POST-GRADUATE COURSE

WEEK IN OBSTETRICS, GYNAECOLOGY AND PAEDIATRICS

May 25th—30th, 1953.
HALIFAX, N. S.

MONDAY, MAY 25th

9.00 Lecture and Demonstration Conduct of Difficult Cephalic Presentations.
10.00 Lecture and Demonstration of X-Ray Pelvimetry.
11.30 Symposium—Ante and post Partum Hemorrhage.
2.00 Gynaecological Outpatient Clinic.
4.00 How to Diagnose and Treat Trichomonas and Monilia.

TUESDAY, MAY 26th.

9.00 Gastro Intestinal Symposium—Feeding Problems—Gastro Enteritis, Vomiting.
11.00 Fluid Balance—Demonstration of Paediatric Procedures i.e. I. V. Technique, Jugular Punctures, Femoral Punctures, etc.
2.00 Endocrine Therapy with particular reference to cases on the ward.
3.00 Itchy Vulva and Anus.
4.00 Why the Monthly Period.
5.00 Gynaecological Departmental Staff Meeting—Discussion of Problem Cases.

WEDNESDAY, MAY 27th.

9.00 Ward Walk—Problems of Puerperal Care—Discussion of some problem cases on the ward.
10.00 Ward Walk—Gynaecological Cases.
11.00 Symposium—Toxaemias of Pregnancy.
2.00 Paediatric Radiology.
3.30 Behaviour Problem in Children.
4.30 Paediatric Surgery.

THURSDAY, MAY 28th.

9.00 Manikin Demonstration—Forceps.
10.00 Lecture by Pharmacologist and Bacteriologist on use of current drugs in Obstetrics and Gynaecology.
11.00 Symposium on Tbc, Heart and Diabetes in Pregnancy.
2.00 Symposium on the Newborn i.e. Prematurity, Resuscitation and Asphyxia Erythroblastosis, Feeding Problems, Congenital Defects.

FRIDAY, MAY 29th.

9.00 Paediatric Dermatology.
10.00 Ward Rounds and Case Presentations by the Staff of the Children's Hospital.
2.00 Pre-Natal Clinic.
4.00 Medical Motion Picture.
5.00 Question Period.

SATURDAY, MAY 30th.

9.00 Demonstration—Vaginal Discharges.
10.00 Gynaecological Examination.
10.30 How to diagnose Patient with Ca of Uterus.
11.00 Constipation and Megacolon.

Applications may be made to Post-Graduate Committee, Victoria General Hospital, Halifax, N. S.

EDITORIAL

APPENDED to this brief editorial is a list of all the officers of the Medical Society of Nova Scotia since its beginning. In itself it makes very interesting reading, even to one who is not familiar with medical life in this province except in recent years. To those whose memories go back further than that the list must serve to recall many interesting stories, details and anecdotes. It is these reminiscences that concern us at the moment.

In order to give the celebration of our hundredth anniversary the character and atmosphere which make it unique the editors of the Bulletin plan to gather together as much material of an historical nature as possible. Much can be garnered from already existing records and these will not be neglected or overlooked. But history is dry stuff without the personal highlights. We can all recollect that the footnotes in our school history books that told us about the gout of the elder Pitt, to mention one that comes readily to the medical mind, were much more entertaining than the text and lingered in the memory long after the acts and facts had faded away.

These personal highlights are not to be found in minutes of meetings. Like folklore of other kinds they will be lost as newer generations arise unless they are passed on and told and retold. The editors believe that a rich fund of this sort of anecdotal treasure exists in this province and we feel that the occasion of our centennary is a most suitable and appropriate time to uncover all that can be found.

We therefore beg that all readers of this journal will take these words as applying to them personally. If you are reminded by the list of names of any little incident or story write it down and send it in. If you are a relative or descendant let us know. If you have any old papers, articles or newspaper clippings or photographs let us have them. If we were to have enough articles of interest in the way of pictures or souvenirs we might arrange a little exhibit. On any object bigger than can be put in an envelope we will pay carriage and promise to return the objects in the condition in which they are received. If you are acquainted with anyone who has or has access to anything pertaining to the history of medicine in Nova Scotia let us know about it. We would welcome reminiscences of annual meetings in years gone by. In short let us turn our backs on the future and away from the present and look to our past whether it be glorious or inglorious. The changing scenes of the hundred years have been decorated by men who stood out because of wisdom, courage, nobility, kindliness and sometimes just plain eccentricity. Let us hear about it all. The observance of our centennary will in this way be enhanced and when another hundred years have gone by perhaps an old copy of our centennary number may come to light to astonish the doctors of a world about which we cannot even speculate.

M. E. B. GOSSE.

THE MEDICAL SOCIETY OF NOVA SCOTIA

NUMBER OF ANNUAL MEETINGS, DATE, PLACE AND OFFICE BEARERS FROM 1854 to 1952

Annual Meeting	Date	Place	President	First Vice-President	Second Vice-President	Treasurer	Secretary
1st Oct. 5,	1854	Halifax	Hon. W. Grigor, Halifax	W. J. Almon, Halifax	A McDonald, Antigonish	D. McN. Parker, Halifax	J. R. DeWolfe, Halifax
2nd Aug. 1,	1855	Halifax	W. J. Almon, Halifax	E. Jennings Antigonish	A. McDonald, Halifax	D. McN. Parker, Halifax	J. R. DeWolf, Halifax
3rd Aug. 1,	1856	Halifax	W. J. Almon, Halifax	E. Jennings, Halifax	A. McDonald, Antigonish	D. McN. Parker Halifax	J. R. DeWolfe, Halifax
4th Aug. 1,	1857	Halifax	D. McN. Parker, Halifax	Chas. Tupper, Amherst	R. S. Black, Halifax	W. J. Almon, Halifax	J. R. DeWolf, Halifax
5th Mar. 3,	1858	Halifax	R. S. Black, Halifax	Chas. Tupper, Amherst	F. W. Morris, Halifax	W. J. Almon, Halifax	J. H. Slayter, Halifax
	1859	Halifax	R. S. Black, Halifax	Chas. Tupper, Amherst	F. W. Morris, Halifax	W. J. Almon, Halifax	J. H. Slayter, Halifax
6th Mar.	1860	Halifax	R. S. Black, Halifax	Chas. Tupper, Amherst	R. S. Black, Halifax	W. J. Almon, Halifax	J. H. Slayter, Halifax
7th Apr. 23,	1861	Halifax	E. Jennings, Halifax	A. Forrest, Halifax	B. DeW. Fraser, Windsor	W. J. Almon, Halifax	Chas. J. Gossip, Halifzx
8th Jan. 7,	1862	Halifax	A. Forrest, Halifax	Chas. Tupper, Halifax	Geo. Snyder, Shelburne	R. S. Black, Halifax	Chas. J. Gossip, Halifax
9th Jan. 6,	1863	Halifax	Chas. Tupper, Halifax	Jas. C. Hume, Halifax	Samuel Muir, Truro	R. S. Black, Halifax	Chas. J. Gossip, Halifax
10th Jan. 5,	1864	Halifax	*Jas. C. Hume, Halifax	Chas. Cogswell, Halifax	B. DeW. Fraser, Windsor	R. S. Black, Halifax	Chas. J. Gossip Halifax
11th Jan. 3,	1865	Halifax	W. J. Almon, Halifax	Jas. R. DeWolfe, Halifax	R. Stephen, Digby	R S. Black, Halifax	A. J. Cowie, Halifax

