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# Recent Advances in the Treatment of Skin Diseases*

By

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"Recent, adjective. not long past, late; not long established, modern."

WITH the freedom allowed me by the above definition taken from the Shorter Oxford Dictionary, I have included in this article an account of some of the changes which have taken place in the treatment of skin diseases during the past ten years or so. Thus many of the drugs mentioned are no longer experimental, and their value has been established after clinical trial in many thousands of cases in many parts of the world.

In Dermatology, perhaps more than in most branches of Medicine, there are marked variations in individual response to therapy. However to make an article of any value it is necessary to be dogmatic. At the same time the writer has attempted to avoid any controversial topics.

## The Sulphonamides

With the discovery that the sulphonamides were remarkably effective in dealing with the organisms which are responsible for most of the superficial infections of the skin, it was only natural that they should be incorporated in many ointments and lotions for treatment of the pyodermas and allied conditions. Sulphathiazole is very effective in dealing with impetigo and the other skin conditions in this group, and a few years ago was very widely used. Unfortunately within a few months reports began to come in of sensitization to the drug and the sulphonamides have fallen into disrepute. Personally I do not consider the sulphonamides should be used at all as topical therapy, and rarely systemically. Various authorities report percentages of sensitization as high as 25% of all cases treated. The index of sensitization is very low in the infant, low in the child, rising in adolescence to reach its peak in adult life. This accounts for the fact that sulphonamides can be used on the skin of infants and children with relative impunity, but there is the danger that their use early in life may sensitize the patient, thus producing most undesirable effects when the individual is exposed to sulphonamides in after years. The principal danger of sensitization is not so much the local irritation which may occur, or even the rare case of generalised exfoliative dermatitis, but the fact that a sensitized patient may be unable to tolerate sulphonamides when they are needed for a more serious illness later on.

With regard to systemic use of sulphonamides, *Sulphapyridine* is always worth a trial in cases of dermatitis herpetiformis. It appears to be almost a specific in some cases, and many patients who do not respond to arsenicals are controlled well by this drug. It would appear to be the pyridine radical which is the important one, as the other sulphonamides are ineffective. Once

*Based on a paper presented to the Valley Medical Society in December, 1950.

the acute attack has been controlled it is often necessary to keep the patient on a minute maintenance dose for many weeks or months. This dosage may be as small as one tablet daily, a quantity insufficient for a perceptible sulphapyridine blood level to be noted, but often if the drug is discontinued altogether fresh lesions develop.

### The Antibiotics

The dangers of sensitization presented by the sulphonamides are to some extent reproduced by *penicillin*. It will be remembered that sensitization to a drug occurs much more easily when it is applied topically, in the form of ointment, or nose drops or lozenges, than when given by injection, and penicillin is used very sparingly, if at all, in modern dermatologic practice. When it is used for such conditions as impetigo in children, it should be given in large doses (about 1,000 units to the gram), prescribed four or five times a day, and for not more than a total of five days. If this course of treatment is followed the dangers of sensitization are minimised.

Another antibiotic which has given most excellent results is *Bacitracin*. This appears to deal satisfactorily with impetigo, ecthyma, infectious eczematoid dermatitis, secondarily infected dermatoses, and, notably with sycosis barbae or barber's itch. It is well known that the latter condition may be extremely stubborn and require several months of treatment, but many cases have responded rapidly to the use of Bacitracin. The main advantage of this drug is that so far sensitization has not been encountered. I say "so far" because of our experience with penicillin in the early days.

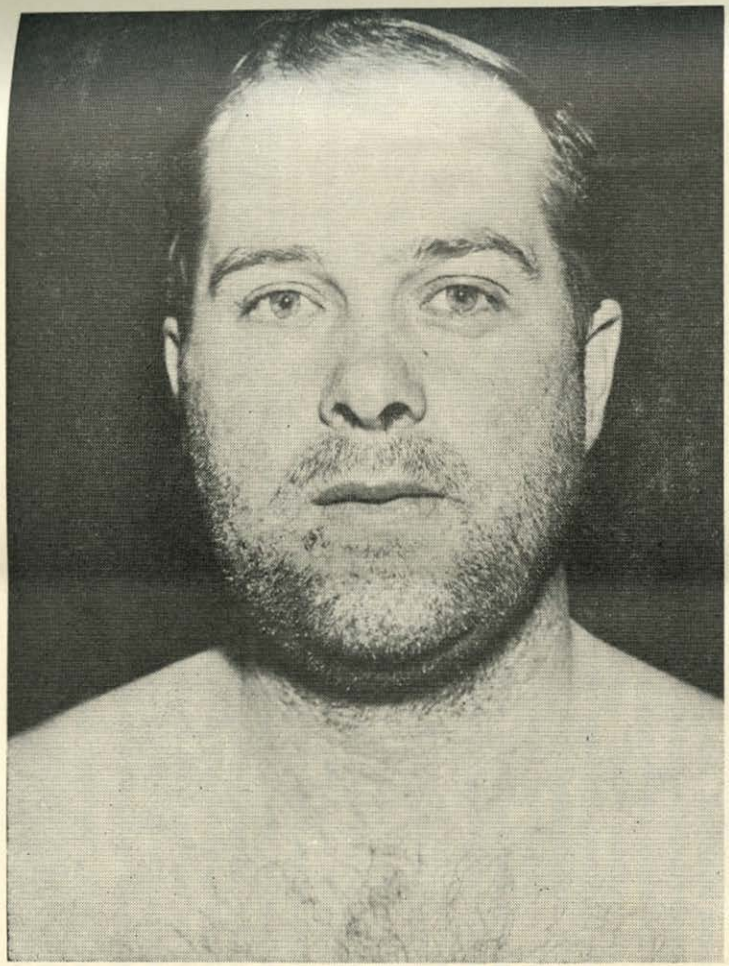
Other workers have reported excellent results with topical *Aureomycin* which is effective against a wide variety of organisms. This also appears to be of some value in dealing with dermatoses which are due to virus infection. These include molluscum contagiosum, herpes simplex, and even some cases of warts. In addition some cases of herpes zoster respond to a combination of topical with oral administration. Finally, in the treatment of superficial pus infections of the skin many workers report results with Aureomycin ointment comparable to those obtained with Bacitracin.

Of the other antibiotics, *Streptomycin* has such a high index of sensitization that it appears to be of little value. It should probably never be used on the skin or in the auditory canal, as its power of producing dermatitis is very high, and also organisms rapidly become resistant to it.

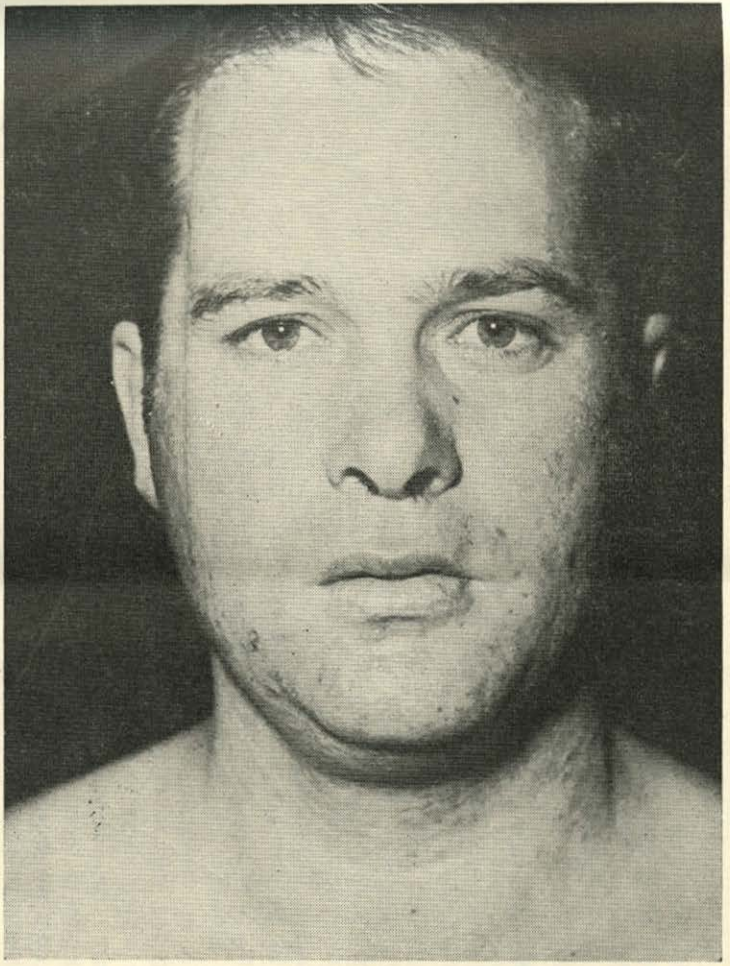
Great hopes were held for *Tyrothrycin* when it was introduced, as it has a low sensitizing index on the skin. However its efficiency in controlling superficial skin infections is extremely doubtful, and some authorities regard Tyroderm as almost completely ineffective. Currently a series of controlled experiments are being conducted, treating cases with a mixture of Tyrothrycin and Bacitracin. It appears possible that there may be some synergy between these two antibiotics.

