenchymal disease, it is generally making the prognosis worse—most serious pleural complications arise in ineffective pneumothoraces. Early stages of pneumothorax should be considered exploratory, and the procedure abandoned as soon as possible if not therapeutic (with or without pneumonolysis). A longer trial is warranted if advanced contralateral disease requires thoracoplasty. Frequently those with incomplete pneumothorax spaces give temporary closure of cavity and conversion of sputum only to reopen after expansion.

It is advocated that all operable adhesions be cut unless clearly removed from the disease area or pneumonolysis is contraindicated (e.g. extensive complex adhesions, lung tissue throughout adhesions). Up to 80% of ineffective pneumothoraces can be made effective by judicious use of pneumonolysis with negligible danger.

In discussing tension cavities, which are due to the bronchial factor, it is noted that most cavities show several centimeters of positive pressure. To allow healing, positive pressure must be neutralized by:

- (1) Bed rest—less variation in bronchial pressures.
- (2) Complete bronchial occlusion—as by thoracoplasty, pneumothorax or phrenic.
- (3) External cavity drainage.

Tension cavities tend to resist closure by pneumothorax. Thoracoplasty is usually effective in the upper part of the lung. Monaldi drainage or cavernostomy are sometimes indicated.

Tuberculous empyema has a mortality of 40%, and is regarded as largely preventable by consideration of the following:

- (1) Only use pneumothorax after a period of bed rest (notably in pneumonic and acute exudative disease).
- (2) Frequent small refills.
- (3) Immediately abandon pneumothorax unless satisfactory (or can be made so with pneumonolysis).
- (4) If fluid forms, stop refills and aspirate. If fluid persists, abandon pneumothorax.

Sometimes pneumothorax is necessary even though the risk of complications is high. Pneumothorax should be avoided with a large apical cavity or exten-

sive bronchial disease; and contraindications to pneumonolysis must be observed.

In treating tuberculous empyema, the antiseptic agent is less important than thorough frequent aspiration. If this is ineffective after a few weeks, thoracoplasty gives the best result. If the parenchymal disease is controlled and the patient is a poor surgical risk, oleothorax with 4-5% gomenol may be considered, subject to contra-indications.

Ambulatory pneumothorax is shown to be much inferior to pneumothorax with proper sanatorium care, but it is definitely better than nothing for a limited group. There are probably 4 to 10 times the number of active cases in U.S.A. as there are tuberculosis beds. It is estimated that 0.75% of the population of U.S.A. have significant pulmonary tuberculosis—53 to 60% minimal, 35 to 43% moderately advanced. (Of known cases now, 30% are moderately advanced and 57% far advanced).

The use of mass radiography is the only way to get cases early. As a future possibility if all cases were thus found, it is suggested that sanatoria be used to isolate far advanced cases, and the remainder of necessity would be treated as out patients. Ambulatory pneumothorax would be effective in most minimal and moderately advanced cases, and its results would be much improved—ininitely better than no treatment.

I would recommend this book, not only to those specifically interested in public health or tuberculosis, but also to the general practitioner. The profession as a whole know too little about this common and dreadful disease; this disease which through our neglect and the ignorance of the public ranks among the highest of the killers; this disease which by an all out effort on the part of all countries would become a rarity.

---

### Closing Date May 15, 1947

The \$34,000 prize contest for physicians' art work on the subject of "Courage and Devotion Beyond the Call of Duty" will be judged at the Atlantic City Centennial Session of the A.M.A. at Atlantic City, June 9-13, 1947.

Art works on other subjects may also be submitted for the regular cups and medals.

For full information, write Dr. F. H. Redewill, Secretary, American Physicians' Art Association, Flood Building, San Francisco, Calif., or to the sponsor, Mead Johnson & Company, Evansville 21, Ind., U. S. A.

## Abstracts from Current Literature

SALICYLATE THERAPY IN RHEUMATIC FEVER. Keith, J.D. and Ross, A.:  
Can. Med. Assoc. Jour., 1945, 52: 554.