Annual Meeting	Date	Place	President	First Vice-President	Second Vice-President	Treasurer	Secretary
12th Jan. 2,	1866	Halifax	Jas. R. DeWolfe, Halifax	J. H. Slayter, Halifax	Geo. Snyder, Shelburne	R. S. Black, Halifax	W. N. Wickwire, Halifax
13th Jan. 8,	1867	Halifax	R. S. Black, Halifax	B. G. Page, Halifax	P. W. Smith, Digby	W. N. Wickwire, Halifax	A. H. Woodill, Halifax
14th Jan. 7,	1868	Halifax	B. G. Page, Halifax	C. J. Gossip, Halifax	Samuel Muir, Truro	W. N. Wickwire, Halifax	T. R. Almon, Halifax
15th June 24,	1868	Pictou	B. DeW. Fraser, Windsor	Presidents of C	ounty Societies	A. J. Cowie, Halifax	Chas. D. Rigby, Halifax
16th July 29,	1869	Windsor	C. C. Hamilton, Cornwallis	G. J. Farrish, Yarmouth	C. J. Gossip, Halifax	A. J. Cowie, Halifax	Edw. Farrell, Halifax
17th June 22,	1870	Halifax	C. C. Hamilton, Cornwallis	R. S. Black, Halifax	S. Dodge, Halifax	A. J. Cowie, Halifax	Chas. D. Rigby, Halifax
18th July 18,	1871	Halifax	Samuel Muir, Truro	R. S. Black, Halifax	A. Sanford, Burlington	A. J. Cowie, Halifax	H. A. Gordon, Halifax
19th June 19,	1872	Truro	Samuel Muir, Truro	W. J. Almon, Halifax	L. Johnstone, Albion Mines	A. Lawson, Halifax	H. A. Gordon, Halifax
20th June 18,	1875	Kentville	R. S. Black, Halifax	H. Shaw, Kentville	A. C. Page, Truro	A. Lawson, Halifax	H. A. Gordon, Halifax
21st June 17,	1874	Amherst	A. C. Page, Truro	A. P. Reid, Halifax	N. Tupper, Amherst	A. Lawson, Halifax	H. A. Gordon, Halifax
22nd Aug. 2,	1875	Halifax	H. Shaw, Kentville	A. J. Cowie, Halifax	L. Johnstone, Albion Mines	A. Lawson, Halifax	John Somers, Halifax
23rd June 21,	1876	New Glasgow	*G. M. Johnson, Pictou	A. Sanford, Burlington	W. H. MacDonald, Antigonish	J. F. Black, Halifax	John Somers, Halifax
24th June 20,	1877	Truro	D. McN. Parker, Halifax	W. Fraser, New Glasgow	A. J. Cowie, Halifax	John Somers, Halifax	John Somers, Halifax
25th June 19,	1878	Halifax	W. B. Slayter, Halifax	D. H. Muir, Truro	H. O. McLatchy, Wolfville	John Somers, Halifax	John Somers, Halifax
26th June 18,	1879	Halifax	D. H. Muir, Truro	Jas Kerr, Acadia Mines	W. N. Wickwire, Halifax	John Somers, Halifax	John Somers, Halifax
27th June 16,	1880	Halifax	Edw. Farrell, Halifax	J. W. McDonald, Acadia Mines	A. Lawson, Halifax	John Somers, Halifax	John Somers, Halifax

Annual Meeting	Date	Place	President	First Vice-President	Second Vice-President	Treasurer	Secretary
28th June 15,	1881	Antigonish	W. H. McDonald, Antigonish	F. W. Borden, Canning	H. B. McPherson, North Sydney	John Somers, Halifax	John Somers, Halifax
29th June 18,	1882	Kentville	W. B. Slayter, Halifax	H. B. McPherson, North Sydney	H. Shaw, Kentville	John Somers, Halifax	John Somers, Halifax
30th June 20,	1883	Truro	John Somers, Halifax	H. B. McPherson, North Sydney	John Stewart, Pictou	J. W. McDonald, Acadia Mines	J. W. McDonald, Acadia Mines
31st June 18,	1884	North Sydney	H. B. McPherson, North Sydney	John Stewart, Pictou	T. R. Almon, Halifax	J. W. McDonald, Acadia Mines	J. W. McDonald, Acadia Mines
32nd June 17,	1885	Halifax	John Stewart, Pictou	G. L. Sinclair, Dartmouth	Wm. McKay, Reserve Mines	J. W. McDonald, Acadia Mines	J. W. McDonald, Acadia Mines
33rd June 23,	1886	Pictou	G. L. Sinclair, Dartmouth	W. McKay, Reserve Mines	G. J. McKenzie, Pictou	J. W. McDonald, Acadia Mines	J. W. McDonald Acadia Mines
34th July 6,	1887	Truro	Wm. McKay, Reserve Mines	D. A. Campbell, Halifax	W. B. Moore, Kentville	W. S. Muir, Truro	W. S. Muir, Truro
35th July 4,	1888	Digby	D. A. Campbell, Halifax	W. B. Moore, Kentville	John T. Cameron, River John	W. S. Muir, Truro	W. S. Muir, Truro
36th July 3,	1889	Halifax	W. B. Moore, Kentville	J. T. Cameron, River John	W. N. Wickwire, Halifax	W. S. Muir, Truro	W. S. Muir, Truro
37th July 2,	1890	Granville Ferry	J. A. Coleman, Granville Ferry	S. Dodge, Halifax	G. E. Buckley, Guysboro	W. S. Muir, Truro	W. S. Muir, Truro
38th July 1,	1891	Baddeck	G. E. Buckley, Guysboro	A. D. McGillivray Sydney	T. C. Lockwoo, Lockeport	W. S. Muir, Truro	W. S. Muir, Truro
39th July 2,	1892	Halifax	S. Dodge, Halifax	C. J. Fox, Pubnico	R. A. H. McKeen, Glace Bay	W. S. Muir, Truro	W. S. Muir, Truro
40th July 5,	1893	Bridgewater	Chas. J. Fox, Pubnico	R. A. H. McKeen Glace Bay	H. A. March, Bridgewater	W. S. Muir, Truro	W. S. Muir, Truro
41st July 4,	1894	Yarmouth	A. P. Reid, Halifax	C. A. Webster, Yarmouth	H. H. MacKay, New Glasgow	W. S. Muir, Truro	W. S. Muir, Truro
42nd July 3,	1895	Halifax	R. A. H. McKeen, Glace Bay	J. F. McDonald, Hopewell	C. A. Foster, Bridgewater	W. S. Muir, Truro	W. S. Muir, Truro
43rd July 1,	1896	Sydney	J. F. McDonald, Hopewell	J. C. McDougall, Parrsboro	J. W. Reid, Windsor	W. S. Muir, Truro	W. S. Muir, Truro

Annual Meeting	Date	Place	President	First Vice-President	Second Vice-President	Treasurer	Secretary
44th July 7,	1897	Pictou	W. Tobin, Halifax	John McMillan, Pictou	Andrew Halliday, Shubenacadie	W. S. Muir, Truro	W. S. Muir, Truro
45th July 6,	1898	Halifax	John McMillan, Pictou	Andrew Halliday, Shubenacadie	M. A. Curry, Halifax	W. S. Muir, Truro	W. S. Muir, Truro
46th July 5,	1899	Truro	D. McIntosh, Pugwash	C. A. Webster, Yarmouth	F. S. Yorston, Truro	W. S. Muir, Halifax	W. S. Muir, Truro
47th July 4,	1900	Amherst	E. A. Kirkpatrick, Halifax	W. Rockwell, River Hebert	J. W. McKay, New Glasgow	W. A. Muir, Truro	W. S. Muir, Truro
48th July 3,	1901	Halifax	J. W. McKay, New Glasgow	J. J. Cameron, Antigonish	W. G. Putnam, Yarmouth	W. S. Muir, Truro	W. S. Muir, Truro
49th July 2,	1902	New Glasgow	J. J. Cameron, Antigonish	W. G. Putnam, Yarmouth	M. Chisholm, Halifax	W. H. McDonald, Antigonish	W. H. McDonald, Antigonish
50th July 1,	1903	Antigonish	M. Chisholm, Halifax	H. E. Kendall, Sydney	H. K. McDonald, Halifax	W. H. McDonald, Antigonish	W. H. McDonald, Antigonish
51st July 5,	1904	Halifax	H.A. March,M.P.P. Bridgewater	J. W. McLean, North Sydney	M. E. Armstrong, Bridgetown	W. H. McDonald, Antigonish	W. H. McDonald, Antigonish
52nd July 5,	1905	Lunenburg	H.A. March, M.P.P. Bridgewater	G. W. T. Farish, Yarmouth	J. A. Sponagle, Middleton	W. H. McDonald, Antigonish	W. H. McDonald, Antogonish
53rd July 4,	1906	Lunenburg	J. B. Black, M.P., Windsor	J. A. Sponagle, Middleton	W. H. MacDonald Rose Bay	J. R. Corston, Halifax	J. R. Corston, Halifax
54th July 3,	1907	Windsor	J. Stewart, Halifax	W. H. MacDonald Antigonish	W. G. Putnam, Yarmouth	J. R. Corston, Halifax	J. R. Corston, Halifax
55th July 1,	1908	Halifax	A.S. Kendall, M.L.A Sydney	J. A. Sponagle, Middleton	H. V. Kent, Truro	J. R. Corston, Halifax	J. R. Corston, Halifax
56th July 7,	1909	Sydney	G. W. T. Farish, Yarmouth	James Ross, Halifax	E. Kennedy, New Glasgow	J. R. Corston, Halifax	J. R. Corston, Halifax
57th July 6,	1910	Yarmouth	James Ross, Halifax	E. Kennedy, New Glasgow	J. S. Morton, Shelburne	J. R. Corston, Halifax	J. R. Corston, Halifax
58th July 6,	1911	Halifax	H. V. Kent, Truro	J. W. Smith, Liverpool	J. J. McKenzie, Mulgrave	J. R. Corston, Halifax	J. R. Corston, Halifax
59th July 3,	1912	Truro	G. E. deWitt, Wolfville	M. A. B. Smith, Halifax	J. W. T. Patton, Truro	J. R. Corston, Halifax	J. R. Corston, Halifax

