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Emotional Adjustment and Morale in War

LIEUT. COL. A. A. JAMES, R.C.A.M.C.

Command M.O., Eastern Command

An Introduction

EACH of us has experienced difficulties in greater or less degree in achieving mastery over emotions which we felt were rather out of place in the particular circumstances. These have often led us into mental tugs of war or frustrational states when our feelings were far from happy and we probably took it out on ourselves, or others, or both. It isn't easy to be really cheerful under all circumstances. Not every person is able to surmount these difficult periods: there may be such a succession of unescapable conflicts that efficiency is impaired or a definite neurosis develops. This is no reflection on the individual because everyone has his breaking point, and the type of strain which affects one is not necessarily the sort that will affect another and vice versa.

The soldier is no different from the civilian, but his lot is more difficult. He is both a citizen and a soldier and sometimes the demands made upon him as a soldier conflict with some of the deeply rooted emotions with which he was born, which in turn have been grouped in varying ways according to the emphasis placed on them in his family life and experience. We are therefore, all somewhat different in our outlook and consequently react differently to the same stimuli. In simple things like the command "eyes right" training can produce uniformity because there is no conflict there, but to train a God fearing man to take life in specified manners, to live in an artificial society, to depend entirely upon a new group or herd for his very existence, all involve a terrific readjustment in moral values and emotions. It is not surprising that it is sometimes but a trivial incident which becomes like unto the straw which broke the camel's back.

We live in a scientific age in which the mechanical aspects of war seem paramount, but man is still the most important weapon of war. No automaton can replace him, because he alone can create and guide such automaton-like machines as we have. But as the complexities of war increase, so in many ways is the emotional strain increased.

Successful emotional adjustment has a great practical value to the soldier, because it is basic to morale and this is a quality without which wars cannot be won. Emotional adjustment studies and applications are but a phase of mental hygiene. Every officer understands the principles of ordinary hygiene and its importance in efficient operations, but he is not yet clear on the implication of mental hygiene and its value. This is a great lack and it is to be hoped that mental hygiene in time will be properly integrated and studied with military hygiene so that the efficiency of the prime weapon of war will be more profitably utilized. This cannot be achieved by the makeshift method of psychiatrists attempting to unscramble the mental omelettes of emotions provoked by bad training, bad administration, bad leadership and bad environment. This approach is analogous to an unthinkable situation where after the Army was provided with fit men they were allowed to be ravaged by typhus fever through disinterest in hygiene, and medical care of the sick was the

only interest taken. Just as Armies have in the past collapsed through typhus and other preventable diseases, so have armies in the past been defeated through mental collapse or, as we have styled it, low morale.

Now that maintenance of morale has been elevated to the status of a principle of war, it behooves us to study the problem in all its ramifications. It is not something that is peculiar to the Services. It is a national problem and good morale in the Services could scarcely exist in a total war if the national will to fight were not soundly based. The national will is in turn but the product of the collective character, emotional adjustment and human values of the individual from every home in the country. If they possess confidence in the intelligence and efficiency of their leadership and administration and the justice of their cause, only then are they able to give of their best and accept to their limit of endurance the necessary sacrifices and risks.

First, what is morale? The word is of French derivation and like so many absorbed into the English tongue, there to be bandied about through long use and misuse until now it undoubtedly means something quite different to most individuals. To some it connotes all things propitious if good and all things malevolent if bad. To others it has a rather restricted moral meaning. Each person according to his vocation, training, experiences, linguistic accuracy or even state of mind tries to shift the meaning or emphasis. The listener or reader is left to place his own interpretation on what is meant by this six letter pot pourri. The sailor, soldier and airman tend to think of morale as specifically applying to their service and being quite distinct from morale of other beings. Many officers seem to think it means only smart saluting and snappy turnout with drastic punishment for infringement. The correspondent, the psychiatrist, the physician, the psychologist, the statesman and others who give the matter professional consideration, each are thinking from a different viewpoint, when they express themselves on the subject. In brief it is a dangerously inexact word but withal a useful one. The confusion is a perfect demonstration of the problem of semantics.

Field Marshall Montgomery regards morale as a vital mental and moral quality which maintains human dignity in battle, and at the same time develops man's heroism and assists him in conquering or at least surmounting fear. The inference is that if it is high it accomplishes just that and it can shade through all degrees downward to the vanishing point when sheer panic takes charge. He considers that four basic factors are essential to high morale —(1) good leadership—(2) good discipline—(3) comradeship and (4) self-respect. In addition he regards as important, such contributory factors as (1) success, (2) regimental tradition, (3) personal happiness, (4) good administration and (5) propaganda.

The American psychiatrists Grinker and Spiegal working with the U. S. Army Air Corps take the view that the process of training induced a man to give up the hardly won independence of adult development, sacrificing his own individual needs, his individual sources of aggressive outlet and gratification, to the needs and discipline of the group. Then what needs he has can only be satisfied by the group. Thus he reverts to a less mature, more dependent level. The soldier therefore comes to love his group and becomes dependent on it for all his needs and mutual protection. Only insofar as self discipline, and co-operation develop has the combat personality become more mature, They regard the basis for good morale as good leadership, since good morale

can only be maintained if the dependent "combat personality" can be given the kind of security a child demands. Morale breaks down and strong and intolerable anxiety develops when leadership is bad. Then interest and affection turn away from the group and then the man begins to think more and more of his home. The group, his superiors and those in authority seem to menace him and stand in his way of obtaining the gratification of his need for love and security. It then only requires some disturbing experience to precipitate a disabling neurosis. The repressed ego, depleted from lack of gratification of its needs and exhausted by fatigue is overwhelmed by anxiety or guilt. Dependent and defenceless the ego re-experiences past conflicts over hostile aggressive activities, and these, no longer directed toward the enemy turn either upon itself giving depression, or upon the group, showing paranoid aggressive reactions. In others the overwhelmed ego develops a passive dependent state or resorts to a primitive expression of its conflicts in some form of neurotic illness.

The above is a useful simplification of the problems, but it must not be forgotten that in spite of the highest morale, both individual and collective, there are those who, depending on the stimulus, will show signs of a neurosis. What will affect one will not necessarily affect another, and the stimulus is not necessarily related to the degree of physical danger. Other emotional stresses such as home worries or job frustration can be equally provocative.

Physical fear is a normal reaction based on the primitive instinct of self survival. Without it, the latent instinct to self destruction such as frequently noted by fliers would be very inimical to the race. We would become like the lemmings who periodically march to their destruction or like startled sheep who will blindly follow the bell wether over a cliff. How delightful would such a situation be to a sadistic tyrant.

Fear being natural and useful, to confess it is good for the soul, rather than let it accumulate in our subconscious mind through an excess of pride. Control of fear should be the aim, not repression. The known is always less frightening than the unknown. Even as it is the first duty of a State to recognize its enemies, so it should be the part of wisdom for the individual to recognize his fears in the open where he may deal with them or easily obtain help from others in so doing. The deep seated fears underlying a neurosis are often distorted or unknown, hence are often so difficult to remove.

But the problem of morale, both individual and collective, is still more vast in its implications. There are certain mental and emotional types of individuals who are too limited in their scope for the required adjustment in present day forces, even though they are perfectly adjusted in their civil environment. According to Rees probably 30% of the population is mentally or emotionally unable to cope with a highly complicated routine of life. Many of them can be most usefully employed in special units such as the Pioneer Corps where like is with like and the work is within their competence. Even the emotionally handicapped can have the highest morale if their employment is intelligent. Actually the citizens of Britain showed fewer breakdowns during the bombing then in peace. Women who would stand placidly in a food queue during an air raid would show great distress when it was rumoured that there was to be a cut in the butter ration. Butter came before guns with them. The national morale during the leadership of Mr. Churchill was excellent. If it had failed, the service morale could not have

been maintained. Now many lament that the closely knit national morale of the war period is no more. The focal objective has faded away and the latent fatigue of war has shown its influence. The stirring leadership is no more, but the discipline remains and has actually increased. Clearly national character alone is insufficient to sustain morale.