Keith and Ross say that during the winter and early summer of 1944 an epidemic of streptococcic infection was prevalent among naval personnel. Cases of rheumatic fever appeared in the wake of this epidemic. Between February and the end of July, 121 cases were admitted to the hospital with definite rheumatic fever. Of the 103 cases in the salicylate study, 70 were treated with a daily dose of 10 to 13.3 Gm. (150 to 200 grains) of sodium salicylate or acetylsalicylic acid. The drug was started on admission to the hospital and was given in five daily doses. Each dose was accompanied with an equal quantity of sodium bicarbonate. In the control group of 33 cases 0 to 2 Gm. of salicylates was given daily. The salicylates were usually kept up for two to four weeks after the sedimentation rate was normal. Plasma salicylate levels were determined on a limited group. Oral administration of 13.3 Gm. (200 grains) of sodium salicylate with an equal quantity of sodium bicarbonate produced an average blood level of 31 mg. per hundred cubic centimeters. Ten Gm. (150 grains) of sodium salicylate with sodium bicarbonate produced a blood level averaging 27 mg. per hundred cubic centimeters. Such levels are sufficient to control joint symptoms, keep the temperature down and reduce the pulse rate. The sedimentation rate returned to normal in an average of four weeks. The incidence of heart disease was approximately the same in the high salicylate group as in the low salicylate group. Ten per cent of the rheumatic patients who entered the hospital with normal hearts developed rheumatic heart disease. Nausea, vomiting and tinnitus are much more common early in the administration of salicylates than after the patient has been receiving the drug for several days. These symptoms are not usually sufficient cause for stopping treatment. There was no evidence of kidney damage in this series.

PREVENTION OF ACUTE RHEUMATIC FEVER. Fullerton, C. W.: Can. Med. Assoc. Jour., 1945, 52: 559.

Fullerton says that in the city of New York in 1938 there were 1,105 reported deaths from rheumatic fever and rheumatic heart disease, whereas from six other common childhood diseases, namely whooping cough, diphtheria, measles, scarlet fever, cerebrospinal fever and infantile paralysis, there were only 247 deaths reported. There were five times as many deaths from rheumatic fever as from a combination of the six common childhood diseases. With the advent of the sulfonamides a practical method for the prevention of hemolytic streptococcic infections presented itself. Numerous investigators have administered since 1936 daily doses of sulfanilamide and latterly sulfadiazine to patients who had rheumatic fever. In the eight year period 815 rheumatic patients have been given this therapy, and only 8, or less than 1 per cent, have developed rheumatic fever, while the incidence among control groups ranged from 10 to 35 per cent. The value of this prophylactic measure has received tremendous impetus by its adoption and whole-

sale use in the U. S. Navy. In the latter part of the winter of 1943, 250,000 men were placed on daily doses of 0.5 Gm. of sulfadiazine twice daily, while another quarter of a million were used as controls. During this period hospitalization for severe respiratory diseases was reduced 80 to 90 per cent, streptococcal infections were reduced 85 per cent and the incidence of acute rheumatic fever dropped so that for every 14 cases in the control group there was only 1 case in the treated group. The greatest hope in the prevention lies in the adequate and prolonged prophylactic use of the salicylates during a rheumatic attack, to be followed by immediate prolonged prophylactic use of sulfadiazine.

USE OF PENICILLIN IN LUDWIG'S ANGINA. Bean, D. M. and MacKenzie, W. C.: *Can. Med. Assoc. Jour.*, 1945, 52: 568.

Bean and MacKenzie have treated Ludwig's angina with penicillin since 1944. At all times they have a tracheotomy set available, so that, if no improvement was noted in the first twenty-four hours, or if the progress of the disease warrants it, they are prepared to carry out surgical drainage without delay. Early surgery has not been necessary in the cases treated so far. Penicillin will control the infection in the early stages of Ludwig's angina in a high percentage of cases and will greatly reduce the number requiring early surgery.

DICUMAROL IN POSTOPERATIVE THROMBOPHLEBITIS AND PHLEBOTHROMBOSIS. Parsons, W. H.: *Surg., Gyn. and Obs.*, 1945, 81: 79.