### The Quinoline Derivatives

While on the subject of superficial pus infections of the skin some mention must be made of the quinoline group. During recent years *Quinolor* has dealt successfully with many cases of sycosis barbae, and *Vioform* has produced excellent results in many of the more chronic pus infections, including folli-



SYCOSIS BARBAE, ("Barber's Itch")—Follicular infection with pyogenic staphylococci. Note oedema and inflammation around the eyes.



After treatment with Bacitracin ointment for six days.

culitis and secondarily infected dermatoses. The latter drug has been in use in Continental Europe for the last twenty-five years but has only recently obtained prominence on this side of the Atlantic. It is best used in strength of about 3%; it has one disadvantage, that it stains the skin and clothing yellow. There have been some favorable reports of *Diodoquin*, another of the quinoline derivatives.

**The Antihistaminics:**

Hardly a week goes by without one of the drug house representatives producing a new antihistaminic and making enthusiastic if not exaggerated claims for its efficiency and the absence of any side reactions. It is impossible to keep count of the number on the market, although I understand there are nearly seventy. Most practising physicians have adopted the policy of confining their attention to three or four of these substances, on the sound therapeutic principle that it is wiser to be certain of the action of a few drugs than to be forever exper menting with others which are almost precisely similar. The popularity of these substances has waned somewhat during recent months, but perhaps we are still using them in many cases in which there is no scientific reason for their use. We have all seen these drugs prescribed for use in conditions which present itching or burning of the skin, but in which there is no experimental or theoretical support for the idea that histamine or "H-substance" may be responsible for the symptoms. The truth appears to be that in many cases we are using these substances as sedatives, and we would be serving the patients' interests much more effectively if we were to use other sedatives which do not present the undesirable side effects which may occur from the antihistaminics. However there are certain conditions in which this group of drugs can be useful. Poison ivy and other forms of dermatit s venenata, will often respond dramatically, and the subjective relief is profound. Some cases of atopic dermatitis and the large group of ecemas which are of allergic origin may be controlled by the use of antihistaminics. However most agree that the control of atopic dermatitis with the antihistaminics is on the whole somewhat disappointing, and it must be remembered that usually there are frequent recurrences over a period of many years, and that prolonged dosage of any antihistaminic is apt to produce most undesirable effects.

**Antihistaminics in Ointment Form:**

Occasionally great relief from itching is experienced from the use of antihistaminic ointments, where other things have failed, but on the whole they have by no means lived up to the extravagant claims which were made for them when they were first introduced.

Numerous cases of dermatitis have been reported from the use of these ointments. In some cases this has merely been an aggravation of the existing skin disease, subsiding quickly when the drug was discontinued, but in others sensitivity to the drug has developed with an acute exacerbation of the original dermatitis and rapid dissemination over the entire body. In the writer's experience Thephorin ointment is particularly dangerous in this regard.

**Tuberculosis of the Skin:**

Since the announcement by Charpy, and the almost simultaneous report by Dowling and Prosser, in 1945, of the efficiency of Vitamin D2 in the treat-

ment of lupus vulgaris and scrofuloderma, there have been many reports of the striking results obtainable with this drug. The writer had the opportunity of witnessing the Out-Patient treatment of a large group of patients with tuberculosis of the skin in England, and the severe toxic reactions reported by other workers was not observed in the patients seen by me. However it is apparent that this form of treatment is not without its dangers, and there have been continued experiments with other forms of therapy, notably Streptomycin. Several reports are available of cases treated with a combination of calciferol and streptomycin, and there is some suggestion that a combination of the two drugs may be more effective than either one of them alone. Recently I have had the opportunity of treating a small number of cases with *para-aminosalicylic acid*, used simultaneously by mouth and in the form of a cream. While the series is too small to draw any definite conclusion it would appear that the results in the treatment of lupus vulgaris, and Bazin's disease (erythema induratum) are comparable with those obtained from the use of Calciferol, with the added advantage that para-aminosalicylic acid appears to be relatively or even completely free from side reactions. I await with interest the opportunity to attempt the treatment of cases of sarcoidosis with this drug.

## Fungous Infections of Hands and Feet

The diagnosis of "Athlete's foot" has become dangerously popular during the last quarter century. All too often every eruption on the feet is regarded as fungous in origin, and the most recent and popular fungicide is ordered for its treatment. Norman Wrong in a recent paper, has pointed out that three types of fungous infection of the feet are commonly seen in this part of North America. The first and most common is that presenting itself as scaling, maceration and fissuring between the toes, usually the fourth and fifth. The reason for this is that the fungi responsible grow much more readily in darkness and in the presence of moisture. The next is a vesicular eruption of the plantar surface of the toes and soles. The third is a warty type which is fortunately rare because it is very resistant to treatment. Fungous infections of the toenails are also seen.

Apart from these well-defined clinical entities, the large proportion of eruptions of the feet so glibly diagnosed as "Athlete's foot" are not due to fungus at all. Eruptions which start on the dorsa of the toes and the feet are rarely fungous in origin, being most usually caused by contact irritation from stockings or shoes, or by infection from pyogenic organisms. Only too frequently do we see eruptions starting on the dorsa of the feet which have been treated and aggravated by a multiplicity of fungicidal remedies and made much worse as a result. If we are dealing with a pyogenic infection we should treat it with bacteriocidal remedies and not fungicides. However in the presence of acute erythema, vesiculation and cracking, fungicides or bacteriocides are contraindicated, and the treatment should be confined to some such measure as foot baths, and extremely mild soothing applications.

In the absence of an acute reaction, the treatment of the superficial mycoses has become considerably simpler during recent years with the use of the fatty acids, the derivatives of undecylenic, proprionic, and caprylic acids. One of the most effective is the proprietary preparation "Desenex". This is also perfectly safe to use for prolonged periods as a prophylactic.

Primary fungous infections of the hands are extremely uncommon. However it is not at all unusual to find allergic manifestations on the hands as a result of primary fungous infection of the feet. These occur as symmetrical fine vesicular lesions on the sides of the fingers and thenar eminences, being much more common during warm weather. This is the "so-called "id" reaction. These lesions should be treated with soothing remedies while the priary focus on the feet is being dealt with by fungicides, and the vesicular lesions of the hands will not clear until the primary focus of the feet has been dealt with.

The commonest eruption on the hands is the so-cal'ed "housewife's eczema". In many ways the profession of housewife is one of the most hazardous of all occupations. This is particularly true since the advent of the detergent soap powders, and the many cleansers and solvents, and the plastics, which the average housewife encounters daily, to say nothing of the multitudinous cosmetics which she handles in her endeavours to overcome the ravages wrought by her labours.—The next commonest eruption of the hands is contact dermatitis due to industrial hazards.

These cases should be treated by the avoidance or removal of the irritant, and by soothing healing remedies. It is a common thing to see such eruptions made much worse by the application of a strong fungicidial remedy such as Whitfield's ointment or Desenex or Sopronol. *Fungous infection is almost the least common cause of hand eruptions.*

Here it should be emphasized that an important point in the management of fungous infections is the simple procedure necessary to establish the diagnosis beyond doubt. This consists in the examination and culture of the infected materials. For some reason this procedure is not carried out as often as its simplicity justifies. The equipment needed for collection of the specimens includes only a pair of fine pointed scissors, some dissection forceps, a blunt scalpel and a good light. The Provincial Laboratory will provide special envelopes for the submission of collected material, which will consist of skin scrapings, nail clippings, debris from under the nails, hairs, (in cases suspected of ringworm of the scalp) and so on. The envelopes contain a piece of black paper, in addition to the usual requisition form. This has been shown to be a much more satisfactory method of collection than the use of a glass container. Direct microscopic examination of the material, after it has been softened with 10% potassium hydroxide for thirty minutes, may show the presence of branching mycelia or spores, and the individual fungus may be recognized after culture on selective media.