Psychiatry alone cannot offer any panacea for morale. There is no acid test to detect in advance all those who will fail, no gunshot mixture to prevent anyone from failing mentally or morally. Needles of the U.S.A. casts grave doubts on the validity of any of the psychiatric screening methods. Whithorn, Dynes and Springer of the U. S. A. have all established the importance of the patient's attitudes in determining his adjustment to service, rather than the severity of his symptoms. Menninger, Braceland and Murray, senior advisors respectively to the U. S. Army, U. S. Navy and U. S. Army Air Force, all feel that for various reasons psychiatry promised too much and could do too little. This honest scientific detachment is most commendable and should not be taken as meaning that psychiatry is useless. Rather it is an intelligent sign of progress far removed from the bigotry of many views held by those whose mind is cast in a fixed mold of self-satisfaction.

McLean of the U.S.A. feels keenly that psychiatry has tended to condone as neurosis too much that which is simply defection of character. However much that lack in character is due to bad or broken homes, he believes, as did everyone in World War I that there is such a thing as pure cowardice of which there are at least two kinds: first, a callous, unmixed selfishness; second, a component of psychoneurosis containing fears which an individual could conquer or allay sufficiently to allow him to carry on his duties. He believes also that there are psychoneurotic disorders, the symptoms of which an individual cannot conquer or allay sufficiently to allow him to carry on his duties. A man with this latter type is therefore not responsible for his failures.

McLean further believes that there were two large divisions of functional disability in war. One of these was a disease of the psyche, the origin of which could be traced to evolution of the personality; the other was an ethical defection, loss of military morale. The ethical defect was often indistinguishable from its psychoneurotic counterpart. It mimicked the irresponsible disorders of the mind, resisted psychotherapy and appeared virulently contagious. This amorality of war did not appear to be limited to the psychoneurotic individual, for normal men and women, in and out of military life, appeared tainted with it. Often it appeared to spread from a civilian focus as a secondary, ethical disorder, the complications of which disabled men in a military sense.

McLean defines morale thus: "The word morale is a polite one, the essence of which I am unable to define. I believe that to possess morale one must have a goal for thought and action; that morale contains, or results in, self confidence, loyalty, trust and honour.

In some of its aspects it is the identification of self with a group, and its values vary from civilization to civilization and from time to time in the same people. I prefer to think of it as a moral virtue no different in peace than in war, a virtue charged with fortitude, courage."

McLean concludes: "With death as the possible reward for possession of morale, the lack of it in battle can be understood. Can we through some

distorted psychiatric concepts, excuse the loss of civilian virtues—morale? Should we disguise our psychiatric failures and then lose the scientific virtue —truth?"

So much for differing concepts of the problem—let us now reflect on some of the methods of inducing high morale to-day and in the past. While man has not changed, his environment has. So has the national character altered from time to time as it varies from country to country. Morale is dependent in part on the national character as well as on the individual character. If the great mass of individuals in a nation is afflicted with selfishness and greed, with a philosophy of "the devil take the hindmost," then so will the whole or any large group thereof, whether in the Service or not, be poor material for a long pull. On the other hand, if the national character is based upon public acceptance of and faith in the solid virtues of religious teaching and ethical conduct as ordained by a Supreme Judge, then each individual in the group is fortified against the greatest adversity and his mind can transcend great vicissitudes and trials. Even patriotism, unless it is solidly linked with the feeling of Divine mission for one's race or country, can be only a contributory factor in morale. The Jap who relied on Shintoism or Ancestor worship along with propaganda of a Supreme mission developed a fine fighting morale and a splendid conquest of fear of death. But, when confronted with a situation for which he had not been conditioned, to wit, the atomic bomb, he folded up completely.

The first Crusades, based on strong Christian faith actually increased the Empire. They prevailed under desperate conditions and inadequate preparations against the religious fanaticism of Saladin. In the later Crusades, when pure vanity and the will to power, pomp and circumstance, supplanted the old genuine convictions, disaster followed disaster.

Oliver Cromwell, a middle aged farmer, became known and recognized throughout Europe as the first military genius of his time. His reputation certainly couldn't have been based on superior tactical and strategic training or knowledge. He was always outnumbered and he demonstrated in his battles no particular novelty, yet he won decisively against trained and experienced soldiers. The only answer can be the deep rooted religious feeling of Cromwell and his Army, with probably a good knowledge of horses and men and their capabilities. Their training was heavily flavoured with religious precepts and the divine purpose of their cause.

The Boer farmers with a solid conviction of the righteousness of their cause and a simple homely faith, resisted and defeated a trained Army. Only when confronted with an Army many times the strength of their own did they capitulate. Perhaps it is not amiss to remind ourselves that Lord Roberts, who was finally called upon to lead the British, was known to be a great believer in prayer.

The tradition of daily prayers in the Navy has obviously done no disservice in their long history. No ship has ever failed to do its best to "seek out and destroy the enemy." Drake, Hawkins, Howard and Grenville filled their ships' companies with the Godliness of their mission before every action. Their men were hardly enthusiastic psalm singers, yet they responded valiantly.

Religious zeal cannot be forgotten in the case of the Fuzzy-wuzzies who

broke the British Square with nothing but spears. There the last man on his feet continued to charge valiantly yet hopelessly.

Nobody can doubt that the Angels of Mons, even though a figment of the imagination, sustained the men who fought, and fortified the resistance of the British Public.

Even the Germans and Russians in the last war, who both officially decried Christianity, tried to substitute a synthetic equivalent. Hitler was subtly put forward as a Godly prophet who tried to claim a divine mission for his people for the next thousand years. The Russians counted on state worship yet tried to effect a compromise with the Orthodox Church and obtain their blessings. Apart from that they depended on patriotism, and discipline based on fear and propaganda.

The Americans depended greatly on pandering to the natural instinct to be on the side of the "Biggest and Best." Even in entertainment money was no object. Boasting was encouraged and some of the weaknesses of character were exploited. But this could be embarrassing when conditions were bad and the going heavy. Punishments had to be unduly harsh at times with the result that wastage due to neurosis was probably increased. Moreover, the system did not successfully maintain morale once the war was concluded.

In many respects Canadian methods were open to similar criticism. We vigorously promoted welfare agencies to improve the creature comforts and entertainment. To an extent these were a useful diversion, but they could never be regarded as an end in themselves. Man has much deeper and more important needs.

Clearly the above very brief survey shows that the practical problem is not childishly simple and naturally one wonders where to begin. Gone are the days when in Britain the Squire or Peer gathered his tenants and retainers about him and personally led them, at the order of the King, into battle. Then there was complete mutual understanding, appreciation and sense of duty. Life was hard but simple. The men deeply respected their leaders and the leaders through long tradition of gentleman-servant relationship honoured their men and took a natural interest in their welfare. Emotional maladjustment must have been rare in this happy state. Certainly there are no records of difficulties.

Later when commissions were bought and sold and men were forced into service unless they could buy themselves off, elaborate scales of punishment had to be evolved. Little was known of the fine balance between reward and punishment, and discipline through fear became the order of the day. Perhaps with the human material to hand much rough justice was necessary. Military Law, as it now stands, clearly shows the imprints of the old "heavy discipline" but has gained respectability through just rules of procedure. However the instrument of discipline through fear is there for those who fear to rule or lead by more intelligent methods.

The system of discipline in the Guards Brigade to-day is in some degree a survival of the earliest system of the Peer and the Squire. Training in drill, deportment, discipline, etc., is largely done by the N.C.O.'s who can speak the men's language. While there is strictness and punctilio there is none the less real comradeship cemented by strong tradition. The officers are deeply imbued with their responsibility for their men and the Unit. To the men they are in reality the Peer and the Squire and the same strong relationship

obtains. Nobody must let the side down and the officer must always remember that his first duty is to protect those under him. And this principle must obtain from top to bottom if that feeling of security inherent in the herd instinct is not to be jeopardized.