Annual Meeting	Date	Place	President	First Vice-President	Second Vice-President	Treasurer	Secretary
60th July 2,	1913	Wolfville	J. G. Macdougall, Amherst	W. H. MacDonald Halifax	M. E. Armstrong, Bridgetown	J. R. Corston, Halifax	J. R. Corston Halifax
61st July 1.	1914	Amherst	C. A. S. McQueen, Amherst	C. McQ. Avard, Amherst	H. E. Kendall, Sydney	J. R. Corston, Halifax	J. R. Corston, Halifax
62nd July 7,	1915	Amherst	C. J. Miller, New Glasgow	E. Kennedy, New Glasgow	J. W. McLean, North Sydney	J. R. Corston, Halifax	J. R. Corston, Halifax
63rd July 5,	1916	New Glasgow	D. Fraser Harris, Halifax	Clarence Miller, Stellarton	A. J. Fuller, Yarmouth	J. R. Corston, Halifax	J. R. Corston, Halifax
64th July 4,	1917	Halifax	J. W. Smith, Liverpool	A. E. G. Forbes, Lunenburg	B. Francis, Sydney Mines	J. R. Corston, Halifax	J. R. Corston, Halifax
65th July 3,	1918	Liverpool	G. H. Murphy, Halifax	Col. F.S.L. Ford, C.M.G., Milton	J. J. Roy, Sydney	J. R. Corston, Halifax	J. R. Corston, Halifax
66th July 2,	1919	Antigonish	John Stewart, Halifax	J. Ross Millar, Amherst	A. F. Miller, Kentville	J.G.D. Campbell, Halifax	J.G.D. Campbell, Halifax
67th July 7,	1920	Kentville	H. K. MacDonald, Halifax	J. Ross Millar, Amherst	M. T. Sullivan, Glace Bay	J.G.D. Campbell, Halifax	J.G.D. Campbell, Halifax
68th July 6,	1921	Halifax	This meeting	was adjourned and	met later in Septem	ber at Truro.	
Sept. 28,	1921	Truro	M. T. Sullivan, Glace Bay	E. V. Hogan, Halifax	C. A. Webster, Yarmouth	J.G.D. Campbell, Halifax	J.G.D. Campbell, Halifax
69th July 5,	1922	Sydney	J. Ross Millar, Amherst	O. B. Keddy, Windsor	J. J. Cameron, Antigonish	J.G.D. Campbell, Halifax	J.G.D. Campbell, Halifax
70th July 4,	1923	Windsor	O. B. Keddy, Windsor	W. N. Rehfuss, Bridgewater	J. J. Roy, Sydney	J.G.D. Campbell, Halifax (Assoc. Sec'y,—S.	J.G.D. Campbell, Halifax L. Walker, Halifax)
71st July 16,	1924	Amherst	W. N. Rehfuss, Bridgewater	E. V. Hogan, Halifax	J. W. Johnston, Sydney Mines	J.G.D. Campbell Halifax	J.G.D. Campbell Assoc. S. L. Walker
72nd July 1,	1925	Bridgewater	E. V. Hogan Halifax	J. J. Roy, Sydney	L. R. Morse, Lawrencetown	J.G.D. Campbell, Halifax	J.G.D. Campbell Halifax
73rd July 7,	1926	Halifax	J. J. Roy, Sydney	L. R. Morse, Lawrencetown	H. K. Macdonald, Halifax	J.G.D. Campbell, Halifax	J.G.D. Campbell, Halifax
74th July 6,	1927	Sydney	L. R. Morse, Lawrencetown	R. H. Sutherland, Pictou	H. K. Macdonald, Halifax	J.G.D. Campbell, Halifax	S. L. Walker Halifax

Annual Meeting	Date	Place	President	First Vice-President	Second Vice-President	Treasurer	Secretary
75th	1928	Annapolis	This was ch	anged at an executi	ve meeting held Ju	ne 1, 1928.	
Oct.	1928	Halifax	R. H. Sutherland, Pictou	G. W. T. Farish, Yarmouth	Allister Calder, Glace Bay	J.G.D. Campbell, Halifax	S. L. Walker, Halifax
76th June 26,	1929	Pictou	E. O. Fallett, Weymouth	A. McD. Morton, Halifax	W. R. Dunbar, Truro	J.G.D. Campbell, Halifax	S. L. Walker, Halifax
77th July 2,	1930	Digby	Dan Murray, Tatamagouche	W. R. Dunbar, Truro	Dan McNeil, Glace Bay	J.G.D. Campbell, Halifax	S. L. Walker, Halifax
78th July 7,	1931	Truro	W. R. Dungar, Truro	Dan McNeil, Glace Bay	W. N. Cochran, Mahone Bay	W. L. Muir, Halifax	S. L. Walker, Halifax
79th July 5,	1932	Kentville	K. A. MacKenzie, Halifax	A. R. Campbell, Yarmouth	J. C. Morrison, New Waterford	W. L. Muir, Halifax	S. L. Walker, Halifax
80th Sept. 4,	1933	Halifax	T. A. Lebbetter, Yarmouth	J. C. Morrison, New Waterford	R. M. Benvie, Stellarton	W. L. Muir, Halifax	H. C. Grant, Halif?
81st July 4,	1934	Yarmouth	Dan McNeil, Glace Bay	G. A. Dunn, Pictou	P. E. Belliveau, Meteghan	W. L. Muir, Halifax	H. C. Grant, Halifax
82nd July 3,	1935	Sydney	R. M. Benvie, Stellarton	J. R. Corston, Halifax	Allister Calder, Glace Bay	W. L. Muir, Halifax	H. C. Grant, Halifax
83rd Sept. 1,	1936	Halifax	J. R. Corston, Halifax	Allister Calder, Glace Bay	J. H. L. Simpson, Springhill	W. L. Muir, Halifax	H. C. Grant, Halifax
84th July 7,	1937	Pictou Lodge	Allister Calder, Glace Bay	J. H. L. Simpson, Springhill	H. K. MacDonald, Halifax	W. L. Muir, Halifax	H. C. Grant, Halifax
85th June 21,	1938	Halifax	J. H. L. Simpson, Springhill	H. K. MacDonald, Halifax	A. B. Campbell, Bear River	W. L. Muir, Halifax	H. C. Grant, Halifax
86th July 5,	1939	Digby	H. K. MacDonald, Halifax	A. B. Campbell, Bear River	J. S. Breen, Mulgrave	W. L. Muir, Halifax	H. C. Grant, Halifax
87th Aug. 27,	1940	Halifax	A. B. Campbell, Bear River	J. G. B. Lynch, Sydney	D. F. McInnis, Shubenacadie	W. L. Muir, Halifax	H. C. Grant, Halifax
88th July 9,	1941	Kentville	J. G. B. Lynch, Sydney	W. Alan Curry, Halifax	J. C. Wickwire, Liverpool	W. L. Muir, Halifax	H. C. Grant, Halifax
89th July 8,	1942	Sydney	W. Alan Curry, Halifax	J. C. Wickwire, Liverpool	P. S. Cochrane, Wolfville	W. L. Muir, Halifax	H. C. Grant, Halifax
90th July 6,	1943	Kentville	J. C. Wickwire, Liverpool	P. S. Cochrane, Wolfville	A. E. Blackett, New Glasgow	W. L. Muir, Halifax	H. C. Grant, Halifax