It probably 95 per cent of all cases postoperative pulmonary emboli which terminate fatally have their origin in thrombosis of the veins of the lower extremities. Both the incidence and the causation of postoperative thrombi are still matters of debate, but wherever the condition has been properly studied the incidence has always been found to be much higher than is believed. The incidence of postoperative thrombosis is related to the proportion of necropsies secured. For the past five years Parsons has been able to obtain necropsies in about 75 per cent of all fatal cases in his surgical service, and he has observed a relatively high incidence of pulmonary embolism and of antecedent venous thrombosis. The complication is most often observed after surgery, particularly on the pelvic organs. A non-pelvic origin is not infrequent, and surgery does not necessarily precede the development of a pulmonary embolism. Thrombosis should be borne in mind as a possibility following any operative procedure and should be immediately presumed to exist if several days after operation there is unexpected or unexplained low grade fever or if there is tenderness in the calf of the leg on dorsiflexion of the foot (Homans' sign). When thrombosis or thrombophlebitis has been diagnosed or is seriously suspected, exploration of the femoral vein is a wise precaution. If pulmonary infarction has developed, it should be carried out without delay. With this treatment should be combined the administration of dicumarol, which is also a prophylactic measure; but dicumarol should never be employed without adequate control in the form of daily estimation of the plasma prothrombin time. If the plasma prothrombin time becomes dangerously lengthened, the administration of a vitamin K preparation or transfusion is indicated.

PRIMARY ATYPICAL PNEUMONIA: AN EPIDEMIC ASSOCIATED WITH MALARIA.  
Fleming, J., Lindbeck, E. W. and Evans, I. H.: *Brit. Med. Jour.*,  
1945, 1, 689.

Fleming and his associates report 112 cases treated in a military hospital in Italy. In most of the cases the onset was acute, and a high intermittent fever was present for an average of eight days. There was considerable debility, requiring from four to six weeks of convalescence, so that the majority of these men were off duty for about eight weeks. Many of the patients were admitted during a period when there was a heavy incidence of malaria. About one-third had the typical lung lesion in association with malaria. The presence of malaria had no influence on the period of pyrexia. The authors think that if they had not been aware of the prevalence of atypical pneumonia many of the malaria infected cases might, from physical signs alone, have been assumed to be merely associated bronchitis of malarial origin. Several cases presented an acute onset resembling malaria, and the diagnosis became clear only as the illness progressed unaffected by quinine therapy. There was no evidence that the association of atypical pneumonia and malaria was other than fortuitous. Sulfathiazole and sulfapyridine had no effect on the course of the illness, but the authors ascribe the absence of complications to their routine use. There was no indication that they had any toxic effect on the polymorphonuclear leukocytes, and when used in combination with full doses of quinine, in the malaria cases, no adverse effect was noted.

HYPOPLASIA OF UTERUS AND SPASMODIC DYSMENORRHEA. Jeffcoate, T. N. A.  
and Lerer, Sylvia: *Jour. of Obs. and Gyn. of Brit. Empire*, 1945,  
52: 97.

According to Jeffcoate and Lerer dysmenorrhea is related to contracture of the uterus. The difference between painful and painless contractions lies in their character rather than their strength. The pattern of uterine motility causing pain during menstruation is unknown which supposes incoordination of different areas of the uterus, or disturbed polarity of the uterus, has still to be disproved. The theory which supposes uterine hypoplasia as the cause of the abnormal uterine contractions, and the evidence on which it is based, are critically examined in the light of what is known about the development of the uterus. An analysis of the histories of 829 patients suffering from spasmodic dysmenorrhea shows that not more than 27 patients had signs of uterine hypoplasia. The age at the menarche was usually within normal limits. Scanty and infrequent menstruation was exceptional, and most women had a regular cycle. Endometrial studies showed that the histologic phase generally agreed with the time of the menstrual cycle. Painful menstruation is usually ovular in type. Of 457 patients, some had minor malformations of the uterus; but these faults are not accepted as an indication of hypoplasia. The existence of an interval between the menarche and the onset of dysmenorrhea in a large percentage of cases is confirmed. This in itself is evidence against the hypoplasia theory. An analysis of a second series of 86 patients, all of whom had a hypoplastic or atrophic uterus, shows that of the 28 women who were menstruating only one had dysmenorrhea of an incapacitating degree. The value of the estrogen therapy in spasmodic dysmenorrhea is open to question. If it gives relief, it does not necessarily do so by overcoming

hypoplasia. The evidence is insufficient to prove or disprove the hypoplasia theory of dysmenorrhea, and it will remain so long as the pathology of uterine hypoplasia is in doubt.