Every person values most highly what psychologists term job identification. The officer servant likes to have his work appreciated, the good shot likes to be commended. Every man, no matter who he is, can do something well. Carping criticism is destructive. Positive seeking out and encouragement of ability in any branch should be the aim of all officers from the top down. A pat on the back is an excellent builder of morale. Encourage good and evil will tend to discourage itself.

Poor leaders attempt to force respect. The good leader by using intelligent practical psychology and displaying a just character worthy of respect and confidence invokes a desire in those under him to be led. The good leader appeals to the conscience, personal standards and high ideals of those under him. He never forgets in all humility that everyone placed under him is an individual, possibly finer in some respects than himself. He plays according to time and place on the feelings and emotions and above all he shows true love for all those under him. He plays by the rules with other officers and men according to the best traditions of a gentleman. Self interest is never allowed to influence any decision which might adversely affect others. He goes out of his way to be fair and just.

The officer should realize that emotional conflicts in humans are brought on by the varying emotional demands of ego, sex, and herd in their broad interpretation. The exigencies of the Service demand considerable adjustment at times, but sympathetic handling of human relations based on a full knowledge of the facts and freedom from prejudice can make a great contribution to efficiency.

Everyone accordng to Cabot should try to develop a healthy balanced philosophy of work, play, love and worship. This is a simple rule, good for anyone. To this might be added tolerance and the practice of the Golden Rule. A sense of humour is a saving grace not only in the group but in the leader. How cheering to all were the quips of Mr. Churchill. He never took himself too seriously.

War itself, with all its aggression and wilful destructiveness compared to the ideals of Peace, might easily be considered as a mass psychosis. Man's normal reactions to the abnormal situatons in war are often in marked contrast to the abnormal mental reactions to normal situations in peace. Learning to get along with each other is difficult enough in peace, but the strain of so doing in total war is heightened unless we call upon and reinforce all the constructive values making up a heathy personality. Welfare must not be thought of as a cure-all, however useful or diverting such may be. Often over zealous humanitarianism accomplishes more for the donor's ego than the ego of the recipient. Probably what most individuals really want, if they would but express it or realize it, is to feel significant some way or another in this complicated and troublous age. The worship of the false Gods of Mammon lead ultimately to emptiness and further searching. Happy is he who believes in a Soul and a God and thereby feels himself to be socially significant. The man who finds little significance in his own life will see but little significance in the life of others and less cause to defend the individuality and dig-

nity of others. He is happy enough to surrender his individual rights to the State, hoping thereby to find new significance. This is the appeal of the various forms of state worship, but humanity throughout the ages has repeatedly tried such methods and found them wanting. The fighting services in a democratic state, which believes in the dignity of the individual, (finding itself opposed in a total war in the future, by a tyrannical state which subjugates all human rights to the whim of the leader), must be scrupulously careful to bring their methods into line with the national feeling and ideals. More can be accomplished by sensible co-operation and education in human relations than by force or decree. It is the obvious duty of the services to maintain and, if possible, increase morale and to foster emotional adjustment in the individual and the group. Gone, seemingly, are the days when in a small limited war the Army or Navy looked after itself, for better or for worse. Great human forces, values, and ideals are now being tried in the world crucible.

The public is hourly aware of situations through fast communications, and reacts accordingly. All classes of citizens are vital cogs in the wheels of war and may even be equally involved in the actual fighting. Each group is sensitive to the morale of the other and its spirit may reinforce or deplete the others. Herein lies strength if properly used, but it would give rise to weakness if any group were encouraged to feel superior to any other which was carrying out its essential duty to the best of its ability. To the extent that each individual citizen feels significant and useful in a just cause, no matter where he be placed, so will the sum total of all their co-operative spirit add up to the grand total of the national morale.

In conclusion one might usefully attempt to define the present trend in meaning of morale, at least for purposes of argument. The following is suggested.

The highest individual morale in war is a form of emotional determination arising out of a profound belief in the divine nature of a cause. It is characterized by an unselfish acceptance, whilst being significantly employed up to the limit of physical, mental, and spiritual strength, of any necessary discomfort or risk unto death, in the prosecution of that cause. It tends to be fortified by the co-operative endeavours of the like-minded and to be depressed by lack of faith in the honesty of purpose, justice and efficiency of leadership and administration.

It is not our purpose to summarize the various points and reduce them to a didactic system. To stimulate further study and possibly point the way towards an effective barrier against fifth columns is our wish. We need to know and understand more not only of the individual forces but also of the national and international forces conducive to or opposed to emotional adjustment and high morale to day. It is hoped that while we welter in social and political ideologies, psychological and psychiatric methods and theories, the lessons of the past will not be forgotten nor the immense motivating strength inherent in religious conviction be overlooked.

Napoleon considered that in war the moral is to the physical as three is to one. In the future with national, and possibly even international survival at stake, he would be a bold man indeed to reduce the ratio.

Modern Trends in the Surgical Treatment of Carcinoma of the Colon and Rectum

GAVIN MILLER, M.D.*

Mr. Chairman, Members and Guests:

A few years ago I addressed this Society on a very similar subject, foreshadowing the improvements in technique which were allowing one-stage operations to displace multi-stage operations, and which tended to lessen the percentage of cases which are left with a permanent colostomy.

At that time I stressed the need for earlier diagnosis, pointing out that all technical improvements were valueless unless the diagnosis was made in time. I suggested that all patients visiting the doctor because of bleeding per rectum, increasng constipation, or crampy discomfort in the abdomen, should receive a rectal examination, a sigmoidoscopic examination and a barium enema. The stool should be searched for occult blood. It was pointed out that cancer, in its early stages, is a symptomless disease and that therefore the early symptoms, no matter how mild, should be viewed with grave suspicion. At that time we were especially interested in the preoperative and postoperative care of the patients.

Preoperative care has continued to command our attention and approximately five days are now devoted to this purpose. In large bowel surgery, before the discovery of the use of chemo-therapy and antibiotics, infection was the great cause of death. Peritonitis caused about half the deaths, and broncho-pneumonia or embolism most of the others. At times the patients were simply too anaemic and cachetic to withstand these major surgical procedures.

It was obvious that to avoid the high mortality, usually about twenty per cent, the bowel must be cleaned out, in order to avoid the surgical field being contaminated with stool. The Devine defunctioning colostomy appeared to be the answer but this meant a multi-stage operation, and at least two weeks of irrigation of the bowel above the growth to get rid of its infected contents. Such procedures definitely lessened mortality.

In 1939 and 1940 the use of sulpha drugs, either by mouth or in the abdomen at the time of operation, proved their value. The mortality dropped strikingly. With the development of succinyl sulphathiazole, and later sulphathalidine, deaths from general peritonitis dropped to about one third. More recently penicillin has been added to our armamentarium, and during the past year we have streptomycin which, as Dr. Morton has shown, really sterilizes the bowel.

In Dr. Morton's investigations of 50 cases at the Royal Victoria Hospital which have been prepared for colon surgery by the use of streptomycin, he has found that, by using the sulfonamides and streptomycin administered orally, 90% of the cases have no growth in the stool cultures. In the 10% where a clean field has not been obtained, there has been obstruction preventing the antibiotics reaching the site of the lesion. Therefore it is essential to relieve the obstruction and then carry out irrigations containing 1 gm. each

*Read on the 17 May, 1948, before the Regional Meeting of the American College of Surgeons, Halifax, Nova Scotia.

of streptomycin and sulfathalidine both through the colostomy and per rectum. The advantage of giving the sulfathalidine or sulfasuccidine combined with streptomycin is that none of these are absorbed, therefore complications of the drug are eliminated, the danger of peritonitis is greatly reduced, and primary resection and anastomosis can be carried out as a one-stage procedure.

Thus, our routine preoperative care is carried out as follows:

1. A bland, low residue diet.
2. Extra vitamin intake, especially of B-plex and C.
3. A mild aperient to keep the bowel contents semi-liquid.
4. Adequate blood, plasma, protein, hydrolysates, and gluco-saline to overcome anaemia, low total plasma proteins and dehydration.
5. Sulphathalidine, 1 gm. every three hours, or succinyl sulphathalidine, 1.5 gms. every three hours for 5 days.
6. For 48 hours before operation the patient receives 2-4 gms. a day of streptomycin.