**Psoriasis:**

Mention of fatty acids in the treatment of superficial mycoses brings us naturally to another disease, which has been treated during recent months with the fatty acids taken internally. Since the publication by Perlman, in the early part of last year, of his results in the apparently successful treatment of psoriasis with undecylenic acid by mouth, this form of therapy has received very wide trials in other centres. Those of you who have used these capsules, marketed under the name of "Declid", will agree that this drug is almost consistently unsuccessful, and in addition is extremely unpleasant to take. Its use has recently been universally condemned by dermatologists in Canada and the United States.

Perhaps it would hardly be fair to mention psoriasis without freely admitting our failure to produce any semblance of a cure for th s distressing and all too common compla nt. Winston Churchill, during the recent war, referred to Joseph Stalin as a "riddle, inside a mystery, wrapped in an enigma." The aetiology of psoriasis is still as obscure as are the motives of the ruler of the Soviet. Its various clinical forms are well known to all of us: they present themselves in our offices every day, and it is not therefore proposed to describe them. The acute guttate variety can be very acute, and the chronic form is often depressingly chronic. Finger and toe-nails may be destroyed, joints may be deformed, or the patient may be hospitalized for many months with a generalized exfoliative dermatitis—all this may be just psoriasis The diagnosis of his condition is usually simple but in its mor unusual forms it may closely simulate tinea, neurodermatiti , or seborrhoea, and it should not be forgotten that it is not uncommon for a patient to be diagnosed as having psor asis for many years before eventually he becomes a well-defined lymphoblastoma.

Another relatively common condition which very closely resembles psoriasis in some people is pityriasis rosea This condition commonly occurs in mild epidemics, usually in the Spring or Fall. It is characterised by tawny or reddish-brown papules, with moderate or even very marked scaling, usua ly fairly evenly distributed over the trunk and the peripheral part of the limbs. The papules are mostly oval, with their long axis running parallel to the lines of cleavage. Itching is mild as it is in many cases of psorasis, and close inspection usually reveals the presence of one lesion larger than the rest, this representing the so-called "herald patch" which makes its appearance a few days before the remainder of the lesions.

To return to psoriasis—during the centuries the treatment of this disease has changed but little. The acute case must be soothed at all costs, and not exposed to more than a weak concentration of ammoniated mercury ointment. For the chronic long-standing case, as we have already pointed out, there is still no certain cure, although indeed some long-suffering individuals have been temporarily rid of their disease by the use of Cortisone or ACTH. I do not consider that arsenic plays any part in the modern treatment of psoraisis, and X-rays are similarly contra-indicated in all but the occasional case which presents one or two small plaques only. The use of tar in one form or another is a time-honored one. Macauley's writings show that many inhabitants of the Scottish Highlands in the early eighteenth century "were covered with cutaneous eruptions, and smeared with tar, like sheep." One of the most efficient of the treatments now available to us is a modification of the Goeckerman-O'Leary routine, namely, application of tar, and the administration of ultra-violet light in erythema or near erythema doses. The obvious objection to the use of crude coal tar ointment is its unpleasantness, and the fact that after prolonged application pustules often develop on the skin. These difficulties may be overcome by the use of the colorless alcoholic suspension of tar known as liquor carbonis detergens. As one of the main beneficial actions of tar appears to be its property of sensitising the skin to ultra-violet light, it is usual to recommend that this liquid be painted on the affected areas immediately before exposure to ultrayiolet light. Preliminary softening and shedding of the heaped-up micaceous scales may be encouraged with the use of bran or oatmeal baths.

The remarks about the use of X-rays do not apply to the treatment of psoriasis of the nails. In this extremely disfiguring condition X-rays offer the only chance of success, and response usually occurs in only about 50% of cases. All in all, psoriasis is one of the more obvious of our many therapeutic failures. However, almost all cases can be cleared by the treatment outlined, even if there is no way of preventing recurrences.

There are certain other drugs which are perhaps in less common use in dermatological practice but which are of general interest.

**Podophyllin:**

This resinous substance has been in use for many years as a cathartic, and has fairly recently been found to be effective in the treatment of most cases of condyloma acuminata, the so-called "venereal warts." It is best used in a 25% concentration of mineral oil, and some have used a 20% suspension in alcohol. It is inadvisable to apply this substance for more than five hours before washing it off, for fear of severe inflammatory reaction.

The drug acts by causing a spasm of the small blood vessels resulting in necrosis and sloughing and in addition the active element, Podophyllotoxin, acts as a nuclear poison, interfering with mitosis. This latter property has led to experimental research in the treatment of various forms of cancer with Podophyllin, but so far the result has not been very encouraging. There is no explanation, as far as I am aware, of the fact that this substance is effective only upon condyloma acuminata, and not upon warts elsewhere.

**Bistrimate:**

The use of bismuth in many skin diseases has been common for generations. Recently a soluble form, bismuth triglycolomate, marketed as "Bistrimate", has been used with some success, notably in the treatment of chronic discoid lupus erythematosus. Reports of success of this line of treatment have by no means all been enthusiastic, and it is well known that many cases of this form of lupus erythematosus undergo spontaneous remissions from time to time. However there are a certain number of encouraging reports, and this form of therapy should be borne in mind when the injectable bismuth or gold therapy has been unsuccessful, or is contra-indicated. The drug can be continued for long periods of time, up to six months with periodic examinations for signs of impending toxicity or intolerance.

**Cortisone and ACTH:**

No scientific paper today would be complete without some reference to the wonder hormones. Perhaps the most dramatic results in the dermatological field accrue from the use of Cortisone in the treatment of sub-acute and acute disseminated lupus erythematosus. There have been many reports of the prompt efficiency of this hormone, and dramatic remissions occur. Unfortunately treatment cannot be maintained for very long periods at a time, and there are the usual recurrences, sometimes even aggravation of the original condition, once the therapy is discontinued.

**Ointments and Ointment Bases:**

Dermatology, while still very much an art, has become more and more a science, but, perhaps, the outstanding advance has been in ensuring that the

drugs employed are being used in the best way possible, and that they reach the portion of the skin in which they can exert their most beneficial effect. One example of this is in the treatment of acne vulgaris. The time honored remedies of sulphur, salicylic acid and resorcin, are still the most efficient topical treatments in this disease, but with the use of penetrating bases these drugs can now be made available at a sufficient depth in the corium for them to have their full effect on the sebaceous glands. These penetrating bases include water-in-oil and oil-in-water emulsions, sundry alcohols, wetting agents, and so on. When all is said and done, the major changes in treatment of skin diseases during recent years has largely been in the vehicles employed, and not so much in the drugs prescribed.

Perhaps it is appropriate to close with two quotations, which may justify the existence of the dermatological expert.

The first is from an address by Dr. G. H. Percival of Edinburgh on the occasion of his first assuming the chair of Dermatology in that University. "In the vast majority of cases, diagnosis of skin diseases is rapid and accurate, but their cure is another matter, and treatment is often a weary process. Diseases of the skin differ from those of other organs in that they are visible to the patient as well as felt by him, and no cure is complete from his point of view, until he no longer experiences their sensation and can no longer see his eruption.

Nevertheless it is possible with care and perseverance, and given adequate facilities, to influence favorably or to cure almost all skin diseases, many of which left to themselves would be of a more or less continuous permanent nature."

The other quotation is taken from a textbook of Medicine by Dr. Hughes Bennett, published about one hundred years ago. "Ignorance of skin diseases, although it seldom occasions danger to human life, produces great inconveniences, exasperates the progress of other maladies, renders life miserable, and frequently destroys those social relations and ties which constitute happiness.'

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# Mistaken Identity

Bertha O. Archibald

I WONDER how many people now recall that Halifax once had a South Common, which extended from South Park Street to Robie, and from Spring Garden Road to South Street and beyond, probably as far as Point Pleasant Park. About ninety years ago in this area—then practically the centre of the Common, a building of brick and stone was built, which was the nucleus of the Victoria General Hospital. The north and south wings and the front structure of the old hospital were not added until about twenty years later.