Annual Meeting	Date	Place	President	First Vice-President	Second Vice-President	Treasurer	Secretary
91st July 6,	1944	White Point Beach	P. S. Cochrane, Wolfville	A. E. Blackett, New Glasgow	E. W. Macdonald, Glace Bay	W. L. Muir, Halifax	H. G. Grant, Halifax
92nd Oct. 10-12	1945	Kentville	A. E. Blackett, New Glasgow	N. H. Gosse, Halifax	E. W. Macdonald, Glace Bay	W. L. Muir, Halifax	H. G. Grant, Halifax
93rd Oct. 8-10	1946	Halifax	N. H. Gosse, Halifax	E. W. Macdonald, Glace Bay	H. A. Fraser, Bridgewater	R. O. Jones, Halifax	H. G. Grant, Halifax
94th Oct. 7- 9	1947	Halifax	E. W. Macdonald, Glace Bay	H. A. Fraser, Bridgewater	J. J. Carroll, Antigonish	R. O. Jones, Halifax	H. G. Grant, Halifax
95th Sept. 13-16	1948	Keltic Lodge Ingonish	H. A. Fraser, Bridgewater	E. F. Ross, Halifax	J. J. Carroll, Antigonish	R. O. Jones, Halifax	H. G. Grant, Halifax
96th Sept. 6- 9	1949	White Point Beach	E. F. Ross, Halifax	J. J. Carroll, Antigonish	L. M. Morton, Yarmouth	R. O. Jones, Halifax	H. G. Grant, Halifax
97th Sept. 5- 6	1950	Halifax	J. J. Carroll, Antigonish	L. M. Morton, Yarmouth	J. W. Reid, Halifax	R. O. Jones, Halifax	H. G. Grant, Halifax
98th Sept. 10-13	1951	Antigonish	L. M. Morton, Yarmouth	J. W. Reid, Halifax	M. G. Tompkins, Dominion	R. O. Jones, Halifax	H. G. Grant, Halifax
99th Sept. 13-16	1952	Yarmouth	J. W. Reid, Halifax	M. G. Tompkins, Dominion	H. F. McKay, New Glasgow	R. O. Jones, Halifax	H. G. Grant, Halifax

Corneal Transplantation: Keratoplasty

D. K. Murray, M.D.

AS recently as 1949, in a competent review of the literature, Dr. F. C. Stansbury states "Although the literature contains many papers on corneal transplantations, comparatively few authors have experience with more than a dozen operations."

This is exceedingly real, and a competent opinion as to the results of this operation cannot be expressed on the basis of a few successful cases. This must revolve upon the careful analysis of several complete series of cases in which the procedure was attempted and which contain all the pertinent data. The successes and failures must be carefully weighed.

As early as 1894 Fuchs reported 30 corneal transplantations. The earliest report ante-dates this by 50 odd years. Almost all of this era met with little success.

In 1923, Elsching and Gradle discussed the results of 9 permanently clear grafts in a series of 93 operations.

In 1930, Elsching reviewed his entire twenty years experience with this operation. His total series numbered 174 such procedures. In properly selected operative cases, apart from such as were of purely cosmetic intention, his conclusions were—improved visions in 46.7 per cent; opaque grafts in 36.7 per cent; dislocation of graft in 16.6 per cent.

In 1935 Filator reported 96 operations between 1923-32. In 1937 he again reported a series of 95 cases—these between 1932 and 1937. He admitted to poor selection—e.g. glaucoma, buphthalmos and so forth, and felt that the 18 per cent transparent grafts was not a fair representation of the possibilities of the operation.

In 1937 Thomas published a series of 36 cases. He claimed that upon a careful breakdown of his figures into appropriate categories as to suitability that there was a 58 per cent rate of success.

In 1938 Castroviejo, reporting over 100 cases during 1933 to 1937, found improved vision and transparent grafts in 70 per cent of favourable cases.

Recent European writers are not so enthusiastic, I may add. In 1943 Franceschetti and Streiff reported 50 cases. This series yielded a 32 per cent success rate i.e. 20/200 or better.

Most of the series reported contain no exact reference as to optical correction either pre- or post-operatively. There is a paucity of post-operative follow up. There is a great brevity of reported visual results in the unselected series. Consequently, it becomes difficult to draw an accurate base line for fair evaluation.

In 1947, Owens, Baltimore, gave these figures at a symposium. A final acuity of 20/30-20/20 was obtained in only 11.4 per cent of cases. In 9.1 per cent all light perception was lost as the result of keratoplasty. Of 229 cases, preoperatively 20/200 or less, vision of 20/100 or better was obtained in 36.2 per cent. In 58 cases, selected as most favourable, with pre-operative vision of 20/200 or less a rate of 55.5 per cent obtained 20/100 or better. He concluded that a case having 20/100 or better does not warrant the risk of operation.

In December, 1949, Stansbury reported a carefully conducted series of 182 cases, from 1933-1947. Adequate follow-up of 37.7 months was conducted on the logical basis of success—namely visual results. In as much as 20/200 visual acuity is accepted as the threshold of industrial blindness, a result to be classified as successful must be better than 20/200. He found that clear grafts and improved vision ran anything but a parallel course. The clear grafts occurred twice as often as improved vision occurred.

His figures break down thus,—in 16 per cent of cases visual acuity was improved to better than 20/200; no significant change in 41 per cent; total loss of perception in 39 per cent: results unknown 4 per cent.

FAVOURABLE CASES—He found that best results were obtained in Keratoconus. This is an interesting condition which in advanced degree per se is optically impossible. The normal corneal curvature is replaced by one of a cone-type or conical formation. This in turn gives a diffuse focal point with reference to the plane of the retina or "image screen" so that a clear representation of the object of regard is not obtained. The contact lens and fluid aims to "wipe out" this aberrant curvature and establish a proper, calculated new corneal curvature. When the contact lens fails or corneal degenerative changes due to pressure are instituted, keratoplasty is the recourse.

Castroviejo, in a recent article "Keratoplasty in Kerataconus", claims as high as 90 per cent permanently improved vision in these conical corneae.

The worst results were found in chemical burns. A high percentage of grafts tend to bulge, presenting the need of a high minus lens.

The best results were obtained in bilateral keratoplasty. 50 per cent of such cases obtain 20/100 or better. Results were better in eyes having been subjected to single procedure, as opposed to multiple operations.

Results of transplant in interstitial keratitis are gratifying. The graft is likely to remain clear if the surrounding substantia propria is not disorganized. Therefore these cases do well, as the interstitial type gives no pathological changes to the corneal lamellae, but mainly interlamellar lymphocytic infiltration and vascularization, posteriorly placed in the cornea.

The results in disciform keratitis and acne rosacea keratitis are also considered encouraging.

UNFAVOURABLE CASES. Poor results can be expected in total leucoma, extensive anterior synechiae, shallow or absent anterior chamber, corneal dystrophy, excepting Salzmann's and Groenouw's dystrophy. Other contra-contradictions are extensive superficial or deep vascularization of the cornea, glaucoma or hypotony or aphakia. This means that in the presence of a cataract, the graft should be done first. Marked nystagmus is a definite contra-indication.

To become less general in our remarks—

Corneal transplants may be 1. Penetrating, full thickness grafts.
2. Non-penetrating or lameller grafts.

The latter may be used for preparatory and therapeutic reasons, as well as to improve visual acuity when such is possible. Such grafts have a therapeutic value in cases of corneal disease such as keratitis and hypopyon about to perforate. In these cases the hope is to obviate the havoc of perforation with a view to later full thickness graft if indicated. This new tissue culture often has a clearing effect on the adjacent cornea.

The former,—penetrating grafts, are justifiable when vision is 20/200 or less, owing to corneal nebulae, the degree of which is either stationary, or progressive as in the case of degeneration. It is indicated in Kerataconus, unimproved by contact lens. It is definitely indicated in such cases as blood staining of the cornea.

Selection of cases—As there is aways a chance of a graft becoming more opaque than the area it is replacing, this operation should not be undertaken in acuity better than 20/200. A well adjusted patient, who is self supporting, is better off left alone even although his acuity is below 20/200 in one or both eyes.

Patients requiring corneal grafts belong to a much younger group than cataract patients. Failure of a corneal graft therefore leads to more serious consequences from an emotional and economic standpoint. In the very young it is to be avoided as the handling becomes a very great problem. Corneal grafting should never be done in cases where an iridectomy will bring about improvement of vision.

A favoured graft size is from 4.5 to 6.5 m.m., 5 m.m. being the choice of most surgeons. A graft smaller than 4 m.m. becomes cloudy too easily, one larger than 6.5 m.m. is thought to endanger the filtration angle with resultant glaucoma.