With these measures the patient is brought into condition so that he can withstand the operation and there is no reason why this should be delayed.

With this emphasis on early diagnosis and careful preoperative care having been reviewed, the type of operation to be carried out demands our consideration. Many surgeons are still carrying out multi-stage procedures, that is, making a preliminary colostomy, later resecting the growth, and finally closing the colostomy. There are two reasons from the patients' point of view why multi-stage operations are unsatisfactory. First, patients dread repeated operations; secondly, the great expense of prolonged hospitalization, and thirdly, that no operation, especially in older patients, is altogether free from risk. If we omit for the moment those lesions of the bowel which are causing intestinal obstruction, we may well consider the advisability or necessity of carrying out a primary colostomy. As previosuly stated, colostomies were carried out primarily to clean out, and in a measure to sterilize the bowel. The second purpose was to prevent postoperative distention which might put too great a strain on the suture line of the anastomosis thereby causing a leak which is too apt to lead to peritonitis and death.

The first reason for colostomy, the cleansing of the bowel above the growth, is no longer valid for in the absence of obstruction the bowel can be cleaned and sterilized by the preoperative treatment outlined above.

The second reason, that a colostomy will prevent postoperative distention and strain upon the anastomosis still has some weight. I remember, years ago, the first case in which I did not do a caecostomy following the resection of a growth in the transverse colon. The simple truth is I forgot to do it and later watched the patient carefully, fully prepared to do a caecostomy if she became distended. However, her postoperative course was uneventful. I then decided not to carry out routine caecostomies but to be prepared to do one if postoperative distention warranted it. Only on one occasion has this second operation been required.

In cases of obstruction it is still necessary to carry out a preliminary

colostomy to overcome the obstruction, as a life-saving measure. In all other cases multi-stage operations may be safely abandoned.

The next consideration demanding our attention is the type of operation and of course this will depend on the position of the growth. Seventy-five per cent of growths are within reach of the sigmoidoscope and are considered as rectal and recto-sigmoid growths. The remaining growths are found scattered through the bowel from caecum to upper sigmoid.

With the exception of growths of the rectum and recto-sigmoid which will be described later, I have adopted a more or less standardized procedure during the past number of years.

With the abdomen opened and the tumour demonstrated, the first question to be answered is "can this growth be removed." Just what constitutes operability can only be decided by the operating surgeon and then a great variation in the criteria exists among different surgeons, and this variation makes the problem of assessing results almost insoluble. Now here one may severely criticize the surgeon who, not very experienced in major abdominal procedures, still accepts such cases and opens the abdomen hoping the growth will prove to be inoperable, dreading the death that might occur should his training and experience prove inadequate. To some of you this state of affairs will appear unbelievable, but I assure you it is all too prevalent.

A growth may be considered inoperable if, no matter how skilled the surgeon, it cannot be completely removed. Unfortunately this fact often cannot be finally determined until removal has been attempted and it is too late to turn back. Attempting such operations increases the mortality, but I have always felt it is better to take these chances than to leave removable growths in situ. After all, what has such a patient to live for? Increasing pain, cachexia, oedema, urinary obstruction, tenesmus, backache, sciatica and so on until, after a miserable few months, death, I think one might say, kindly steps in. Of course such increased risks the experienced abdominal surgeon may legitimately take, must be no excuse for the high mortality experienced by the occasional operator.

Operability rates are dependent on various factors and range from 50 to 80%. They should include only those cases in which the growth can be removed, i.e., they should exclude all palliative operations. The operability depends a great deal on the awareness of the public of the changes of insignificant symptoms and the thoroughness of the general practitioner in finding the cause of these symptoms. In our experience the operability of tumours of the large bowel is higher among private patients than among public patients and higher in patients residing in Montreal than among those coming from country places. These facts suggest the value of education of the public and general practitioner, especially in rural districts, to make them aware of the diagnostic possibilities lying behind the most trivial symptoms. As these standards are improved, the percentage of operable cases will increase. It is already recognized that operability is further greatly increased when the patient finds himself in the hands of a really experienced and courageous surgeon, for I think it takes courage to attempt massive resections of fixed growths.

I would like to illustrate these points with three successful cases, without, of course, suggesting we do not have unsuccessful cases.

Case 1—This patient had a colostomy performed in the country for obstruction, and was sent to me for further surgery. At operation the colostomy was inconveniently placed and had to be removed. The tumour was lower in the pelvis and fixed to the bladder. Both ureters were fixed to the mass. One ureter could be freed, the other was sacrificed, the posterior wall of the bladder excised, the growth resected and an end to end anastomosis made. The patient made an uneventful recovery and three years later was well, with no signs of recurrence.

Case 2—This patient had a large mass in the hepatic flexure. Exploration showed the growth to be fixed to the liver, gall bladder, stomach and duodenum. A right hemicolectomy was carried out with end to side ileocolic anastomosis, and a portion of the stomach and duodenum and the liver together with the gall-bladder were excised. The patient made an uneventful recovery and is working and well after eighteen months.

Case 3—This patient was explored and informed she had an inoperable carcinoma of the rectum and only a palliative colostomy was carried out. A year later, because of tenesmus, continual bleeding, pain and marked anaemia she came to me with a request that a further attempt be made to remove the growth. Of course I refused, feeling that a year after an inoperable growth had been present there was nothing more I could do. Finally, however, because of her suffering and the urging of the family, I re-explored her, found the growth removable, carried out an abdomino-perineal resection. After two years the patient is alive and well, and free of her terrible symptoms.

These cases surely show the necessity of doing everything that can be done in a surgical way to help these unfortunate sufferers.

In regard to the location, for growths down to the lower sigmoid, operative procedures are pretty well standardized. For a right-sided lesion a right hemicolectomy is performed in one stage. The ileum is cut through about six to eight inches proximal to the ileocaecal valve. The distal portion of the ileum, the caecum, ascending colon and transverse colon, to within two or three inches of the mid-colic artery are resected and an end to side anastomosis is made. The lymph spread of the large bowel down to the peritoneal attachment in the pelvis ascends along the vessels to the portal system and the glands in the subhepatic space. Metastases in the liver substance proper have probably travelled by the main blood stream. Nothing can be done about the latter but a wide and deep removal of the mesocolon down to the main vessels must be carried out.

Though in the left colon a more limited resection, perhaps six inches above and below the growth is usually performed, the deep resection of the mesocolon is still essential. In these cases an end to end anastomosis is carried out, using aseptic technique. I think it advisable to use an aseptic technique because it lessens gross soiling, prevents spilling of faecal contents into the abdomen, and therefore inevitably lessens the danger of infection.

Twenty-five years ago Halstead's prime interest was the development of a means to carry out a large bowel resection and anastomosis under aseptic precautions and he stimulated great interest in this subject. In 1922-24 I was allowed at times to assist Dr. Jerome Webster, who invented an instrument to cut ligatures around the ends of the bowel after the anastomosis was

completed. I used this method, and demonstrated it about ten years ago but abandoned it because three of my cases developed late postoperative obstruction. Since then I have anastomosed the bowel over bayonet clamps, removing the clamps after the anastomosis is completed. This method has proven very satisfactory in my experience, no trouble with obstruction having occurred. These one-stage resections with immediate anastomosis and no colostomy or caecostomy are very comforting to the patient, and the postoperative course is similar to that of an appendectomy, or gastric resection. A caecostomy can always be added later if large bowel obstruction at the stoma occurs.