ANALYSIS OF COLDS IN INDUSTRY. Kler, J. H.: Arch. of Otolaryng, 1945, 41: 395.

Colds are responsible for more than one-third of the total number of days lost in American industry. They cause a loss of 100 million working days each year. There is a definite pattern to the incidence of colds, with the highest peak in December (or December-January) and a lesser peak in October. July is the month of the lowest incidence of colds. Sudden drops in temperature are followed by rises in the incidence and in the severity of colds. Both incidence and severity are much greater among office workers than among factory workers and greater among women than among men. A majority of the colds in women appeared at the time of the menstrual period. There is decreasing incidence of colds with increasing age. The severity of colds increases with age. There are fewer colds in air conditioned plants. The incidence of colds is highest in drafty places. More colds start on Monday than on any other day of the week. This is especially true of colds among men. Posture is an important factor in that the incidence and the severity of colds are lowest among those whose work necessitates walking about most of the time. Early therapy seems to be of greatest value.

PENICILLIN AND PRIMARY SUTURE IN ACUTE SURGICAL MASTOIDITIS. Johnson, L. F., Weinstein, L. and Spence, P. S.: Arch. of Otolaryng., 1945, 41: 408.

Johnson and his associates report their experience in treating 23 patients with acute surgical mastoiditis by primary closure of the wound and instillation of penicillin into the mastoid cavity. Seventeen patients showed complete cure after one course of treatment, while six remained well after a second course of penicillin. The recommended dose of the drug is 10,000 units every eight hours for four days (a total of 120,000 units). Local application of penicillin in the mastoid cavity through a urethral catheter after mastoidectomy appears to be a feasible and practical procedure. When this drug is given in proper dosage, healing of the postaural wound and a dry external auditory canal usually are present on the fifth postoperative day. In cases in which aural discharge occurs, reinsertion of the catheter and reinjection of penicillin for an appropriate period of time produce complete clearing of the discharge. Local treatment with penicillin seems preferable to the use of sulfonamide compounds for infections with *Staphylococcus aureus*, hemolytic streptococci and other organisms susceptible to the antibiotic agent because of the absence of any harmful toxic effects, the slight risk of sensitization and the increased speed of healing.