Looking north from the hospital were clear open spaces extending as far as Camp Hill Cemetery, with practically no houses to obstruct the view. Even the Forrest building had not been thought of.

The first building to make its appearance was the old Halifax Medical College, which was situated at the corner of College and Carleton Streets. There were a few houses between South Park and Summer Streets on Spring Garden Road, the land having been leased from the City for a period of 999 years. On the west side stretched three large estates—Gorsebrook, Oakland and Studley, also the City Home. The latter was a wooden structure and was burned some years later with great loss of life. It was known as the City Poor's Asylum.

Connected with the hospital were two buildings, one a large barn containing many head of cattle which supplied the hospital with milk. These were herded on the Gorsebrook grounds. The other building was a Poultice House, and was equipped with a furnace suitable for disposing of the discarded poultices which were so commonly used in those days.

Surrounding the hospital grounds was a high board fence, which not only kept prowlers out, but helped to keep the patients from escaping from the institution. Assisting in this was a very vicious Bulldog who performed the duty of night watchman for the grounds, and many an interesting story is told of his faithfulness in not only preventing people from entering, but giving the alarm when some patient essayed to scale the fence. When escapes were successful they were spoken of as 'elopements'.

The hospital was heated by means of fireplaces, which proved very unsatisfactory. They are still visible in the old building at the time of writing. Later, groups of stoves were erected in the basement and gratings placed in the floor above, not unlike the pipeless furnaces of today. The men patients would sit around these gratings and talk and smoke, and as some of them chewed tobacco the grating served as a convenient cuspidor, while the smokers used the grating to shake the dottle from their old clay pipes. One could see that cleanliness was a major problem as far as the men's wards were concerned.

Later, an Exhibition Building was erected on the South Common, and a race track circled where All Saints Cathedral now stands. At one time this parcel of land had been used as a city dump and when the excavations were made quantities of old bottles, oyster shells etc. revealed this fact. When the Cathedral corporation bought this site a Skating Rink which had stood there had to be removed to South Street where a service station is now situated.

Through all this area ran a fairly large stream of water, which formed a natural bathing pool back of what is now the Grace Maternity Hospital. A stream coming from the Public Gardens united with another running through the Hospital grounds and entering the Harbour at Inglis Street. The Public Gardens were not then enclosed, and one could hear—particularly on moonlight winter nights—the laughter of happy skating parties. A man was hanged on the little island or near the pool by the name of Griffin and these gardens were often spoken of as "Griffins Public Gardens".

Looking towards the sea from the Hospital eastward there were few houses until one came to the Cemetery on South Park Street. On these grounds still stands a little chapel which is unique in having been completely built in one day by volunteer labour.

One of the first superintendents of the hospital was Dr. A. P. Read. He was domiciled in the hospital and occupied what later was known as the Eye Ward. He had many hobbies, among them being the repairing of clocks. The walls of his room were adorned with various types and sizes of clocks, and one might hear gongs at almost any moment of the day or night. Another hobby of the doctor's was his farm, which was situated at Windsor, and where he grew and cured tobacco. He used orange peeling in his curing process.

The writer had been on duty for only a few weeks having received the appointment of Assistant Pharmacist at the hospital in 1917 when an embarassing situation occurred. The Pharmacy was then known as the Dispensary and all the dispensing for the City Home was done there as well as the prescriptions for the Hospital. The empty containers and bottles from the City Home were placed in a wooden box with various sections, and around the box was a horses rein strongly knotted. Each morning a bald-headed little man would bring the box over to be replenished, and at noon would call for it. One day about noon an elderly man came to the door of the Pharmacy and asked for Dr. Puttner, the Pharmacist. His coat was somewhat faded and his steel-rimmed spectacles were worn well down on his nose, and he looked a bit bedraggled since it was a stormy day. I replied that Dr. Puttner was in town. I looked at my Visitor and hesitated, and finally, pushing the box towards him I said "Did you come over for this? It is all ready." I can still recall the look I received from those piercing blue eyes. He looked at the box of drugs—having seen it a multitude of times before, no doubt, and straightening himself with all the dignity of a Prince he remarked "Do you not know who I am?" "I" with an agitated tremor in his voice "I am Dr. A. P. Read, the former superintendent of this hospital, I will have you know." He gave one more searing glance at me and one look at the old box, and before I had time to make my apologies turned and stamped out of the Pharmacy. It occurred to me when he spoke that he might not be from the Home but my slogan was Service, and I was trying to render service even to the inmates of the City Home.

COMMITTEE ON FRACTURES AND OTHER TRAUMAS
AMERICAN COLLEGE OF SURGEONS

# Principles of Early Management of Hand Injuries

## 1. Protection of the Hand

Following injury, the hand is particularly susceptible to the development of complications leading to serious disabilities. For this reason it is important that the freshly injured hand be given the most careful protection against such complications as result from added infection, additional tissue damage and stiffening.

The principles governing the provision of this protection may be briefly stated as follows:

### 1. Protection against added infection

Any open accidental wound of the hand may be assumed to be contaminated. It is mportant that no additional infection be added. This requires

(a) Protection of the wound at once with a sterile dressing.

(b) Avoidance of putting anything into the wound, such as instruments, gauze applicators sponges or any sort of antiseptic.

(c) If any cleansing of the areas around the covered wound is done, it should be with soap and water only.

(d) Avoidance of all efforts at treatment of the wound by exploration, debridement or repair of damaged structures until adequate facilities are available. Adequate facilities for this purpose should include a location where surgically aseptic technic is employed, adequate anaesthesia, proper instruments, sufficient assistance, good lighting and the provision of a bloodless operative field.

(e) Application of a sterile dressing which will protect against the entrance of foreign material. Such a dressing should be voluminous, firmly applied with moderate pressure, separating the fingers from each other, and should maintain the hand and fingers in the position of function.

(f) Antibiotic drug should be administered systemically, not locally, in full dosage. Tetanus antitoxin (or toxoid) should be administered when the conditions warrant.

### 2. Protection against added tissue damage and deformity

Immobilization of the hand is required in any major injury, whether the wound involves skin, tendons, nerves, joints or bones. Immobilization should be governed by the following principles:

(a) Immobilization should be employed as soon as possible after receipt of the injury for protection from further tissue damage.

(b) Following definitive treatment of the injury, the immobilization should be continued as long as may be required for healing to occur.

(c) Immobilization should be in the position of function (position of grasp) in order to maintain optimum relation of bone fragments and soft tissue structures.

(d) The position of function in immobilization is necessary to prevent disabling deformities, contractures, muscle weakness and joint stiffening, and to insure the earliest return of usefulness after healing.

(e) Flat splinting of the hand or any of its digits must be avoided at all time.

Prepared by the American Society for Surgery of the Hand.

# Minutes of A Special Meeting of the Executive of The Medical Society of Nova Scotia, 1951

A SPECIAL meeting of the Executive of The Medical Society of Nova Scotia was held in the lecture room of the Dalhousie Public Health Clinic, Halifax, N. S., on March 20th, 1951, at 2.30 p.m. to consider the report of the Committee on Economics dealing with the agreement regarding the medical care of pensioners between The Medical Society of Nova Scotia and the Department of Welfare of the Provincial Government.

Present: Doctor J. J. Carroll, President, Doctors A. R. Morton, E. T. Granville, A. W. Titus, J. H. Slayter, K. P. Hayes, H. R. Peel, P. R. Little, P. E. Belliveau, D. F. Macdonald, M. J. Macaulay, J. R. Macneil, H. F. Sutherland, K. J. C. MacKinnon, S. Marcus, W. A. Hewat, A. E. Blackett, P. S. Cochrane, G. R. Mahaney, J. R. Ryan, E. I. Glenister, A. G. MacLeod, J. W. Reid, H. J. Devereux, C. H. Reardon, H. G. Grant, and N. H. Gosse, President of the Canadian Medical Association, A. B. Campbell, J. S. Robertson, Hon. A. B. DeWolfe, Minister in charge of Civil Defence and Mr. D. C. Macneill, General Manager of Maritime Medical Care Incorporated.

The President called the meeting to order.