The carcinoma of the rectum and recto-sigmoid are of course the most interesting to the surgeon, for here, the hazards and difficulties are increased, and we all have the desire to avoid the permanent colostomy. I have a patient who is still alive and well, on whom ten years ago I made my first attempt at avoiding a colostomy where the growth was just above the peritoneal reflection. Previously I had carried out a one-stage Miles abdomino-perineal resection on these cases. This woman, who was a life insurance agent, was very averse to a colostomy so I carried out an end to end anastomosis in the pelvis. We had no chemo-therapy or antibiotics at that time and the convalescence was stormy but she has recovered and is very grateful for her normal bowel function. Two years ago Dr. McIntosh carried out a lobectomy for a metastatic nodule in the right lung with success. She still works and is thankful for her years living, as she admits, on "borrowed time."

With adequate preparation we now know it is safe to carry out anterior resections for growths at any level of the sigmoid and rectum which lie high enough above the anus to make local excision feasible. We have also been intrigued for the last two years with Bacon's so-called pull through operation. In these cases the procedure is identical with Miles' operation down to the levator ani muscles, but these we have not widely removed. In several cases following the "pull through" operation in which the sphincter ani muscles are preserved, control has been excellent and the patients are delighted to avoid a permanent colostomy.

However, Dr. Jessie Gray reported 74 cases of anterior resection for carcinomata of the rectum carried out on the service of Dr. Roscoe Graham at the Toronto General Hospital. The mortality was splendid, viz., 4 per cent. The rate of operability was high but her follow-up figures were very disquieting to me. While 73 per cent of the cases were alive and well where the growth was immediately above the peritoneal reflection, only 17 per cent remained alive and well where the growth was below the reflection. In other words, this method is not sufficiently radical for growths in this area. A review of statistics following Miles' resection show much better figures than this. This brings us to a renewed consideration of Miles' early work on lymphatic drainage of the rectum, and this reconsideration makes us wonder if, in the desire to avoid permanent colostomies, we have overlooked some fundamental principles.

Rectal lymphatics are in three groups—intramural, intermediary and extramural. Our interest at this time lies in the latter, which are the most important. These lymphatic channels pass upwards, downwards and laterally. The upward channels are removed by our conservative measures as well as by the abdomino-perineal operation. It has been shown by Gilchrist, Wilkie

and others that only rarely do cancer cells spread downward and then only when the ascending lymphatics are already plugged with cancer cells. The inferior lymphatics accompany the inferior haemorrhoidal vessels through Alcock's channel and drain into the internal iliac glands.

It appears to me that in these low growths in the rectum the lateral spread is most important. These lymphatics drain between the levator ani muscles and the pelvic fascia to the obturator gland and on to the internal iliac glands and to the innermost of the glands accompanying the external iliac vessels. The lateral zone of spread drains with the lymphatics of the levator ani and coccygeus muscles, the pelvic peritoneum, the prostate gland and adjacent structures. The levator ani muscles are especially prone to invasion by cancer cells which have gained access to the extramural lymphatic spread and should always be completely removed. The pelvic peritoneum is also especially liable to invasion, and therefore the peritoneum of the entire pelvic floor as far as the brim of the true pelvis should be excised.

When we review these original observations of Ernest Miles, we realize perhaps that any conservative procedure for growths below the peritoneal reflection will lessen the percentage of five year cures and should be abandoned, unless the pelvis can be as thoroughly cleaned out as is accomplished by a Miles abdomino-perineal resection. This means that the levator ani muscles must be removed. I have frequently noticed the spread of malignancy along the lateral ligaments suspending the rectum in which lie the middle haemorrhoidal vessels. Here, in my mind, lies the earliest and most significant spread in these groups of malignancies, and here one must excise these structures as widely as possible.

In conclusion, I again wish to emphasize the importance of these diagnostic points, since the symptoms of cancer may be most insignificant, and unless the doctor fully appreciates this, and thoroughly investigates any patient coming to his office, no matter how minimal the symptoms, early diagnosis cannot be made. Diagnosis having been established, surgical intervention must be immediately advised. The operative treatment has been outlined. One-stage hemicolectomy for lesions of the right bowel, with end to side anastomosis between the ileum and the transverse colon to the right of the mid-colic artery remains the operation of choice. For growths of the transverse colon and descending colon down to the peritoneal reflection, resection with end to end anastomosis, without the necessity of carrying out a caecostomy, unless post-operative distention makes it advisable. For a growth below the peritoneal reflection a one-stage abdomino-perineal resection after the manner of Ernest Miles is advisable. This can be more readily carried out by having two teams working, one on the abdominal portion, and the other on the perineal portion of the operation. If obstruction and distention be present, a preliminary caecostomy or colostomy is advisable to overcome the distention, and to make it possible to clean the bowel with the use of streptomycin and sulfonamides. As Dr. Morton has shown, it is impossible to sterilize the bowel with streptomycin in the presence of obstruction. It is urged further that where a diagnosis of carcinoma of the bowel or rectum has been made, care should be taken in the choice of a surgeon, as the occasional operator can have a lower operability rate, a higher mortality, and a lower percentage of five year cures. Experience and practise are important considerations in the choice of a surgeon for these operations.

The World Medical Association

T. C. Routley, C.B.E.,M.D.,LL.D.,F.R.C.P.(C)

AT three o'clock in the afternoon of Thursday, September 18, 1947, in "Domus Medica", Paris, the home of the French Confederation of Medicine, it was my privilege and pleasure as Chairman of the International Medical Conference to announce to 125 delegates and observers from 48 nations that the World Medical Association was born. The significance of that moment and the potentialities wrapped up in it remain to be unfolded; but there can be no doubt that the representatives who were present realized the importance of what they were doing and were persuaded that this new body, federating all national medical associations for the lofty purpose of assisting all mankind to attain the highest possible level of health, might become one of the most potent influences in the promotion of health and world peace.

It will be recalled that, in September, 1946, on the invitation of the British Medical Association and the former Association Professionnelle Internationale des Medecins, delegates from thirty-two national medical associations assembled in London to consider the formation of an international medical association. At that conference, it was unanimously agreed that such a body should be formed. An Organizing Committee of twelve persons, of whom I had the honour to be chairman, was appointed and instructed to work out the details. During the past year, this committee has met four times—twice in London and twice in Paris. Its main task was the construction of a constitution and by-laws and the preparation of a program for the new body. The committee presented its report to the second conference called to meet in Paris on September 16, 1947.

The response of the national medical associations to send delegates and observers to the second conference was indeed gratifying as 125 persons representing 48 nations answered the roll call. The Canadian Medical Association was represented by Dr. Wallace Wilson of Vancouver, immediate Past President, Dr. Leon Gerin-Lajoie of Montreal, Dr. G. D. W. Cameron of Ottawa, Deputy Minister of National Health for Canada, and Dr. T. C. Routley, General Secretary. The first two days were devoted to a detailed consideration of the constitution and by-laws and a clause by clause study of the report of the Organizing Committee. It was clear from the outset that the documents which had been circulated earlier had been carefully studied, and most of the clauses were subject to explanation and elucidation with a number of them undergoing amendments.

The South American delegates, representing 21 countries, which are closely knit in a Pan American group, spoke and voted as a unit, but, because of language difficulties, sometimes reversed their votes when they became better acquainted with the questions in issue. Our South American colleagues desired the Spanish language to be recognized as an official language of the Association, in addition to the French and English languages which had already been agreed upon as the two official languages. This group further desired that there should be appointed an Assistant Secretary in each of the three official languages. The conference having agreed to these suggestions, the South American delegates enthusiastically threw themselves into the organization and assured it of the hearty support of the more than 70,000 doctors whom they represented.

While the representatives of some countries were more vocal than others, it was abundantly clear from the keen debate and close attention given to the two days' consideration of the articles, that there was widespread unanimity of opinion with respect to the importance of what was being written. Indeed, it may be said that the World Medical Association was born with every hope of receiving strong support throughout the world when its aims and objects become thoroughly known and appreciated.

And now a word about the aims and objects. They are seven in number, the first six having been put forward by the Organizing Committee with the seventh being added on the unanimous recommendation of the Conference:

(1) To promote closer ties among the national medical organizations and among the doctors of the world by personal contact and all other means available.

(2) To maintain the honour and protect the interests of the medical profession.

(3) To study and report on the professional problems which confront the medical profession in the different countries.