E. DAVID SHERMAN, M.D.

Abstract Editor



# Registration 21st Dalhousie Medical School Refresher Course

October 7th to 11th, 1946

- Dr. Henry Moyse, Summerside, P. E. I.  
Dr. R. S. Henderson, Halifax  
Dr. K. A. MacKenzie, Halifax  
Dr. W. G. Colwell, Halifax  
Dr. T. M. Sieniewicz, Halifax  
Dr. F. D. Wanamaker, Saint John, N. B.  
Dr. Arthur Green, Glace Bay  
Dr. F. A. Dunsworth, Halifax  
Dr. D. Murray, Tatamagouche  
Dr. C. M. Harlow, Halifax  
Dr. C. L. Gosse, Halifax  
Dr. M. J. Carney, Halifax  
Dr. E. H. Anderson, Halifax  
Dr. C. MacLeod, Halifax  
Dr. B. R. Wilson, Halifax  
Dr. N. G. Pritchett, Halifax  
Dr. Arthur W. Ormiston, Sydney  
Dr. J. C. Morrison, Halifax  
Dr. A. K. Sutherland, Sydney  
Dr. C. J. W. Beckwith, Halifax  
Dr. J. S. Miller, Halifax  
Dr. S. S. Bland, Halifax  
Dr. Wallace Wilson, Vancouver, B. C.  
Dr. H. E. Britton, Moncton, N. B.  
Dr. K. P. Hayes, Halifax  
Dr. H. D. O'Brien, Halifax  
Dr. A. R. Parsons, Halifax  
Captain H. N. MacKinnon, Calgary,  
Alberta  
Dr. A. L. Winsor, Norton, N. B.  
Dr. D. F. MacInnis, Shubenacadie  
Dr. L. A. Collier, Halifax  
Dr. Hugh MacKinnon, Halifax  
Dr. R. B. Eaton, Sackville, N. B.  
Dr. J. C. Worrell, Halifax  
Dr. R. A. Moreash, Berwick  
Dr. C. H. Smith, Liverpool  
Dr. A. D. Kelly, Toronto, Ontario  
Dr. Howard McCart, Toronto, Ontario  
Dr. C. G. MacKinnon, Halifax  
Dr. F. E. Walsh, Springhill  
Dr. W. Alan Curry, Halifax  
Dr. H. J. Pothier, Weymouth  
Dr. L. M. Morton, Yarmouth  
Dr. F. V. Woodbury, Halifax  
Dr. C. M. Leighton, Shediac, N. B.  
Dr. H. C. S. Elliot, Halifax  
Dr. C. M. Marshall, Halifax  
Dr. J. P. Debly, Mulgrave  
Dr. C. L. MacMillan, Baddeck  
Dr. John F. Woodbury, Halifax  
Dr. W. W. Bennett, Bridgewater  
Dr. V. D. Schaffner, Kentville  
Dr. J. A. Noble, Halifax  
Dr. B. Bernstein, Halifax  
Dr. H. C. Read, Halifax  
Dr. I. S. Robb, Halifax  
Dr. E. M. Fogo, Halifax  
Dr. G. A. Black, Halifax  
Dr. A. B. Crosby, Halifax  
Dr. V. O. Mader, Halifax  
Dr. F. J. Barton, New Waterford  
Dr. H. G. Grant, Halifax  
Dr. M. G. Whillans, Halifax  
Dr. Henry Reardon, Halifax  
Dr. Robert O. Jones, Halifax  
Dr. Edwin F. Ross, Halifax  
Dr. Allan R. Morton, Halifax  
Dr. J. W. Merritt, Halifax  
Dr. M. Hubar, Halifax  
Dr. D. S. MacKeigan, Halifax  
Dr. H. E. Taylor, Halifax  
Dr. F. R. Little, Halifax  
Dr. S. G. MacKenzie, Halifax  
Dr. D. C. Cantelopo, Lunenburg  
Dr. E. P. Hopgood, Dartmouth  
Dr. M. G. Patterson, Dartmouth  
Dr. S. B. Bird, Liverpool  
Dr. E. A. Brasnet, Antigonish  
Dr. A. M. Marshall, Halifax  
Dr. D. J. Tinning, Halifax  
Dr. Carl C. Stoddard, Halifax  
Dr. S. C. Strickland, Halifax  
Dr. H. L. Stewart, Halifax  
Dr. W. R. C. Tupper, Halifax  
Dr. E. K. Woodroffe, Chester  
Dr. R. W. Begg, Halifax  
Dr. C. B. Stewart, Halifax  
Dr. R. C. G. Hawkins, Halifax  
Dr. C. O. Homans, Hubbards  
Dr. W. K. House, Halifax  
Dr. T. B. Acker, Halifax  
Dr. D. M. Cochrane, River Hebert  
Dr. G. D. Donaldson, Mahone Bay  
Dr. J. Stewart Murray, River John  
Dr. H. W. Schwartz, Halifax  
Dr. D. W. N. Zwicker, Chester  
Dr. Margaret E. B. Gosse, Halifax