Previous to the meeting the report of the Committee on Economics had been sent to all Branch Societies and each Branch Society had been requested to deal with the report before their representatives came to the meeting of the Executive.

Although the meeting was especially called to deal with the report of the Committee on Economics the Society had been asked by Doctor J. S. Robertson, Assistant Deputy Minister of Health, if they would hear Colonel A. B. DeWolfe, the Provincial Minister of Civil Defence, on the question of civil defence in the event of an emergency. This had been agreed upon by the president.

Doctor Robertson in introducing Colonel DeWolfe spoke about the importance of civilian defence in the event of war, and also pointed out the responsibility of the medical profession.

Colonel DeWolfe told the meeting of the organization he had in mind for civil defence. He referred to such committees as that for fire control, welfare, medical care, etc. He pointed out the importance of a proper medical organization so that one part of the Province might help in the event of a disaster in another part. He gave the National organization telling us that all defence was under the Hon. Paul Martin, of Health and Welfare, that under him there is a committee for the whole Dominion, and that each of the ten Provinces is headed up by a Minister in charge of Civil Defence. He said that the chief reason for speaking to the Executive was to seek their help. He referred to the fact that Doctor Noble was leaving for Scotland and asked that someone be appointed to take his place in the interim. (This already has been done; Doctor A. B. Campbell, of the Workmen's Compensation Board, is filling in for Doctor Noble in the interim.)

The President, Doctor Carroll, thanked Colonel DeWolfe for his remarks.

Doctor J. S. Robertson: "There has been the question as to how we could best go about getting the entire medical group in the Province into the picture. If the Executive can suggest to the Branch Societies that one member from each Branch could be named they could meet together, and with authority from their local association they could get further ahead."

Doctor A. B. Campbell stated that although he will be away a good part of the time during the year, he would be quite willing to act for Doctor Noble during his absence in Scotland.

Doctor W. A. Hewat thought it would be a good idea to have members from each Branch Society to meet together. He moved that each Branch Society be requested to appoint a member to the central committee of which Doctor Campbell is chairman.

Doctor A. E. Blackett thought that it would be a good idea if each Branch Society appointed one member who could be contacted by the main medical group.

Doctor J. W. Reid: "It seems to me that the medical profession should not just appoint a body to take dictation from some other body, but should have a committee of their own. Should we not organize our own committee?"

Dr. A. R. Morton thought that the medical profession should have their own committee and work in close liasion with Colonel DeWolfe's committee.

Doctor N. H. Gosse said the committee had been set up before we knew anything about it. He thought we should set up our own organization. He referred to the confusion in Winnipeg during the flood disaster and thought we should know exactly what our duties would be.

Doctor H. G. Grant: "I think that the organization would be to have Doctor Noble in contact with the Government's medical committee and also to have him build around himself an organization within The Medical Society. If the Government's committee would give us the information we are quite capable of organizing the profession from the medical standpoint."

Doctor C. H. Reardon: "One other important feature, I think it is very important that we have our own medical Society active with the group."

Doctor H. G. Grant: "I think we should ask Doctor A. B. Campbell if he would find out just what authority could be given to The Medical Society of Nova Scotia."

Doctor A. B. Campbell thought that The Medical Society of Nova Scotia had proven itself capable of meeting any call that had come on it.

Doctor A. E. Blackett thought there should be a central committee of about three.

Doctor D. F. Macdonald seconded Doctor W. A. Hewat's motion. Carried.

Report of the Committee of Medical Economics.

Doctor H. J. Devereux, Chairman of the Committee, stated that after their last meeting the Committee on Medical Economics came to the decision that they would write a letter to the Department of Welfare asking for an increase of ten cents per month per beneficiary, and read the two following letters.

Sydney, N. S. March 6, 1951

Dear Doctor:

Your Medical Economics Committee wishes to make a report to your society on our dealings with the Department of Welfare concerning medical care to the Welfare Group. We have journeyed to Halifax on three separate occasions, the last one on February 9, 1951. The Medical Economics Committee met and decided that they would not accept any less than 85 cents per beneficiary per month. The copy of Mr. Connolly's reply shows that this was not acceptable to the Department of Welfare. On the other hand, Mr. Connolly's reply states that the fee of 75 cents per beneficiary per month is adequate, was not acceptable to the Medical Economics Committee.

As Chairman of this Committee I have written to Dr. James Carroll, Antigonish, recommending to the Executive that the contract be discontinued, as we feel we can do no further bargaining without further instructions from the Nova Scotia Medical Society. A copy of this letter has been sent to all Branch Secretaries and we suggest that you bring it up with your society as soon as possible for discussion. The Medical Economics Committee feel that no further move should be made until all the members of the Society have had a chance to express their feelings.

Very sincerely,

(Sgd.) H. J. Devereux, M.D.
Chairman of the Medical Economics Committee

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Halifax, N. S., March 2nd, 1951

Dear Dr. Devereux:

This is to acknowledge your letter of February 13th in which you say "the Medical Economics Committee cannot recommend to the Nova Scotia Medical Society that they renew the present contract unless the grant be increased from 75c to 85 cents per beneficiary per month. This increase to go into effect as of March 1, 1951."

Further, you say, "if this decision is not acceptable to your Department (meaning the Department of Public Welfare) then we have no recourse but to recommend to the Executive of the Nova Scotia Medical Society that the contract be discontinued sixty days after March 1, 1951."

In reply I must say that the Department considers that the fee of 75c per beneficiary per month is adequate. If therefore the Nova Scotia Medical Society decides to discontinue the present contract we shall accept the notice of discontinuance.

Yours very truly
(Sgd.) Harold Connolly, Minister

Doctor A. G. MacLeod moved that the Society discontinue the present contract.

Doctor H. G. Grant read the resolution which was moved by Doctor M. G. Tompkins at the semi-annual meeting of the Executive on January 16th, 1951, and which had been seconded by Doctor C. H. Reardon—"that the Executive of The Medical Society of Nova Scotia endorse the work of the Committee on Medical Economics so far, and further that they would meet with the Government and make the best possible arrangements to draw up a satisfactory agreement under the plans drawn up by the Committee on Medical Economics, and later that they report to the Executive and have it voted on.

The question was asked whether the Executive had the power to discontinue a policy.

Doctor H. G. Grant read from the Constitution and By-Laws the sec-

tion dealing with the duties of the Executive Committee—"The Executive Committee shall submit to the Constitution, attend to matters of business which arise, between the annual meetings, which demand prompt attention and do not require a special meeting of the Society." He said if the Executive think a matter is of sufficient consequence to be referred to a special meeting, they have the authority to do so.

Doctor Smauel Marcus asked if he might propose a resolution in the form of an amendment to Doctor MacLeod's motion.

Copy of resolution presented at a special meeting of the Executive of The Medical Society of Nova Scotia on hebalf of the Lunenburg-Queens Medical Society on March 20, 1951. Its adoption moved by Dr. Samuel Marcus and seconded by Dr. W. A. Hewat.

WHEREAS we, the members of The Medical Society of Nova Scotia' consider that the present agreement with the Department of Welfare of the Province of Nova Scotia for the medical care of the welfare group, in the light of the experience of the past twelve months, imposes too great a burden on the members of the medical profession, since about 50% of the cost is borne by about 400 individuals;

AND WHEREAS we, the members of The Medical Society of Nova Scotia, find it difficult to understand the uncompromising attitude of the Department of Welfare of the Province of Nova Scotia, in its refusal to consider an increase of but a few cents per month per pensioner, in order to compensate us partially for our 50% contribution;

AND WHEREAS we, the members of The Medical Society of Nova Scotia, are keenly disappointed at the failure of the Department of Public Welfare of the Province of Nova Scotia to inform the welfare group of the type of medical care to which they are entitled, and of the contribution by the members of the medical profession;

Be it RESOLVED, therefore, that this special meeting of the Executive of The Medical Society of Nova Scotia go on record as being in favor of continuing negotiations with the Department of Welfare of the Province of Nova Scotia, in an attempt to arrive at some basis, in the light of the experience of Maritime Medical Care Incorporated, whereby there would be a more equitable distribution of the burden that exists at present, and in order that this service, promised to the welfare group by our elected representatives as a responsibility of *all* the people of Nova Scotia, may be continued;

Be it further RESOLVED that we, the members of The Medical Society of Nova Scotia, realizing our responsibilities as members of an ancient and honorable profession, and realizing also the great need of a large proportion of the welfare group for this recently inaugurated service, shall, pending the outcome of further negotiations, continue to provide the medical needs of this group as we have done during the past twelve months;

Be it further RESOLVED that, if this meeting of the Executive of The Medical Society of Nova Scotia deem it necessary in order to clarify our position, a copy of this resolution be given to the press for publication.