(4) To organize an exchange of information on matters of interest to the medical profession.

(5) To establish relations with, and to present the views of the medical profession to, the World Health Organization, U.N.E.S.C.O. and other appropriate bodies.

(6) To assist all peoples of the world to attain the highest possible level of health.

(7) To promote World Peace.

Inter alia, the constitution provides for the following:

The election of a President, a President-Elect, an Honorary Treasurer, an Honorary Secretary and an Administrative Council of ten persons; an annual meeting to be moved from country to country; the publication of a Journal and (or) bulletins; and such other activities as will promote the aims and objects of the Association.

A careful review of these objects will disclose that the program of the new body encompasses practically everything which would tend to improve or protect the health of the people of the world.

Upon the completion of the conference and the acceptance of its Articles and By-laws, the meeting resolved itself into the first session of the General Assembly of the Word Medical Association. At this juncture, it fell to my lot to instal Professor E. Marquis, Directeur de l'Ecole de Medicine de Rennes, France, as the first President of the World Medical Association. For the next two and one-half days, President Marquis tactfully guided the deliberations of the Assembly through its first session. The Assembly by formal motion, thanked the Organizing Committee for the work it had done during the past year and particularly extended its thanks to Dr. Chas. Hill and Dr. Paul Cibrie who had acted as joint honorary secretaries of the Committee and who had been largely responsible for the activities of the Committee

and the assembling of the documents which were presented to the conference.

Until such time as a permanent secretary is appointed Dr. Chas. Hill, Secretary of the B.M.A., kindly agreed to act as the honorary secretary of the Association. His appointment to this post was unanimously approved by the Assembly.

Dr. Otto Leuch of Zurich, Switzerland, who had been acting as Treasurer during the organizing period was unanimously elected honorary treasurer of the Association.

Dr. Leuch proposed that there be levied upon each national association an annual subscription of not less than 1000 Swiss Francs ($250.00) and not more than 10,000 Swiss Francs ($2,500.00), based upon a per capita contribution of 10 Swiss Centimes. This will be better understood when it is pointed out that the Canadian Medical Association will pay an annual subscription of less than $300.00 while the American Medical Association will pay approximately $2,500.00, which is the ceiling. It is estimated that the total income from subscriptions will be somewhere in the neighbourhood of $20,000.00 a year.

The Assembly recognized that the annual income based upon such modest subscriptions will not be large and that additional funds will be required if the World Medical Association is to perform adequately many of the functions which it visualizes. When world conditions improve, the Association no doubt can greatly increase its fees but for the present, many nations adversely affected by the recent war, will find even the proposed modest assessment something of a burden. To offset this situation, the delegates from the American Medical Association made a handsome offer to the Association. The American Medical Association was represented in the conference by Dr. Ross Sensenick, President-Elect of the Association, and three members of its Board of Trustees in the persons of Dr. Elmer Henderson, the Chairman, Dr. Louis Bauer, and Dr. Ernest Irons, the Secretary. Before leaving America, these gentlemen had conferred with some prominent business men who had become interested in the potentialities of the World Medical Association. Accordingly, the delegates were in a position to offer the World Medical Association $50,000 a year for five years with certain definite conditions attached to the offer. These were:

1. That the head office of the World Medical Association should be in North America.

2. That the American funds would be used for the following purposes:

   (a) The remuneration and expenses of the secretary, other officials and clerical staff.

   (b) The rent, rates and other disbursements in connection with the the official headquarters.

   (c) The general office expenses of the headquarters Office Staff.

   (d) The cost of publication of the Association's official journal or bulletin.

   (e) The travelling costs of members of Council.

3. That the cost of the developments listed above be estimated to be not more than $50,000 in the first year; and an amount in the sum of $50,000 to be made available by the Committee each year for five years.

4. That the Council be authorized to act on the Assembly's behalf in appointing a Secretary to the World Medical Association and to make all other staff arrangements, regional and other.

5. That member-Associations be recommended to consider the formation of W.M.A. supporting committees in their several countries.

6. That the Council be authorized to prepare plans of development, entering into any necessary consultation, and submit their proposals to the Assembly.

7. That nothing in these suggestions shall be construed as diminishing the authority of the General Assembly for the control of the policy and affairs of the Association.

NOTE:—The conditions cited do not in any manner encroach upon the authority or autonomy of the Association.

After long and careful debate, the American proposal was adopted almost unanimously. Coupled with acceptance was a resolution of thanks to the American Committee and particularly to the lay members of the Committee for their generosity. The Assembly passed a further resolution instructing the Council to make appropriate studies to ascertain if it would be possible for gift funds as might be provided to the W.M.A. being considered tax free in the respective countries.

Proceeding with its program, the Assembly dealt with the following:

Medical and Allied Problems—Instructed that a complete survey and inventory be made by all the member associations with respect to medical and allied problems in their several countries, the results of this inquiry to be reported to the next annual meeting.

Medical War Crimes—Considered reports emanating from the United Kingdom, France, Greece, Bulgaria and Denmark, dealing with medical war crimes. It was unanimously agreed that such medical war crimes as were on record during the past war should be considered outlawed, and it was agreed that the medical association of Germany would not be admitted to the W.M.A. until the former body had repudiated the war crimes committed by members of the medical profession in Germany and had given assurance that they would not be repeated in the future.

Annual Meeting, 1948—The Association had before it four invitations for the annual meeting of 1948. After careful consideration the invitation from Czechoslovakia to meet in Prague was accepted and on the nomination of the Czechoslovakian delegation Dr. James Stucklich of Prague was unanimously elected to the office of President-Elect.

Election of Council—The Constitution and By-laws provide that the affairs of the Association between annual meetings shall be conducted by an administrative Council of ten elected members, with the President, President-Elect, Honorary Treasurer and Honorary Secretary being members ex-officio. The election resulted in the following ten persons being named to Council:

Dr. D. Knutson	Sweden
Dr. Louis H. Bauer	U. S. A.
Dr. Jose Angel Bustamante	Cuba
Dr. Paul Cibrie	France
Dr. Alexander Hartwich	Austria
Dr. P. Z. King	China
Dr. J. A. Pridham	Great Britain
Dr. S. C. Sen	India
Dr. L. G. Tornel	Spain
Dr. T. C. Routley	Canada

At its first meeting held on Saturday, September 20th, the Council elected Dr. T. C. Routley of Canada, Chairman, and Dr. D. Knutson of Sweden, Vice-Chairman.

Council authorized the Chairman and the American delegate, Dr. Bauer, to make all necessary arrangements to set up the Association office in North America, including the appointment of staff. It is hoped that during the coming year, the Chairman and Dr. Bauer will be enabled to make recommendations to Council for the selection of a permanent Secretary. Meanwhile, Dr. Chas. Hill, Secretary of the B.M.A., has kindly consented to act as Honorary Secretary to the Council.

With respect to the recommendation of the General Assembly that assistant secretaries be appointed as speedily as possible, Council was pleased to make its first appointment of an assistant secretary in the person of Dr. Jose Angel Bustamante of Cuba who will represent the Association in the South American Countries. Further consideration is being given to the appointment of Assistant Secretaries in other parts of the world.

Council resolved to hold its next meeting in North America in the Spring of 1948—the exact time and place to be decided by the Chairman and Dr. Bauer.

This report which merely attempts to touch upon the highlights of the Paris meeting would be incomplete without a word of thanks and appreciation to our French hosts for their delightful hospitality throughout the week which included a banquet on Thursday night, an official reception at the City Hall, a long-to be-remembered visit to Versailles with a reception by the Mayor of that city.