- Dr. Norman H. Gosse, Halifax  
 Dr. H. E. Kelley, Middleton  
 Dr. R. G. A. Wood, Lunenburg  
 Dr. B. E. Barnhill, Sackville, N. B.  
 Dr. Cecil E. Kinley, Halifax  
 Dr. C. M. Bethune, Halifax  
 Dr. C. E. Stuart, New Glasgow  
 Dr. M. J. Wardrope, Springhill  
 Dr. J. H. Charman, Halifax  
 Dr. L. E. Cogswell, Berwick  
 Dr. T. W. MacLean, Westville  
 Dr. Frank W. Morse, Lawrencetown  
 Dr. M. D. Brennan, Dartmouth  
 Dr. W. L. Muir, Halifax  
 Dr. M. Jacobson, Halifax  
 Dr. H. K. MacDonald, Halifax  
 Dr. G. B. Wiswell, Halifax  
 Dr. J. G. D. Campbell, Halifax  
 Dr. J. L. Sutherland, Halifax  
 Dr. C. H. L. Baker, Halifax  
 Dr. A. Ernest Doull, Halifax  
 Dr. M. G. Tompkins, Dominion  
 Dr. G. W. Turner, Windsor  
 Dr. J. A. MacDougall, Arichat  
 Dr. J. C. Ballem, New Glasgow  
 Dr. G. H. Murphy, Halifax  
 Dr. J. R. Corston, Halifax  
 Dr. S. H. Keshen, Halifax  
 Dr. J. W. MacIntosh, Halifax  
 Dr. A. G. MacLeod, Dartmouth  
 Dr. J. W. Sutherland, Amherst  
 Dr. H. I. MacGregor, Halifax  
 Dr. T. E. Grant, Saint John, N. B.  
 Dr. A. E. Murray, Halifax  
 Dr. P. A. Macdonald, Halifax  
 Dr. W. B. Howatt, Summerside, P. E. I.  
 Dr. P. S. Cochrane, Wolfville  
 Dr. E. T. Granville, Halifax  
 Dr. J. P. McGrath, Kentville  
 Dr. D. M. MacRae, Halifax  
 Dr. R. H. Sutherland, Pictou  
 Dr. F. R. Davis, Halifax  
 Dr. C. E. A. deWitt, Wolfville  
 Dr. G. A. Dunn, Pictou  
 Dr. B. C. Archibald, Glace Bay  
 Dr. Eldon L. Eagles, Windsor  
 Dr. W. A. Hewat, Lunenburg  
 Dr. J. S. Robertson, Yarmouth  
 Dr. A. E. Blackett, New Glasgow  
 Dr. H. A. Fraser, Bridgewater  
 Dr. P. E. Belliveau, Meteghan  
 Dr. F. R. Shankel, Windsor  
 Dr. Elizabeth C. Eaton, Sackville, N. B.  
 Dr. C. S. Morton, Halifax  
 Dr. J. G. B. Lynch, Sydney  
 Dr. A. L. Wilkie, Montreal
- Dr. M. R. Elliott, Wolfville  
 Dr. Elizabeth Young, Halifax  
 Dr. Ralph A. Young, Halifax  
 Dr. N. Barrie Coward, Halifax  
 Dr. L. A. MacLeod, Malagash  
 Dr. Samuel Marcus, Bridgewater  
 Dr. C. N. Morehouse, Noel  
 Dr. C. W. Holland, Halifax  
 Dr. H. F. Sutherland, Sydney  
 Dr. D. V. Graham, Halifax  
 Dr. L. P. Churchill, Shelburne  
 Dr. R. G. Wright, Elmsdale  
 Dr. Hugh F. McKay, New Glasgow  
 Dr. D. M. Grant, Halifax  
 Dr. L. G. Holland, Halifax  
 Dr. Arthur L. Murphy, Halifax  
 Dr. J. H. Buntain, Kentville  
 Dr. Frank G. Mack, Halifax  
 Dr. H. Devlin, Halifax  
 Dr. Ralph P. Smith, Halifax  
 Dr. E. I. Glenister, Halifax  
 Dr. F. L. Akin, Windsor  
 Dr. E. Paul Nonamaker, Halifax  
 Dr. G. M. Murray, Elmsdale  
 Dr. E. P. Brison, Halifax  
 Dr. A. A. Giffin, Kentville  
 Dr. Wm. H. Graves, Boston, Mass.  
 Dr. H. G. Quigley, Halifax  
 Dr. W. J. Dyer, Halifax  
 Dr. J. W. Smith, Liverpool  
 Dr. D. K. Murray, Liverpool  
 Dr. C. B. Greene, Port Dufferin  
 Dr. S. Y. Shirley, Shelburne  
 Dr. D. S. McCurdy, Truro  
 Dr. D. MacMillan, Sheet Harbour  
 Dr. H. B. Havey, Stewiacke  
 Dr. R. M. Benvie, Stellarton  
 Dr. V. G. Bowes, Moncton, N. B.  
 Dr. Stan James, Toronto, Ontario  
 Dr. Lewis Thomas, Halifax  
 Dr. R. H. Fitch, Moncton, N. B.  
 Dr. F. F. P. Malcolm, Dartmouth  
 Dr. N. C. Delarue, Toronto, Ontario  
 Dr. H. S. Smith, Caledonia  
 Dr. J. B. Jewell, Halifax  
 Dr. J. V. Graham, Halifax  
 Dr. Peter Hebb, Dartmouth  
 Dr. John C. Whitehorn, Baltimore, Md.  
 Dr. D. Drury, Amherst  
 Dr. J. W. Reid, Halifax  
 Dr. C. B. Cameron, Petite Riviere  
 Dr. H. A. Creighton, Lunenburg  
 Dr. A. M. Creighton, Tatamagouche  
 Dr. K. M. Grant, Halifax  
 Dr. Grace Rice, Halifax  
 Dr. Francis M. Rackemann Boston, Mass.  
 Dr. George M. White, Saint John, N. B.