Doctor Marcus stated they did not feel they could turn back the clock to where they were before this went into effect, but they did feel they should know very clearly where they stood.

Doctor H. J. Devereux: "Is that amendment in opposition to the original motion?"

Doctor J. W. Reid stated that the amendment could not be considered an amendment because it was entirely opposite to the original motion.

Doctor A. E. Blackett stated he would like to give a word of commendation to the Committee who had worked so hard against a stone wall. He said they had had a meeting of the Pictou County Medical Society and that the Society had expressed an opinion disagreeing with the report of the Committee on Medical Economics. He also said that the Government would like to discontinue the agreement, but if they did he felt they would blame the doctors for it. He thought it would be a moral mistake to throw it over and that it would hurt our public relations. He thought it should be presented to the public that the 400 doctors in the Province are really paying for 50% of the treatment.

Doctor C. H. Reardon stated that the Minister had given his word they would not blame the medical profession, nor would the Government.

Doctor P. S. Cochrane stated they had had a meeting of the Valley Medical Society and the opinion was unanimous that the contract should be cancelled, and that publicity should be given it before the Government gave out any, and that if any negotiations were entered into we should be paid 100c on the dollar and net 50c on the dollar. He thought the Executive should take a definite stand on the question.

Doctor A. R. Morton stated that the Halifax Medical Society had met a week ago and this question had been discussed, and it had been decided by a small margin to instruct their delegates to keep the matter open.

Doctor A. E. Blackett stated that the Government had to be notified if the resolution were passed, and that it would have to be done in black and white.

Doctor D. F. Macdonald stated that the Western Nova Scotia Medical Society had not had a meeting to discuss the question, but they had had some informal discussion, and had circularized the doctors, and their Society were practically unanimous as being in favor of the Committee's recommendation. He wondered if the pensioner could not be made to pay for the first call.

Doctor Samuel Marcus stated that the Lunenburg-Queens Medical Society had opposed the thing from the beginning, and they realized there were sections in the Province who did not hold their views. Their resolution was presented for the common good of the profession as a whole, because it was his opinion that the letter of Mr. Connolly's was not necessarily the final word. The Society could get a lot of adverse publicity out of this matter. Personally he was opposed to it, but their Society felt that negotiations should be continued.

Doctor E. T. Granville stated that the Medical Economics Committee's recommendation represented a good deal of work and trouble, and they had been unsuccessful. He did not see that anything else could be done except endorse their recommendations.

Doctor J. R. Ryan: "Perhaps further negotiations might be carried out. I am not in favour of closing the door."

Doctor C. H. Reardon: "I think it might be easier to negotiate with the Government if there were no contract. I think we should cancel it."

Doctor P. R. Little: "We did enter into a contract with the Government, and we were supposed to give a modified type of treatment. Before we cancel the contract we should look into it and see if we are giving a modified type of treatment. Eighty-five cents would not be giving us much more. If we got $1.50 we would not be getting 100%. We might inquire what the Maritime Medical Care have done."

Doctor J. R. Ryan: "Possibly the Economics Committee could negotiate further with the Government, and possibly the mileage might be modified, because I am convinced that it is mileage that is killing the contract."

Doctor N. H. Gosse: "Maritime Medical Care has just been mentioned. We have gone over the business of Maritime Medical Care and some very interesting things came out. Regarding the care of pensioners in Ontario they started at 25c. and are up now to 83c. I was against signing this at 75c when it first came up. The Medical Society decided that 75c should be accepted as fair. It is a gentleman's agreement. I am very glad that a quarter of millions roughly is going out to the doctors of Nova Scotia. I do not think that we are under any obligation to carry on. In the last few days our General Manager has been getting some information from other Provinces. They pay their accounts on a taxing system; 80c is paid per beneficiary per month. One hundred and forty thousand pensioners are handled through their welfare board. Mileage is worked out at 25c in the summer, and 50c in the winter."

Doctor E. T. Granville stated that the roads in Nova Scotia and the roads in Ontario were vastly different.

Mr. D. C. Macneill stated there were 30,000 welfare pensioners in the Province of Nova Scotia.

Doctor J. W. Reid: "There is nothing in the world that would ever make a mileage scheme work. Now is the time to get out from under and to negotiate for a new contract.

Doctor H. G. Grant read the following from the completed agreement—"This agreement shall take effect on the First day of March, A.D., 1950, and shall continue for one year thereafter. If neither party had given to the other notice in writing sixty days before the expiration of the said terms of one year of his or its desire to terminate this Agreement it shall continue in force until the expiration of three months from written notice by one party to the other or his or its desire to terminate the Agreement. Upon the expiration of three months from the giving of such written notice this Agreement shall come to an end and be of no further force or effect." He said if you want to terminate that agreement a letter would have to be drawn up and signed by the President.

Doctor A. E. Blackett stated that it was his impression that this contract had been authorized by The Medical Society at a general Meeting.

Doctor H. G. Grant: "The Committee headed up by Doctor G. R. Forbes was given authority to go ahead and finalize the matter in the care of old age pensioners."

Doctor A. E. Blackett: "The only body that gave that authority is the only body that can take it away."

Doctor K. J. C. MacKinnon stated that at a meeting of the Antigonish-

Guysborough Medical Society the general feeling had been that negotiations should be carried on.

Doctor C. H. Reardon: "I would like to make an amendment that if the present contract is discontinued that we negotiate for a new contract."

Doctor P. S. Cochrane stated that the amendment was not necessary.

Doctor P. R. Little: "We are a small committee, that vote should be carried over to the general meeting. It would appear that we are all against it. I would suggest that we adjourn without pushing this motion to a finish."

Doctor A. E. Blackett thought that the views of the medical profession in the Province should be obtained. That there were two conflicting views, and the same procedure might be used as when the Maritime Medical Care was put into effect.

Doctor P. R. Little: "I wish to make a motion that we defer our action to a general meeting."

Dr. H. R. Peel: "If that motion is in order I take pleasure in seconding it."

Doctor P. R. Little: "The report of our vote will have a tremendous influence on the general meeting."

Doctor P. S. Cochrane: "Any motion before the question pending further information is always in order."

Doctor J. J. Carroll: "I do not think that is in order."

Doctor P. S. Cochrane stated that the Economics Committee were asking for instructions from the Executive.

Doctor J. J. Carroll asked if the Executive were ready for the question on Doctor MacLeod's motion, that the present contract be discontinued.

Doctor N. H. Gosse: "Would that stop all negotiations?"

A show of hands gave a count of fifteen in favor of Doctor MaLeod's motion, and six against. Motion carried.

Doctor P. R. Little: "I would ask the secretary to record that the vote was out of order."

Doctor C. H. Reardon: "I would move that a special general meeting of The Medical Society of Nova Scotia be held the first week in April to rule on this matter of old age pensioners; the place to be decided to-day."

Doctor M. J. Macaulay: " I believe that we should go back to the Government. I believe that we should go over the head of the Department of Welfare and go to the Cabinet."

Doctor N. H. Gosse: "A decision has been taken here to-day. I think it would be a very great pity indeed if the Economics Committee were not further empowered to go back to the Minister. I think that before any action is taken to go over the Minister's head that negotiations should be carried on."

Doctor J. W. Reid suggested that they negotiate for a full and newly written agreement.

Doctor H. J. Devereux seconded Doctor's Rearden's motion.

Dr. H. G. Grant: "I do not think that we would get much of a meeting."

A show of hands on Doctor Reardon's motion gave thirteen for the motion, and five against. Motion carried.

Doctor D. F. MacDonald moved that the whole matter should be published

Doctor H. G. Grant stated it had been decided not to publish the minutes of the meeting in the Bulletin.

Doctor J. W. Reid moved that the Ecnomics Committee be empowered to continue negotiations with the Government of a new contract. This was seconded by Doctor P. S. Cochrane. Doctor Reid reworded his motion to read that the present Economics Committee be empowered to open negotiations for a new contract, and that the Executive Council should go on record as wanting to continue their interest in the welare group. Motion carried.