Herewith follows a list of the countries from which delegates answered the roll call of the first General Assembly:

Africa
Argentine
Australia
Austria
Belgium
Brazil
Bulgaria
Canada
Chile
China
Colombia
Costa Rica
Cuba
Denmark
Egypt
Ecuador
Spain
United States
France
Great Britain
Greece
Guatemala
Honduras
Hungary
India
Iraque
Ireland (Eire)
Iceland
Italy
Luxembourg
Mexico
Nicaragua
Norway
Palestine (Arabs)
Palestine (Jews)
Panama
Netherlands
Peru
Poland
Porto Rico
Portugal
Czechoslovakia
San Salvador
Sweden
Switzerland
Turkey
Uruguay
Venezuela

DOCTOR WANTED

The Sackville Medical Centre, Sackville, N. B., would like a doctor for a period of three or four months beginning any time from April to June. For further particulars apply to Doctor C. L. Gass, Sackville, N. B.

Correspondence

NOTICE

I have received a letter from the Canadian National Railways in which they offer to supply a private car from Halifax to Saskatoon for those planning to attend the convention. It will be available to anyone interested and accommodation may be secured at any point from Halifax to Moncton. If you plan to attend, will you kindly notify me immediately, telling me the number in your party and the accommodation required. The car has twelve lowers, twelve uppers, and one drawing room. As the preference naturally will be for the drawing room and the lowers, will you kindly also state whether you are agreeable that the space be allocated from this office. By securing a private car the pullman charges will be reduced by fifty per cent. Also, if you desire it, you can use the pullman car for hotel accommodation at Saskatoon.

H. G. Grant, M.D.
Secretary

Halifax, N. S.
January 14, 1949
File: C.V. 4071

Dr. H. G. Grant
Secretary
Medical Society of Nova Scotia
c/o Dalhousie Public Health Clinic
Morris Street
Halifax, N. S.

Dear Sir:

Referring to recent conversation regarding fares and other arrangements, in connection with the Canadian Medical Association Convention in Saskatoon, Sask., June 13-18, 1949. I am submitting the following information, in the hope that it may be of interest to you, and your members.

Below is a table of round trip First Class fares, from representative Nova Scotia points to Saskatoon, Sask. The Convention fare will only become effective, if arrangements are made with the Canadian Passenger Association, Montreal, well in advance of the Convention. Convention fares normally carry a limit of thirty days, and are applicable via the same route going and returning. The regular fares carry a limit of six months, and allow certain variations in routings.

	Convention Fares First Class Return	Regular Six Months Fares First Class Return
Halifax, N. S.—Saskatoon, Sask. . . .	$139.50	$163.65
Sydney, N. S.—Saskatoon, Sask. . . .	145.20	169.80
Truro, N. S.—Saskatoon, Sask.	136.95	161.00
Yarmouth, N. S.—Saskatoon, Sask.	144.15	169.20

Sleeping car fares are additional to the above figures, and I am quoting below the one way fares for various types of sleeping car space. Service is

also available, via Toronto, and sleeping car charges would be slightly higher via that route.

Between	Lower	Upper	Compartment For 1	Compartment For 2 or more	Drawing Room For 1	Drawing Room For 2 or more
Halifax and Montreal	$ 6.85	$ 5.45	$17.25	$19.55	$20.70	$24.15
Montreal and Saskatoon	19.05	15.25	47.75	53.50	57.50	66.70

A suggested itinerary is given below for those who desire to travel direct to Saskatoon, and back again.

Lv. Halifax, N. S.	No. 1	3.10 p.m.	June 11th
Lv. Truro, N. S.		5.15 p.m.	June 11th
Lv. Amherst, N. S.		7.54 p.m.	June 11th
Lv. Sackville, N. B.		8.21 p.m.	June 11th
Lv. Moncton, N. B.		10.00 p.m.	June 11th
Lv. Newcastle, N. B.		12.20 a.m.	June 12th
Ar. Montreal, Que.		6.40 p.m.	June 12th
Lv. Montreal, Que.		8.20 p.m.	June 12th
Ar. Winnipeg, Man.		10.10 a.m.	June 14th
Lv. Winnipeg, Man.		11.20 a.m.	June 14th
Ar. Saskatoon, Sask.		10.45 p.m.	June 14th
Lv. Saskatoon, Sask.	No. 2	5.15 a.m.	June 18th*
Ar. Winnipeg, Man.		6.00 p.m.	June 18th
Lv. Winnipeg, Man.		6.45 p.m.	June 18th
Ar. Montreal, Que.		9.00 a.m.	June 20th
Lv. Montreal, Que.	No. 4	8.00 p.m.	June 20th
Ar. Newcastle, N. B.		12.25 p.m.	June 21st
Ar. Moncton, N. B.		2.30 p.m.	June 21st
Ar. Sackville, N. B.		3.40 p.m.	June 21st
Ar. Amherst, N. S.		3.55 p.m.	June 21st
Ar. Truro, N. S.		6.05 p.m.	June 21st
Ar. Halifax, N. S.		7.50 p.m.	June 21st

*Sleeper parked for occupancy 10.00 p.m., June 17th.

In connection with the above schedule, we are prepared to set up a special sleeping car, to operate Halifax to Saskatoon and return to Halifax, with but one possible change, i.e., on the going trip, at Montreal, due to close connections, and a busy terminal, it may not be possible to operate the same car through. We would endeavor to have this car one of our new type sleepers. We can quote a price of $675.00 for this service, which will give the party exclusive occupancy of the car throughout, and will also permit car to be occupied while in Saskatoon, if desired, with air-conditioning equipment in operation, and car conveniently parked. You will note that if all space in car is filled, or nearly filled, a substantial saving will be realized in sleeping car fares. It is anticipated that the equipment supplied will be either a car containing twelve sections, and one drawing room, or possibly a car containing eight sections, one drawing room, and two compartments. In order to take advantage of this offer, one representative should be named to deal with the Railway, and assign space to members of the party. As equipment for use

next summer already is being assigned, we should have early advice in connection with this car, not later than the middle of March.

I trust the foregoing information will be of interest to you, and to your members, and I will be glad to furnish any other information you may desire.

Very truly yours

W. C. Moir,
District Passenger Agent

Navy Hospital
Halifax, Nova Scotia
4th January, 1949

Dear Doctor:

With reference to the obituary on page 356 of the December issue of the Nova Scotia Medical Bulletin, Henry Greggs Farish, ex-Surgeon Lieutenant, was demobilized 26th August, 1945, in Victoria and is believed to be practising in the West.

Yours truly

R. A. G. Lane
Surgeon Commander, R.C.N.
Principal Medical Officer
Navy Hospital

The Editor
Nova Scotia Medical Bulletin
c/o Dr. H. G. Grant
Dalhousie Public Health Clinic
Halifax, Nova Scotia

Personal Interest Notes

SEVEN appointments to the staff of the Victoria General Hospital in Halifax were announced early in December; Doctor J. H. Charman, who graduaded from Dalhousie September 1, 1943, Doctor Basil K. Coady, in 1938, Doctor W. E. Pollett, in 1934, Doctor G. W. Bethune, in September 1, 1943, Doctor E. P. Nonamaker in 1942, Doctor Jean Macdonald in 1944, and Doctor W. K. House who graduated from the University of Manitoba in 1931.

Doctor C. A. Gordon, who has been attached to the D. V. A. Department at the R. C. N. Tuberculosis Hospital at Cornwallis, is now residing in Halifax.

Doctor H. C. Read who graduated from Dalhousie January 5, 1943 recently returned to Halifax from England. Doctor Read has been studying haematology at Oxford for the past fifteen months on a Nuffield Medical Fellowship, and will practise in Halifax.

Doctor R. L. Aikens who graduated from Dalhousie in 1939 was recently awarded a Fellowship of the Royal College of Physicians and Surgeons of Canada, and plans to practise in Halifax.

Doctor S. T. Laufer of Halifax has been made a Fellow of the American College of Physicians.

Dr. W. A. Murray, who graduated from Dalhousie January 5, 1943, left for London, England, the end of December, where he will take a Post-graduate course.

Britain's National Health Service, the world's biggest experiment in socialized medicine, is undergoing a strain. Health Minister Bevin says too many are demanding too much. All the bills are paid out of general taxation. To ease the load, beginning February first, each dentist taking part will be paid only half of anything he earns over $4,800 a year. The Health Minister says one-fifth of the dentists in the programme are now earning money at that rate. S. Donald Coc, assistant secretary of the British Dental Association, says abuses should be proved before any limit is placed.