Castroviejo favours a square graft, employing a double cutting edged knife, i.e. parallel cutting edges, and used in a cross-hatch fashion. Thomas, and the greatest number of surgeons follow his procedure, uses a trephine to prepare the donor and recipient material. J. Barraquer uses a round trephine with a central fixation pin to "center" the pupil. Weiner has created and uses a pouch-like instrument to good advantage.

The exact surgical technique adds nothing to a paper of this sort, so we make no remarks other than to observe that the donor graft, having replaced the recipient's excised pupillary area, is held in place by fine corneal sutures until union is firmly established—usually 10 days. Again, there are a number of ways of approaching this item, but all aim simply at close approximation of the donor-recipient edges until union permits their removal.

Sources of Donor Material.—The donor material must be from an eye just enucleated or from an eye which has been satisfactorily preserved. Most of the latter eyes are obtained at autopsy. In either event the cornea must be in good condition, free from local disease and from a patient who was free from communicable disease, including syphilis. Race, age, sex and blood type are not important. The donor cornea must be human, however.

Eyes obtained post-mortem should be obtained within 4 hours. Some authors give 6 hours as the outside limit. They are kept at 4 degrees centigrade. They are best stored in a tightly sealed container in a saturated atmosphere of water vapour. The allowable duration of storage has not been well worked out, but the criterion of suitability is not the time since removal but the condition of the cornea upon close inspection. The institution of eye banks materially aids in securing and distributing the donor material.

There exists in New York, for instance, such a bank. This bank is in effect a clearing station. A request for donor material may be on file for some time, and then suddenly advice is forthcoming that an eye will be available at a certain hour via air mail. The patient is hospitalized on previously ar-

ranged short notice. The author is acquainted with an eye which travelled half way across the continent from the point of origin to the eye bank and so to its eventual destination. The case was successful.

This eye bank supplies to the surrounding States about 150 eyes yearly. This gives a fair idea of the yearly indications for this procedure in the Eastern half of the U. S. A. This same source is also available to Eastern Canada.

Although corneal transplantation should not be enjoined without careful evaluation of each case, and close scrutiny of the figures pertaining to its chances of success, it is a very real court of appeal in selected cases which otherwise are committed to the catagory of the essentially blind.

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Abdominal Pain

as a Symptom of

Emotional Disturbance In Children*

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SERIOUS behavior problems seldom arise abruptly in later childhood. The maladjustment in the child and the tension between him and his parents have usually accumulated step by step as the child passed through successive stages in his development." (Spock, Benjamin, Avoiding Behavior Problems, Journal of Paediatrics, **Vol. 27,** pp. 363-382, October 1945).

I felt the most useful contribution I could make tonight would be from practical experience so I reviewed in our files at the Child Guidance Clinic all cases in which abdominal pain was an early and *disabling* presenting symptom (*not* just mentioned in passing). I have neglected minor details but instead have emphasized the most important characteristics.

Out of *six* cases, *all* were girls. (The numbers are too small statistically, but these cases were all studied in detail and the psychopathological findings are thus of importance greater than their number). The age distribution was 9 to 12 but this is probably artificial since: (1) This is the usual age of our Child Guidance Clinic population. (2) In almost all cases the symptoms were present for many years.

The complaint was *never* solitary—invariably the mother stated other important symptoms—e.g. listlessness, nervousness, headaches, bedwetting or school difficulties.

The abdominal pain was dated back to the age of 2 or 3 in several cases, i.e. up to 9 years duration.

Most of these cases were seen by numerous doctors, collected as many diagnosis, and thus many forms of therapy. These varied from months of bed rest to an appendectomy and removal of an ovarian cyst (with amelioration of symptoms for only a few weeks).

The Children—

These children differed from the average—most of them were oversensitive, cried easily, wanted affection and one came close to a diagnosis of *neurosis*. Only one was aggressive at times. We thus obtain the picture of a particular type of Primary Behavior Disorder.

The Primary Behavior Disorder with Neurotic Trends—

Briefly there are three subtypes of Primary Behavior Disorder—the Habit Disturbance where infantile habits are prolonged—the child does not grow up. It is usually linked with an overindulgent inconsistent mother. The second type if the Conduct Disorder. They are invariably the product of marked and long disagreement between the parents. The child expresses

*Presented as a contribution to a Round Table Discussion, "Abdominal Pain in Children", meeting of Halifax Medical Society, 14 Jan. '53.

all his aggressiveness outwardly and has little internal control (i.e. does not turn aggression inwardly to control himself as he should) and has an exaggerated picture of himself ("big shot"). He shows a delinquent type of behavior. The group under discussion has a minor mixture of these symptoms but mostly shows neurotic mechanisms. We are seeing a neurosis in the making! Thus we term it "with neurotic trends", they are *not yet* neurotic but it is getting close. These children bottle up too much and are thus in direct contrast to the Conduct Disorder.

Most of them are overly sensitive, unhappy and poorly adjusted with other children. In school, they cry easily and when problems arise that produce too much anxiety for them to cope with, e.g. a new situation, in school or with companions, where competition might be difficult and they fear failure and its consequences, physical symptoms appear ("somatization"), similar to the adult pattern but fortunately more easily reversible.

The Family—

The most important Factors however, are found in the home. WE FIND AN EMOTIONALLY ILL MOTHER. She has numerous symptoms herself and these are frequently mirrored by the daughter. In 2 of our children the mothers were "Illness Conscious." One wonders if this might be becoming more common.

Frequently the fathers were nonentities. One is amazed that they do nothing while their wives drag their daughters to numerous clinics and doctors, spending money on these and various medications, prescribed and proprietary. In fact, father had little part in the etiological dynamics and even less in the psychiatric treatment! Is father becoming only a biological incident of impregnation? In retrospect we feel that father could have supplied a lot of support and affection that these youngsters craved, they could have helped to break the neurotic cycle of their wives, in fact these fathers were not "fathers," "husbands" or "men".

One last interesting finding from our group—four of our children used their complaints for secondary gain. In other words during treatment we had to stop this trend. Before treatment in a new situation anxiety would appear, thus more symptoms, therefore the more withdrawl from new situations. The final result involves *the whole family.*

How often do we doctors nourish this neurotic cycle by failing to consider the total dynamics and instead narrowly treating "a patient", as if anyone—let alone a child—can exist in a vacuum!

Once the cycle has been established treatment is difficult. It requires the sincere co-operation of the family (and the family doctor) and a willingness to change. The emphasis of treatment is helping the mother. She needs help so she can mature, learn to handle her own problems and then the problems of her children. The child will at first be confused by the change in tactics as mother stops her oversolicitude and dosing with medicines, as she urges into normal activities and secondary gains are removed. The patient will naturally react with everything she has, and mother will need a lot of encouragement to stand up to this little actress but if she will persevere a very gratifying change should be expected often in a few weeks.

Phyllis M., age 11, referred to C. G. Clinic by Out Patient Department, Victoria General Hospital, Feb. 13, 1951. The mother brought her with com-

plaints of spells of being preoccupied and listless ever since an operation for appendicitis and an ovarian cyst three months before. However, the operation was performed for the relief of abdominal pain present since the age of 5 (6 years). After the operation the pain was relieved for 6 weeks but returned with resumption of school. The Family History revealed a short tempered father but the greatest disturbance was in the mother. "I get upset easily—I cry easily", she stated"; "my two year old has been sickly ever since birth. I worry a great deal about him too". "For the first 5 months Phyllis coughed and vomited nearly everything and this cough persisted till 5 years at least, and since the age of 5 has had pains in her abdomen". The patient stated: "I've had a nervous stomach as far back as I can remember—I had my appendix out—after being in hospital twice. Now the pain is all over the stomach. I forget what I'm doing in school at times and teacher gets after me. Its like I have plugs in my ears". She went on to say, "Mother told me I was a cranky baby and was hard to look after".

She was a bright (too bright) youngster, talkative and active. She was in Grade 6 (despite all the time missed with her abdominal symptoms). Psychological tests revealed a somewhat above average I. Q. No projective tests were done. In therapy, the mother in her interviews with the psychiatric social worker, (A. J. Crook) quickly revealed herself as "Illness conscious." The paediatrician's statement about Phyllis' good health was used to attempt to stop the mother's neurotic over-concern. Mother stated in the last interview, "I'm just a worry wart. I've been that way all my life. I've just worried and put too much stress on illness."