Doctor A. E. Blackett suggested that the Minister be told verbally that the Executive had held a meeting this afternoon.

It was decided that the special meeting of The Medical Society of Nova Scotia be held on Wednesday afternoon, April fourth, at Halifax.

On motion the meeting adjourned at 5:55 p.m.

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## CANADIAN SOCIETY OF LABORATORY TECHNOLOGISTS

The national convention of the Canadian Society o' Laboratory Technologists will be held in Winnipeg, Manitoba, at the Fort Garry Hotel from June 24th to June 27th, inclusive. A fine programme of scientific papers and technical exhibits has been planned. The entertainment will be varied and interesting. It is hoped that all parts of Canada will be well represented, not only by members of the Society, but all others who are interested in laboratory work.

More detailed information can be obtained by writing to Miss Miriam Wiseman, Municipal Hospitals, Winnipeg, Manitoba.

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## LOCUM TENENS WANTED

**A locum tenens is wanted for a period of three to four weeks during the summer at Grand Manan, N. B. Salary $300 for the period; all expenses paid. Anyone interested kindly notify the Secretary.**

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## PRACTICE VACANT

**There is a good practice vacant at Advocate Harbour, Cumberland County, N. S. Doctor's office available. Anyone interested kindly get in touch with the Secretary.**

# REGISTRATION

**SPECIAL MEETING THE MEDICAL SOCIETY OF NOVA SCOTIA**
**APRIL 4, 1951**
**HALIFAX, N. S.**

Dr. W. M. Grant, Amherst
Dr. H. A. Locke, New Glasgow
Dr. J. B. Reid, Jr., Truro
Dr. T. H. Earle, Upper Stewiacke
Dr. H. F. McKay, New Glasgow
Dr. H. A. Myers, Amherst
Dr. J. A. Langille, Amherst
Dr. D. Drury, Amherst
Dr. R. M. Rowter, Bridgewater
Dr. W. O. Coates, Amherst
Dr. D. A. Campbell, New Ross
Dr. R. G. A. Wood, Lunenburg
Dr. D. W. MacInnis, Kennetcook
Dr. D. F. MacInnis, Shubenacadie
Dr. H. G. Grant, Halifax
Dr. J. J. Carroll, Antigonish
Dr. C. R. Adams, Springhill
Dr. D. McD. Archibald, Kingston
Dr. C. H. Young, Dartmouth
Dr. C. H. Reardon, Halifax
Dr. W. M. D. Robertson, Dartmouth
Dr. A. M. Creighton, Tatamagouche
Dr. P. O. Hebb, Dartmouth
Dr. I. E. Mackay, Stellarton
Dr. H. J. Townsend, New Glasgow
Dr. V. O. Mader, Halifax
Dr. A. W. Titus, Halifax
Dr. W. H. Eagar, Wolfville
Dr. B. E. Goodwin, Amherst
Dr. F. F. P. Malcolm, Dartmouth
Dr. A. G. MacLeod, Dartmouth
Dr. V. D. Schaffner, Kentville
Dr. G. R. Forbes, Kentville
Dr. E. T. Granville, Halifax
Dr. R. O. Jones, Halifax
Dr. H. W. Kirkpatrick, Halifax
Dr. D. M. MacRae, Halifax
Dr. A. E. Murray, Halifax
Dr. J. W. Reid, Halifax
Dr. J. McD. Corston, Halifax
Dr. H. A. Foley, Canning
Dr. H. W. Schwartz, Halifax
Dr. C. F. Keays, Halifax
Dr. E. I. Glenister, Halifax
Dr. P. E. Belliveau, Meteghan
Dr. J. C. Ballem, New Glasgow
Dr. F. J. Granville, Stellarton
Dr. T. B. Murphy, Antigonish
Dr. M. F. Fitzgerald, New Glasgow
Dr. A. R. Morton, Halifax
Dr. A. J. MacLeod, Moser River
Dr. A. M. Marshall, Halifax
Dr. F. L. Akin, Windsor
Dr. W. C. Rice, Windsor
Dr. D. B. Morris, Windsor
Dr. G. W. Turner, Windsor
Dr. D. S. McCurdy, Truro
Dr. G. D. Donaldson, Mahone Bay
Dr. M. J. Macaulay, Sydney
Dr. H. J. Devereux, Sydney
Dr. S. Marcus, Bridgewater
Dr. A. L. Sutherland, Sydney
Dr. T. W. MacLean, Westville
Dr. J. C. Wickwire, Liverpool
Dr. W. J. MacDonald, Truro
Dr. A. M. MacPherson, Kentville
Dr. H. F. Sutherland, Sydney
Dr. G. E. Davis, Annapolis Royal
Dr. G. R. Mahaney, Bridgetown
Dr. J. S. Munro, North Sydney
Dr. R. A. MacLellan, Rawdon Gold Mines
Dr. H. R. Peel, Truro
Dr. H. D. O'Brien, Halifax
Dr. H. E. Kelley, Middleton
Dr. K. P. Hayes, Halifax
Dr. R. F. Ross, Truro
Dr. T. B. Acker, Halifax
Dr. D. M. Cochrane, River Hebert
Dr. H. E. Christie, Amherst
Dr. H. A. Fraser, Bridgewater
Dr. J. A. Webster, Yarmouth
Dr. W. W. Bennett, Bridgewater
Dr. G. K. Smith, Hantsport
Dr. C. B. Stewart, Halifax
Dr. E. K. Woodroofe, Chester
Dr. J. R. Ryan, Springhill
Dr. H. B. Havey, Stewiacke
Dr. M. G. Tompkins, Dominion
Dr. L. E. Bashow, Hantsport
Dr. R. A. Moreash, Berwick
Dr. P. R. Little, Truro
Dr. W. A. Hewat, Lunenburg
Dr. R. L. Aikens, Halifax
Dr. W. E. Pollett, Halifax
Dr. A. E. Blackett, New Glasgow
Dr. C. L. Gosse, Halifax
Dr. C. J. W. Beckwith, Halifax
Dr. M. E. B. Gosse, Halifax
Dr. C. K. Fuller, Yarmouth
Dr. W. G. Colwell, Halifax
Dr. J. A. MacCormick, Antigonish
Dr. N. H. Gosse, Halifax

# Post-graduate Week in Obstetrics, Gynaecology and Paediatrics

The Department of Obstetrics, Gynaecology and Paediatrics of Dalhousie University and the Victoria General, Grace and Children's Hospitals will put on a course in obstetrics, gynaecology and paediatrics outlined below. This is not a specialists course, but one aimed entirely at helping the general practitioner solve his ordinary obstetrical, gynaecological and paediatric problems.

1. It will be limited to 6 applicants and the first six who apply will be accepted. Only those intending to take the entire course will be accepted and applicants should state whether or not they will be able to do this.

2. The dates will be May 14th-19th inclusive.

3. Applications should be made to Dr. Carl Tupper, Victoria General Hospital as soon as possible.

4. Men taking the course will be given a bed in a dormitory at the Grace Hospital for the entire week, so that they can see all public cases delivered at the hospital that week. They will pay the Grace $5.00 for this purpose at the beginning of the course.

5. They will be able to get their meals in the cafeteria of the Victoria General Hospital at the usual meal rate charged there.

6. They should be in the front hall of the Grace Maternity Hospital at 8.45 p.m. on Monday, May 14th, where they will be met and have further deatils explained.