The loudest complaining from many of the doctors under the plan is that they are underpaid and overworked. To that, the Ministry replies that the question of the number of patients for each doctor and the question of the fees is under review. The National Health Service started July fifth. It is designed to give the men and women of Britain "free" medical, dental and optical care.

Providing the care—and collecting fees from the Ministry—are 18,165 of the country's 22,900 doctors, 8,753 of the 11,000 dentists, nearly all of the 7,000 opticians and 14,000 of the 16,000 drug stores which fill the prescriptions. All are in the scheme voluntarily. Ultimately, all of Britain's hospitals

will be taken over under the plan; already 2,587 have been purchased by the Government. Others are to be built.

The Government's original estimation of the yearly cost of the plan was £150,000,000. The British Medical Association, which is co-operating now although it first fought the proposal, says the annual cost will exceed £250,000,000.

The most vocal—but by no means the only—opponent of the plan is a group of largely anti-socialist doctors who have organized the "Fellowship of Freedom in Medicine." Lord Horder, physician-in-ordinary to the Royal Family, is head of the group and its principal spokesman. It claims a membership of 700.

The Bulletin extends congratulations to Doctor and Mrs. J. A. Webster of Shelburne on the birth of a son on December 7th, and to Doctor and Mrs. J. A. Muir of Truro on the birth of a son on December 11th.

Buy Pasteurized Milk . . . The only Safe Milk

No one doubts the health value of milk and few will disagree with the statement that milk can carry disease. Fortunately a method has been devised to kill the disease-transmitting germs which may be found in milk. This process is called pasteurization.

It may be surprising to learn that Ontario is the only province which has a law prohibiting the sale of unpasteurized milk. This is the more amazing when it is well known that milk may be the means of spreading such serious diseases as tuberculosis, typhoid and paratyphoid fever, undulant fever and summer diarrhoea.

Pasteurization consists of the rapid heating and cooling of milk, the germs being killed by the heat. When both the heating and cooling processes are rapid the taste of the milk is not markedly affected. Its food value is not decreased to any important degree. Above all it is made safe to drink. What a tremendous boon this is for growing children who are our chief milk drinkers!

You may well ask why pasteurization of milk is not compulsory in all the provinces of Canada. The passage of such laws is dependent upon an educated public. Only when large numbers of people realize the wisdom of drinking nothing but pasteurized milk and make their voices heard, will the legislation be introduced and enforced.

In the meantime we can ensure safe milk to members of our own family by buying only milk that has been pasteurized and encouraging others to do the same.—*The Committee on Industrial Medicine of the Canadian Medical Association.*

IMPORTANT NOTICE

Physicians registered in Nova Scotia who contemplate future registration on the Colonial List of the General Medical Council of Great Britain by virtue of Reciprocity should communicate, at once, with the Registrar of the Provincial Medical Board, Dalhousie University, Halifax, N. S.

Department of National Health and Welfare

Ottawa, Jan. 12—The federal government has agreed to contribute $55,000 from its hospital construction grants toward the cost of building the new Lunenburg Hospital the minister of National Health and Welfare, Hon. Paul Martin, revealed here today.

This amount will be matched by the provincial government. Notice of the federal concurrence in the grant has already been forwarded to the provincial health minister, Hon L. D. Currie. It was Mr. Currie who suggested the project to the Federal Department of Health and Welfare.

The new hospital which is being erected by the Lunenburg Hospital Association, Inc., was begun last June, and plans call for its completion by next November 30. It will serve the town of Lunenberg and surrounding district which has a total population of nearly 20,000. By bringing hospitalization to an area not previously so served, it fits into the provincial plan for providing adequate hospital services for all parts of the province.

When completed, the hospital will have 55 beds and will be equipped to handle general medical cases.

"The federal contribution, which will be matched by the province, is based on $1,000 for each of the 55 beds for active treatment. Total allocation for hospital construction in Nova Scotia under the national health plan is more than $640,000 annually," Mr. Martin said.

Summer Diarrhea in Babies

Casec (calciu caseinate), which is almost wholly a combination of protein and calcium, offers a quickly effective method of treating all types of diarrhea, both in bottle-fed and breast-fed infants. For the former, the carbohydrate is temporarily omitted from the 24-hour formula and replaced with 4 packed level tablespoonfuls of Casec. Within a day or two the diarrhea will usually be arrested, and carbohydrate in the form of Dextri-Maltose may safely be added to the formula and the Casec gradually eliminated. One to to three packed level teaspoonfuls of a thin paste of Casec and water, given before each nursing, is well indicated for loose stools in breast-fed babies. For further information, write to Mead Johnson & Company, Evansville 21, Indiana.

Maritime Medical Care Incorporated

The response to the request for the signing of Participating Physicians Agreements has been very satisfactory, about 60% having returned their forms to date. Each day signed forms continue to arrive, and indications are that organized medicine in this province will again express itself very positively in the way that matters.

The management would like to see these forms completed before the day of the opening for business arrives, and asks that any of our members who have, for one reason or another, deferred sending them in, would kindly do so at their earliest convenience. Knowing how busy doctors are, one may well be surpised at the excellence of the returns to date. They would now like the extra sprint which will bring in all the rest of the forms.

They also wish to say that there have been indications that their mailing list was not as perfect as it should have been or that the typist who transferred the names to envelopes made some omissions. They have knowledge of two who did not receive forms and there may be others. Will any doctor who did not receive copies of Participating Physicians' Agreements, kindly write: "Maritime Medical Care Incorporated, Halifax," and let them know?

It is the desire to have every doctor contacted, and to have them all among the original participants in the plan. Certainly the greater number of doctors signing, the better it is for the doctors and the better for all concerned.

Swiss Drug Firm Establishes Canadian Headquarters in Montreal

Gordon E. Graham, Secretary and Manager of the newly established Sandoz Pharmaceuticals, Limited.

Sandoz Ltd. of Basle, Switzerland, have recently established Canadian headquarters in Montreal under the name of Sandoz Pharmaceuticals Limited. Heading the newly-formed Canadian firm, as secretary and manager, is Gordon E. Graham, well-known pharmaceutical sales representative. Associated with Mr. Graham as Director of the Medical Service will be John M. Grosheintz, D.Sc.

Mr. Graham, who has been representing the parent Swiss firm in Canada for the past two and a half years, received his technical training in the Sandoz plant in Basle, Switzerland. Mr. Grosheintz, who holds his degree of D.Sc. from the Federal Technical University of Zurich, Switzerland, was a Research Associate at the Banting Institute from 1937 to 1944 and has also served at the head Sandoz plant at Basle.

Sandoz is noted throughout the world for its original research work in the fields of plant and synthetic chemistry. Its specialties include preparations for treatment of migraine headaches, heart and circulatory disorders, nervous affections, allergies, etc.

The expansion of distributing facilities resulting from this new Sandoz establishment in Canada has long been desired by the parent firm in Basle as a necessary step in its constant growth in the world-wide pharmaceutical field.

Group Survey Proves Handicapped Workers Excellent Employees

"A recent sample survey shows that the physically handicapped worker in Canadian industry is proving himself as efficient as those with no physical handicaps," it was stated by Hon. Humphrey Mitchell, Minister of Labour, in announcing the results of a survey of physically handicapped workers, carried out by the National Employment Service in late 1946.

The sample covered 467 Canadian firms employing 2,315 workers classified as "handicapped personnel."

The Minister added that the evidence secured in the survey bore out the contention of the officers of the National Employment Service concerned with the placement of disabled workers, that physical handicaps are not necessarily vocational handicaps.

Food for Growth

Teen-agers play hard, grow fast—and find time to study in between times. Generally they are as hungry as wolves. They need plenty of the right foods to give them energy and growing power and vitality.

Parents usually have little trouble persuading their teen-aged children to eat well. It is merely a matter of supplying the right foods including milk, fruits, vegetables and whole grain cereals. And for 'teeners, the servings should be *large*.