Phyllis was seen at the same time as the mother by the psychiatrist. She played quite well and didn't discuss her symptoms much. She showed some neglect, holes in shoes and socks—not in keeping with the family's income level. When Phyllis would meet her mother after the first few interviews she would again complain of her abdominal pains.

In all, there were 5 interviews. The patient's improvement followed her mother's improvement. At last contact the mother stated she felt Phyllis (and she herself) had improved enough to carry on. Phyllis was getting along fairly well at school and in sports and rarely if ever complained of her abdomen.

We would have preferred more interviews so we left the door open for Mrs. M. to contact us at any time for further treatment if she felt it was required.

In Summary Then—

All of our cases with complaints of severe abdominal pain were girls between 9 and 12. Their symptoms were usually of several years duration. Almost all were unhappy, tense youngsters with illness-conscious, unstable mothers and in several cases the symptoms were *used* by the children to avoid difficult situations. The results of our treatment were encouraging. One parent stopped treatment as soon as the youngster returned to school. Three made good recoveries after 6-12 weeks treatment and are getting along well. One is improving with therapy and another is just starting therapy.

Case Report

RUPTURE OF SIGMOID COLON

Gordon W. Bethune, M.D.

THIS report is presented as an unusual case, one that was very interesting as a diagnostic problem and, post-operatively, remained a problem in etiology.

The patient was a rather small thin woman of forty-two years of age. She was admitted to a surgical service of the Victoria General Hospital, at about nine o'clock the evening of 24 January, 1953, as an acute abdominal emergency.

She was of average intelligence, and appeared to be a good witness. On questioning her, the relevant points in her history were as follows:

Two days before admission she began to feel a steady, mild, low abdominal pain. This feeling persisted till the morning of the day of admission, when the pain became more severe and patient vomited a small amount. As the day passed, no great change was noted until about 5.00 P.M. when the low abdominal pain suddenly became very much more severe, and patient was admitted to hospital.

The only other positive note in the history was that the patient stated that all during the day she felt an urge to defecate but was unable to do so. However, she stated that her bowels had been moving well and had moved normally the morning of admission.

The remainder of a complete functional enquiry was negative. There were no symptoms suggestive of antecedent disease of gastro-intestinal or genito-urinary tracts, the pulmonary or circulatory systems. Her last period had been normal in every way, ending about a week before the onset of the present illness.

On physical examination, this was a small, thin woman, appearing older than the stated age of 42 years. She was lying in bed with both legs drawn up, groaning continuously and complaining bitterly of abdominal pain. Her face was pinched, eyes sunken in, and her lips appeared rather cyanotic. Her tongue was very dry, almost leathery in appearance, and patient showed other usual signs of a fairly marked dehydration.

The abdomen showed very slight central distension. On deep respiration, the movement of the abdominal wall appeared somewhat restricted, especially in the lower left quadrant. There was moderate guarding and rigidity in the low abdomen, together with rebound pain and increased skin sensitivity. Peristaltic bowel sounds were somewhat diminished, but present. There was no clinical evidence of free fluid, or gas, in the peritoneal cavity.

On rectal examination, patient complained of mild tenderness high up, anteriorly. Here, there was a sense of "something", in the Pouch of Douglas, that was certainly not an inflammatory mass or an abscess.

Pelvic examination confirmed the rectal findings but did not add any further information.

Laboratory findings were also equivocal. Temperature, pulse and respirations were within normal limits. The leucocyte count was 9,300. Serum amylase level was normal. Urinalysis was normal.

A flat plate of the abdomen, in the upright position, showed a somewhat elevated diaphragm on the right side but no definite pocketing of free air could be seen.

At this time, the conditions considered were the usual ones causative of a peritonitis, viz., a perforated peptic ulcer; or perforated colonic diverticulum (which were considered unlikely from the negative history and very equivocal flat plate); acute pancreatitis; pelvic appendicitis, etc. However, because of the low grade of peritonitis present, the not too marked toxic symptoms, and the presence of the previously noted mass in the Pouch of Douglas, a laparotomy was done on the diagnosis of a twisted ovarian cyst.

Operative Report:

The abdomen was opened through a right lower paramedian incision. There was a noted a mild generalized peritonitis, with a moderate amount of turbid fluid giving an odor characteristic of B. Coli.

On exploration, the *whole* of the colon was filled with rock-hard faecal masses. The distal loop of the sigmoid colon showed a rent about 2½″ long, involving about one-half the circumference of the gut. The remarkable feature was that the edges of this rent were perfectly clean, and soft, showing no evidence of induration or other pathology, appearing almost as if cut by a knife. The adjacent gut was quite normal. The pouch of Douglas contained two of these hard faecal masses, each about the size of a hen's egg, which were removed. Rapid exploration of the remaining abdominal contents showed no pathology. The rent in the sigmoid was then sutured easily (no trimming of the edge was required), and a proximal decompressive colostomy done. Drains were inserted and abdomen closed.

Post-operatively, the patient had a completely uneventful course. The morning following operation, the patient, when visited, was sitting up smoking after having had breakfast. Later, after adequate x-ray investigation, the colostomy was closed and patient returned home, 21st February, 1953, completely recovered.

Discussion:

In retrospect, several factors were considered. First, when the plates of the abdomen were examined by our radiologist, he stated that there *was* free gas present in the peritoneal cavity. This information pre-operatively would have helped considerably in the diagnosis.

Secondly, what caused the rupture of the sigmoid colon? As noted in the operative report, the gut, with the exception of the rupture, appeared to be normal in every way. There was no evidence of marginal induration of the wound, inflammation, diverticulitis, distension or obstruction, vascular changes external or internal trauma, etc. The only abnormality noted was the marked degree of constipation. Following a suggestion noted in an article on perforations of the colon, a Widal was done which was negative.

On reviewing the literature, I have been unable to find any similar reports of what appears to have been a completely spontaneous rupture of the sigmoid colon, with no evidence of any contributing disease or trauma.

The only feature that could conceivably have had any causal relation was the marked constipation, and the only explanation we have is that these masses eroded their way through the gut wall by simple pressure necrosis.

Incidentally, on questioning the patient post-operatively, she still maintained that she was not troubled by constipation.

Trans-Canada Medical Plans*

By Dr. E. C. McCoy

Ladies and Gentlemen:

In discussing with you Trans-Canada Medical Plans—and the part it could play in a national plan of health insurance, one should first outline for you what Trans-Canada Medical Plans mean—it is not a new super-plan on a national basis—it is a co-ordinating body set up to co-operate the activities of the various provincial schemes. That is why the name was recently changed from the original name of Trans-Canada Medical Services. Many people were interpreting this as a new plan and it is not. For any of you who know of Blue Shield in the U.S.A.—I might say that this is the Canadian counterpart. It is administered by a Commission consisting of one representative from each member plan plus one representative from C.M.A.—to date the Chairman of Economics Committee of C M A.

In my remarks, I shall attempt briefly to do four things—much of which is a repetition of a speech made in Montreal recently and with headlines so ably misinterpreted by some of the local papers.

(1) Give you a summary of T.C.M.P. to date.
(2) Outline to you what T.C.M.P. consists of to-day and show why service plans provide the best type of prepaid medical care.
(3) Try to show you where we believe T.C.M.P. could play a large part in a national health insurance plan in Canada.
(4) Outline decisions made in T.C.M.P. meeting in Montreal.

Trans-Canada Medical Plans were conceived in Montreal in June, 1951' after a two day conference of representatives from several prepaid medical care plans across Canada, under the Chairmanship of Dr. C. C. White. Discussions had gone on for four years prior to this at annual meetings of representatives—but until 1951 an apparent sterility had been the result and in reviewing these meetings, the apparent cause of the sterility was a constant failure to be able to produce a plan which would have uniform benefits and uniform rates across Canada.

In 1951 the thinking changed somewhat and it was decided to form Trans-Canada Medical Services to co-ordinate the activities of the various provincial schemes—but to retain provincial autonomy—and not create a new super-scheme.

Since June, 1951, there have been four Commission Meetings and a Meeting of the Executive Committee. These have been held in Montreal, Toronto, Edmonton, Banff and Saskatoon, respectively.

A full time Director—Mr. Howard Shillington—has been engaged.

The present coverage across Canada and the needs—have been studied at considerable length—and much spade work has been done in attempting to get a more universal coverage across Canada.

A Constitution and By-laws have been worked out and revised with many revisions already made as need became evident.