## DOCTOR NEEDED

**Doctor O. G. Mills, Oshawa Clinic, 117 King Street East, Oshawa, Ontario is urgently in need of a Doctor. He requires a general practitioner, or internist, for a period up to July 1st, 1951, which period might be extended to a permanent position if the Doctor is satisfactory. Anyone interested kindly contact Doctor Mills directly.**

| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|---|---|---|---|---|---|
| 9-9.50<br>Management of labor | Infant Feeding | Ca. Cervix<br>Diagnostic Pts. | Wet Smears<br>Vaginal Discharge | Rheumatic Fever in Childhood | 9-10.30<br>Symposium on Ante Partum & Post partum Bleeding |
| 10-10.50<br>Care of baby in first hour of life | Diarrhoea and Fluid balance | X-ray Pelvimetry | Ward Walk | Nephritis in Childhood | 10.30-11.30<br>Feminine Hygiene |
| 11-11.50<br>Induction of labor & Indic. for C.S. | Endocrine Prob. in Childhood | Manikin Demonst. with Forceps | Endocrine Therapy | Symposium on Meningitis | |
| 12-1<br>Abortions | | Panel on Toxaemias of Pregnancy | Panel on anything new in Literature | | |
| | | **NOON RECESS** | | | |
| 2-5<br>Gynaecological Out Patient Clinic at V.G.H. | 2-2.30<br>Natural Childbirth<br><br>3.30-4.30<br>Difficult labour & Breech Presentations | Problems of the new born.<br>Resuscitation<br>Prematurity & Infections at Grace Hospital | Problems of Office Paediatrics at D.P.H.C. | PreNatal Clinic at D.P.H.C. | |

# Artists, Photographers Invited to 7th Physicians' Art Salon

All Canadian physicians and medical undergraduates with art or photography as a hobby are invited to exhibit some of their work at the 7th Annual Physicians' Art Salon, to be held in Montreal from June 18th to 22nd, in conjunction with the Canadian Medical Association Convention. All entries in the divisions of fine arts, monochrome photography, and color transparencies will be displayed on the convention floor and judged for awards by a panel of outstanding artists.

Again sponsored by Frank W. Horner Limited, the salon is expected to attract a large number of enthusiasts in the various media. Organized originally to foster restful pursuits in the profession, the Physicians' Art Salon has aroused widespread interest across the Dominion and has become a form at which artistically gifted physicians can exhibit the produce of their leisure hours before an interested medical audience.

### To Enter

Anyone interested in entering work is urged to notify Frank W. Horner Limited, 950 St. Urbain Street, Montreal, who will furnish full details and the necessary entry form. A short note or postcard will do. All expenses, including the transportation of exhibits to and from Montreal, will be borne by Horner.

### Deadline

Entry forms must be completed and in the hands of the sponsor before May 30th to ensure proper listing of exhibits in the catalogue. Exhibitors are also asked to ship entries far enough in advance to allow the inevitable delays in express and parcel post. Full shipping instructions appear on the entry form.

### Calendar Illustrations

It is reported that Frank W. Horner Limited plans to prepare a 1952 version of the popular Physician's Art Salon calendar—a plastic bound desk model, distributed gratis to the profession. The calendar reproduces major award winners in full color. Any physician who has not yet obtained a copy of the 1951 Art Salon calendar can do so by requesting one from Frank W. Horner Ltd., who still have a limited supply.

# Personal Interest Notes

Doctor and Mrs. J. A. Noble of Halifax left about the middle of March on a three months trip to England and Scotland.

Doctor and Mrs. G. L. Covert of Halifax sailed on March 18th on the S.S. Lady Nelson on a month's trip to Bermuda.

Doctor and Mrs. M. R. Elliott of Wolfville left on a six weeks vacation in March, flying from Halifax to Santa Monica, California. They will return home by way of the Western Coast, through the Canadian Rockies and visit their son and his family in Ottawa, Ontario.

Doctor and Mrs. C. B. Smith of Pictou entertained the Pictou doctors and their wives at their home early in April in honour of Doctor and Mrs. G. G. G. Simms who were leaving shortly for Halifax where Doctor Simms has been transferred by the Department of Health. A gift was presented by the group to Doctor and Mrs. Simms.

Doctor and Mrs. F. L. Hill of Parrsboro returned home early in April after a holiday in Florida and the West Indies.

Doctor A. J. Myrden, Dal. 1949, of Halifax, has been awarded a fellowship from the National Research Council of Canada and will spend a year working in the Department of Metabolism and Clinical Investigation at the Victoria General Hospital and also in the Department of Experimental Medicine at Dalhousie University.

Doctor G. G. G. Simms of Pictou and Doctor O. C. MacIntosh of Antigonish addressed the St. Ninian Street School Parent-Teacher Association on health at a largely attended meeting on March 12th at Antigonish.

Doctor A. E. Mackintosh of Amherst left during February on a twenty-one day voyage to Nassau and Jamaica.

Doctor A. G. Shane of Halifax received a Certification in Ear, Nose and Throat from the Royal College of Physicians of Surgeons of Canada last November.

In the January issue of the Bulletin notice was made that Doctor D. F. Smith of Halifax had received a Certification from the Royal College of Physicians and Surgeons of Canada in Obstetrics; this should have read in Obstetrics and Gynaecology.

In a decision made by the County Council in March two Halifax County doctors will receive subsidies of $2,000 each, made up of contribution from the county and the province.

The Medical Committee of the council said that it would pay $800 towards the subsidies. The Provincial Government offered $1,200 on condition the county contributed the remainder.

The scheme would enable the two doctors, one at Moser River and the other in Upper Musquodoboit, to charge lower rates than are ordinarily charged and still maintain adequate income.

The doctors at present charge one dollar per mile travelling expenses. In cases where the patient lived a long distance away, it made the fees prohibitive.

The Bulletin extends congratulations to Doctor and Mrs. D. S. Brennan of Bear River on the birth of a daughter, on February 19th; to Doctor and Mrs. A. S. Mackintosh of Halifax on the birth of a son on March 5th; to Doctor and Mrs. H. I. MacGregor of Halifax on the birth of a daughter, on March 8th and to Doctor and Mrs. B. St.C. Morton of Halifax on the birth of a daughter, Janet Elizabeth, on April 6th.

Doctor H. B. Atlee of Halifax addressed a public meeting in the Lord Nelson Hotel in March, sponsored by the health division of the Halifax Council of Social Agencies, his subject being "Is Having a Baby Worth While?" He stated "there are possibilities that a new maternity structure will be erected in Halifax."

The people of River John, Pictou County, have finally succeeded in interesting a Lithuanian physician, Doctor J. Urbaitis, to settle there. Qualified as a doctor in 1940, he worked for a time as a general practitioner in several hospitals in Lithuania. He left his homeland in 1944 and went to Germany, where he worked at Hospital Stift, in Colbenz. After the war he worked as a medical officer in D.P. Camps before going to England in 1947. Doctor Urbaitis was registered with the General Medical Council in Great Britian in 1949 and has held the post of casualty officer at Manor Hospital in Nuneaton, Warwickshire, since April of last year. The community of River John held a reception on February 28th to welcome Doctor Urbaitis and his wife, when the Doctor was presented with a purse of money, and Mrs. Urbaitis with a cake and silver tray.

At ceremonies held at Government House in Halifax on March 7th Doctor J. J. MacRitchie of Halifax was presented by Hon. J. A. D. McCurdy, Lieutenant-Governor of Nova Scotia, with Honorary Life Membership and a Priory Vote of Thanks of the Order of the Hospital of St. John of Jerusalem in recognition of valuable and gratuitious service to the Order in the field of instruction. Doctor J. H. L. Simpson of Springhill was presented with a Priory Vote of Thanks.

# Obituary

The death occurred at his home in Advocate on March 12th of Doctor Millard James Fillmore, a country doctor, who devoted a lifetime to the service of his native community. He has been ill since last October, but had continued to carry on his practice until about ten days before his death.

Doctor Fillmore was born on February 11, 1889, at Spencer's Island, son of the late Doctor and Mrs E. W. Fillmore. He matriculated from Mt. Allison in 1909, and received his medical degree from McGill in 1914, and started practice at Advocate, and carried on faithfully for thirty-seven years.

It was largely through the untiring efforts of Doctor Fillmore that a Red Cross outpost hospital was established at Advocate in 1945.

In politics he was a Conservative and served for several terms as a municipal councillor.

Surviving, besides his widow, the former Jessie E. Crowell of Yarmouth, are two daughters, Hope (Mrs. William Dunbar), Advocate, and Anna, in high school; also three sons, Doctor Eric E. Fillmore, Montreal; Doctor Edward O. Fillmore, a dentist, Newfoundland, and Paul, a student at Mount Allison.

Also surviving are five brothers, Thomas, Arthur, Walter and Albert, Advocate, and Fred at Baie Verte, N. B.

The Bulletin extends sympathy to Doctor Lewis Thomas of Halifax on the death of his sister, Miss Lucy Evelyn Thomas, which occurred on March first.