# Society Meetings

---

## The Pictou County Medical Society

At a recent meeting of the Pictou County Medical Society the following officers were elected:

President—Dr. Ian E. MacKay, Stellarton.

Vice-President—Dr. J. A. Fraser Young, Pictou.

Secretary-Treasurer—Dr. W. A. MacQuarrie, Trenton.

Representatives to The Medical Society of Nova Scotia—Dr. G. A. Dunn (1946), Pictou, Dr. J. S. Murray (1946-47), River John.

A committee on Industrial Medicine was formed and is composed of the following men:

Dr. A. N. Arbuckle, Chairman—Pictou.

Dr. D. F. MacLellan—New Glasgow.

Dr. V. H. T. Parker—Stellarton.

Dr. W. A. MacQuarrie—Trenton.

Dr. H. B. Whitman—Westville.

W. A. MACQUARRIE

Secretary-Treasurer

---

## FOR SALE

Eye, Ear, Nose and Throat practice of 25 years' standing. Furnished offices, equipment, instruments, case histories. J. A. M. Hemmeon, M.D., Wolfville, Nova Scotia.

## Correspondence

---

135 St. Clair Avenue West  
Toronto 5, October 11, 1946

Doctor H. G. Grant  
Dalhousie Public Health Centre  
Halifax, N.S.

Dear Doctor Grant:

Upon returning from England, I am happy to have your kind telegram. Will you please convey to your colleagues my sincere thanks for having elected me an Honorary Member of your Society.

I am sorry to have missed your meeting this year but hope to be with you again next year.

We had some very interesting sessions in London with representatives of 32 National Medical Associations present. They unanimously agreed that a World Medical Association should be formed, and proceeded accordingly. A committee of nine persons has been appointed to complete the organization and convene the first World Medical Congress in Paris next year. I was honoured by being elected Chairmen of the Committee.

Again very many thanks and kindest regards.

Yours sincerely

T. C. Routley

General Secretary

### A DOCTOR—A POET

In 1928 Dr. Felix A. Crichlow graduated in Medicine from Dalhousie University, and in due course established himself in practice in his native Trinidad. While at Dalhousie he won a Literary D for his writing. Several months ago he published *Dunderland*, a series of satires on Trinidad institutions written in the Popian couplet. In a private communication he relates that one action against him resulted but never reached court. While he lays on the lash with a heavy hand, there are bits which relate anecdotes of an amusing nature. We give you this bit from *Food Shortage* as an example of interest to Medical Readers.

John Chinaman from out his hidden store  
 Produced a salt-fish, only one—no more.  
 Two doctors on the ceaseless hunt for food  
 Eyed the salt prize: "'Tis smelly, but it's good."  
 Quoth one: the other, grim-faced, answered not,  
 But to the waiting John, quick as a shot—  
 "I will buy, John. Here is the cash and more.  
 Now I'll be gone if you will ope the door."  
 "Hold!" cried the other, "I will share in this."  
 "Not on your life," said B., and balled his fist.  
 C. grabbed the salt-fish by its horny tail  
 With strengthly grip that would not break or fail  
 B. on the uppers fastened with a will  
 Bent his broad back and tugged with sinewed skill.  
 And then commenced the battle for the fish,  
 As each envisioned bul-jol in his dish.  
 They tug and strain, they heave; down, down they go  
 Pale C. above, B. breathless down below;  
 Then up again, with many a back and forth;  
 The noble salt-fish parted south from north.  
 The tail remains in C.'s relentless hands;  
 With larger portion B. defiant stands;  
 Glares like a Trojan with his captured prey  
 Then quickly turns and through the open way  
 Darts to his car and makes for home and pot.  
 Despondent C., reflecting on his lot,  
 Eyed the remains: "'tis not a bonnie prize.  
 But salt-fish tail just now we can't despise.