A "Dependents of servicemen Prepaid Care Plan" has been studied at length—and negotiations are in the preliminary stages.

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*Address given before Vancouver Medical Association, February 3, 1953.

T.C.M.P. to-day consists of nine Prepaid Care Plans across Canada—other applications are pending. The total membership of the plans in T.C.M.P. at present is over a million. During the past year, these plans paid out $15,394,075.68 for medical accounts, so you can see that we are already pretty 'big business'.

These plans are all service plans, except one, and this is a point we wish to emphasize. To the best of my knowledge there are only five ways that medicine may be practised and paid for:

(1) Private contract
(2) Indemnity plans
(3) Government sponsored plans
(4) Service contract
(5) Private practice

In looking these over, I think we already know most of their advantages and disadvantages. The private contract denies the free choice of doctor which is one basic principle in which we believe—but it does work adequately in some small isolated communities.

Indemnity plans certainly have a place but do not answer the people's demand for complete coverage. Also, doctors don't particularly favor indemnity plans on a large basis unless the doctors are adequately represented on the governing board because if over 50% of the people in any area become covered, the doctors tend to lose control of the fee schedule. The schedule the company pays comes more and more to be accepted as the schedule. On a small basis this is not an important factor. They have a place—but certainly are not the full answer from either patient or doctor points of view.

Government sponsored plans have many advantages and disadvantages and I need not outline many of these for you. However, in most places where the government sponsored plans have been introduced, the free choice of doctor has been lost—or at best there remains a restricted choice. Also the doctor tends to get involved in a lot of 'red tape' and spends too much time filling in papers instead of practising medicine. Also it seems very hard to retain the proper doctor-patient relationship. Again, it usually becomes expensive.

The service contract where the patient's full bill is paid for—on as full a service basis as possible—seems to approach more nearly what both patients and doctors desire. In working out such a scheme, the service as I mentioned should be as complete as possible—getting rid of all exclusions, if possible, and paying the bills in full. If doctors believe what they say when they say people should be able to prepay for their medical care, then it would seem realistic that this type of plan should be the objective.

The 5th method is that of private practice with the patient paying his own bill. I'm sure many doctors would desire that this method remain—as it had been in Canada for many years. However, medical care is becoming very expensive with newer methods of investigation and treatment, etc. Also I believe one must face the fact that the world is changing with resultant changing philosophies and changing standards of living—with a greater emphasis on security and collectivism—and making as much of everything available to as many people as possible, with the cost spread over groups as a whole—in other words some socialistic trend. Hence, people want to prepay for medical care and not suddenly be faced with a financial catastrophe.

think the doctor who can't see this or understand this, must just have his head buried in the sand—and he had better get it out—and realize that prepayment for medical care is coming whether he likes it or not—and perhaps it would be better if he used his knowledge and ability to help plan some way so that people could prepay.

In other words, I think that private practice where the patient pays his own medical bill—much and all as it has many desirable features that are very difficult to achieve under any plan—is on the decline—and we might as well face it and help mould the new method.

I have attempted to point out to you why the service plan is the best plan available—and that is why, under T.C.M.P., we are primarily co-ordinating service plans. We believe this will give what the people want—and at the same time retain the patient-doctor relationship on a proper level.

In trying to point out to you where we believe T.C.M.P. could play a large part in a national health insurance plan in Canada, one must attempt first of all to aswer several questions that must be answered and one must outline what one means by health insurance. Certainly, many of those who to-day are discussing this problem across Canada know very little about it—but are attempting to play politics with health insurance—and one cannot help but feel that the provision of medical care is too personal a service to be brought into the realm of politics. Health insurance not only enables individuals to prepay their medical costs, but does this in such a way as to secure a wide pooling of risks and distribution of costs in much the same manner as any other form of insurance. Such questions as "Should such a plan be voluntary or compulsory?" "Should it be run by government or by doctors?" "Should it be provincial or national?" "How should it be paid for?"—are all important questions that we should be prepared to answer before we can intelligently deal with the problem.

I believe there are two main aspects to the provision of medical care. The first is the field of public health and preventive medicine on a community basis —the other is the field of curative medicine which also involves preventive medicine on an individual basis and to have a proper health insurance plan, we must consider both of these fields. Curative medicine is the more expensive part while public health and preventive medicine is much less costly. On the other hand, public health and preventive medicine on a community basis must be compulsory. From a public health point of view, there is not much sense in your being immunized against diphtheria if your neighbours aren't also. The only place where such a compulsory scheme properly fits into our way of life is under government sponsorship, therefore, this part of medicine could properly be provided by the government out of the tax dollar—personal contribution here is not necessary. Prevention cannot be properly done by individuals—it must be done by all. Individuals as individuals just aren't sufficiently interested in prevention.

On the other hand, individuals should be vitally interested in curative medicine. It is high-priced as stated before and the individual must share part of that cost at least. This should be done on a voluntary basis—if we are to retain two of the basic principles which we believe to be essential—those are (1) free choice of doctor by the patient and (2) free choice of doctor to refuse any patient. I know of no compulsory scheme that does not inter-

fere with one or both of these principles to a greater or lesser degree. However, if any individual small group wished this to be compulsory for their group, they could have it so without interfering with the desires of the people as a whole to keep it on a voluntary basis—as a matter of fact under some plans at present, compulsion is in effect—as it is a condition of employment in certain groups—agreed upon by management and unions.

One frequently hears it remarked that doctors are against health insurance. They are not—they want health insurance—the C.M.A. has gone on record as being in favor of it—they realize the need of it perhaps more than most laymen as they are dealing with sickness continually. Quite rightly they do not want to become government employees as they believe a personal service like medical care must retain the above mentioned two basic principles—and as government employees it becomes very difficult if not impossible, to retain these two basic principles.

If one accepts the above, one next comes to whether such a scheme should be administered by the Government or by doctors. I don't believe it should be by either one. I don't believe the Government could administer it even on a voluntary basis without getting too much politics and red tape mixed up in it. I don't believe the doctors alone can administer it adequately because it is most important that the subscriber have a choice in the provision of his care.

I believe the plan should be administered by a board composed of representatives of the two groups of people primarily involved—the consumer and the provider of the care. That is, the subscribers and the doctors both—such a board to be elected and selected from the two groups. Several plans in Canada now operate under such a system and operate very well.

Next, we should consider whether such a plan should be provincial or national. I believe that it should be no greater than provincial at outside. Centralization of such a scheme leads to more red tape and book work—and certainly doctors in Nova Scotia or B. C. are not going to take the certain amount of regimentation that must go with such a scheme, from someone sitting at a desk in Ottawa in the same way that they would from someone in Halifax or Vancouver. By the same token, the patient isn't going to accept rulings, etc., from one central office in the same way that he would from a provincial office and more important he isn't going to remain so much interested in keeping down the costs as he would if the scheme is on a more local basis. As a matter of fact, the more local it is the more interested he is in keeping down the costs—but there is a limit to how local the scheme can become and remain economical. I believe that provincial plans or plans of about that size are best. Another point here is that conditions vary tremendously across Canada as we have seen in our deliberations to date in T.C.M.P. Costs of living vary—different provinces have different types of government—some of which provide more medical care than others—also doctors' fees vary as costs of living vary— thus it is most difficult if not impossible to set a fee schedule for all of Canada that is fair. That is one place that indemnity schemes do have an advantage. They can do national coverage fairly readily because they pay only a certain amount toward a bill and the patient pays the rest which varies from province to province. Thus, I'm sure we are on the right track when we say these plans must be no larger than provincial.

This now brings us up to where T.C.M.P. fits into this plan. Provincial schemes alone are not enough—people frequently move from one province to another—usually from any one of nine provinces to British Columbia—and they should not have to lose coverage or undergo new waiting periods, etc. This is where T.C.M.P. fits in. It will co-ordinate these various provincial plans—allow subscribers to move from one to another, without loss of waiting periods and without loss of coverage. Also it provides a means whereby national employers can arrange coverage for employees in several provinces—and at the same time it will be working towards getting as nearly as possible a uniform type of coverage—at possible fairly similar rates.

At the present time, the various provincial plans do not cover enough people—some will only take employed groups—some will not take individuals. T.C.M.P., if it functions efficiently, will have to have all of its member plans enlarging their scope and making prepaid medical care available to all. This applies to our own plan in this province—M-S-A which is our representative in T.C.M.P. It does not cover enough people. If all those were covered who are eligible under present regulations—we should only cover about 35-40% of the people in the province. We must begin relaxing our strict regulations a bit—and make the service available to more people if it is to answer to the demand for health insurance. Of the various members of T.C.M.P., our enrollment increased by the smallest percentage last year. At the same time, I must admit that we have the second largest enrollment—but we must keep enlarging—and quite rapidly—as our experience grows.

You may now well ask—who will pay for this? There is no doubt that the subscriber should pay if able—it might be done in conjunction with employers in some cases—if desired. However, the subscriber must pay at least part—or it becomes too expensive. You do not get anything in life for nothing and if the subscriber is not vitally interested in the cost, he will tend to abuse it. Even when he is interested in the cost, he tends to use it more than he would if he were paying the doctor's bill in full and this is why no government can estimate the cost of medical care in advance—regardless of estimates they may produce. Utilization is a big factor and we are just beginning to realize what it means. In B.C., for instance, under M-S-A, in 1945 one in 20 subscribers used the service each month—in 1952, one in 8 used it each month. This is one of the main reasons why such Plans must grow gradually. The human element in such a personal service is impossible to estimate—and the human element is what makes or breaks the plan.

For those who cannot pay at all, the government must pay—as I'm sure all of us agree that we must look after our indigents. However, I believe the government should contribute these costs—but should not administer the plan. As Raoul Poulin—a very able parliamentarian from Quebec said in November, speaking in the House at Ottawa in referring to the problem of medical care which should be given to the needy:

"I believe, speaking in all sincerity, that governments can strive to attain this goal without intruding into the field of medicine."

Canada is not a poor country—we can afford good medical care—we can afford the best medical care—but we must make sure that what we get is good medical care without too much waste of money.

This, ladies and gentlemen, is where I believe T.C.M.P. could fit into a plan for national health insurance for Canada. I believe it would give us better medical care—better from both patient's and doctor's point of view—than any other plan in existence to-day—although I must admit that the U.S.A., after a lot of investigation and research is now coming to strive for something that is not too unlike what we are trying to do in Canada.

Now, coming to the fourth part of my remarks—telling you what we did in Montreal. There was much discussion about development in Quebec and I must say that as yet the doctors in Quebec have not agreed to sponsor any plan to represent them in T.C.M.P. The two medical associations there—English and French—complicate considerably the matter of arriving at decisions.

It was decided that the Head Office of T.C.M.P. will be in Toronto and it is hoped that it will be established by this summer.

Maritime Hospital Service Association—A Blue Shield Plan—which also provides hospitalization benefits but is not a service plan was accepted as an Associate Member, after much discussion—and after being named by New Brunswick Division of C.M.A. as their representative. One quite agrees that as yet they do not meet the standards set up for membership in T.C.M.P. but they have the approval of the medical profession there and that is one of the chief points we insist on—that the doctors must approve the plan and apparently the doctors like this plan in New Brunswick, although I doubt that either doctors or subscribers would go for it here—to any extent.

I believe we aroused much interest on the part of the doctors in Quebec in the matter of service plans and it is hard to tell what may develop.

Many other matters were discussed which would be of no particular interest to you so I shall not waste your time with them.

However, we had a good round table discussion on national health insurance. We also had a very excellent representative from Blue Shield in the U.S.A., who participated in discussions. As a result, partly of this and partly of other general observations, I believe it is fair to assume that we have probably about two years to provide health insurance for the people of Canada —or it will be provided for them otherwise. We may have less time than this and we may have as much as four years. The Americans figure they have four years and I don't believe we will be too much different from them.

The important thing is that we, as a profession, must at least help to arrange provision of this care and must have a voice in its operation. As individuals or as groups, we may not like some of the regimentation—or other things that go with this—but at least we should keep our dislikes and disagreements within our own profession, and if we do not like some particular treatment we have received over for example some case, we should not take it out on the patients or express our dislike of the scheme to patients—we should get together with the other members of the profession and make the needed corrections and make prepayment work. Also we must remember that it is our effort, and if we abuse it we are only working against ourselves. If doctors and subscribers aren't both vitally interested in making prepayment work and in keeping down costs, then it won't work, and I'm sure we will all end up with much more regimentation and red tape than we would ourselves arrage.

In conclusion, I have attempted to outline to you what type of child T.C.M.P. is at the present time—and to reveal to you some of our feeding problems and why we are being kept awake at night a bit. However, I am sure that it is a good healthy child—and I believe it should grow up to fulfill a very useful manhood—and to play a very useful part in the future of Canada.

E. C. McCOY, M.D.,
President, Vancouver Medical Association,
and Chairman, Trans-Canada Medical Plans.

The Editor,
The Nova Scotia Medical Bulletin,
Halifax, N. S.

Dear Madam:

The aims and objects of "Trans-Canada Medical Plans" have frequently been the subject of some enquiry among your readers and I am sure that there are many who would like to be brought up to date on its present state of development

To that end may I call to your attention an address given by Doctor E. C. McCoy, President of the Vancouver Medical Association and Chairman of the Commission of Trans-Canada Medical Plans, which appeared in the Vancouver Medical Bulletin for March. May I suggest that it might with profit be reproduced in the Bulletin.

Yours truly,

(Sgd.) N. H. GOSSE, M. D.

Abstracts From Current Literature

A STUDY OF THE AETIOLOGY OF CARCINOMA OF THE LUNG
Richard Doll, M.D., M.R.C.P. and A. Bradford Hill, C.B.E., Ph.D., D.Sc.,
B.M.J. 2: 1271-1286, Dec. 13, 1952

THE article reports on an extension of a study begun in 1948. A preliminary report was published in 1950. (Brit. J. Cancer. Jan. 5, 1950).

Careful histories were taken on 1,488 cases of lung carcinoma and a similar number of controls. A statistical analysis of the material is presented.

These investigators found no appreciable difference in the incidence of lung carcinoma with regard to social status, occupation, exposure to fumes in the home (coal, gas, or electric stoves) or proximity of home to gas works. However, there was a smaller incidence of lung carcinoma in rural than in urban areas.

Of the male patients with pulmonary carcinoma 0.5 per cent were non-smokers compared to 4.5 per cent in the control group. The incidence in females was 37 per cent and 54.6 per cent respectively.

Twenty-five percent of males with pulmonary carcinoma were classed as heavy smokers compared with 13 per cent of the male controls. In females the figures are 11.1 per cent and 0.9 per cent respectively.

The risk of males in London between the ages of 45 and 64 developing pulmonary carcinoma was 3 to 5 per 1000 living per year in heavy smoking groups. The incidence was negligible in non-smokers.

No difference was found in the percentage of patients in each group who used fuel lighters, who inhaled, or smoked hand-rolled cigarettes.

Fewer patients in the lung carcinoma group used cigarette holders or filter tip cigarettes than in the controls. These methods may have a bearing in the appreciably lower risk of malignancy found for pipe smokers compared with cigarette smokers. Possibly some active agent is removed by these methods.

The conclusions were: The association between smoking and lung carcinoma is real. It is not argued that smoking contributes to all cases of lung carcinoma, nor that it is the sole cause of increased death rate in recent years. Neither can the study wholly explain the different mortality rates between town and country.

S. L. SPELLER, M.D.

THE SCALPEL, THE SWORD. By Ted Allan and Sydney Gordon, (336 pp). Little, Brown and Company. Boston. 1952.

This is a biography of Dr. Norman Bethune, the Montreal thoracic surgeon, who fought with the International Brigade in Spain, and later with the Reds in China. He died in China on November 13, 1939, as the result of an infection contracted while operating without rubber gloves, and without the necessary drugs to combat the infection.

The story is well apportioned into four parts, his own illness as a sufferer from tuberculosis; his crusade against tuberculosis to which he made several

genuinely important contributions; his next crusade in Spain against Fascism; and the final episode of his life in China.

Dr. Bethune was a very talented individual and a humanitarian. He was also a man of action with a strong missionary zeal. In many instances action seems to have diluted thought. He joined the communist party in Canada after his return from Spain.

The book is repetitious and heavily weighted with Communistic clap-trap. The source material is not specifically credited making it impossible to check on facts.

None the less, it is not without interest. But surely Dr. Bethune deserved a better book than this.

G. A. BLACK.

SOME HORMONAL STUDIES IN NORMAL AND TOXEMIC PREGNANCY. C. W. Lloyd, E. C. Hughes, J. Lobotcky, J. Rienzo and G. M. Avery. The Journal of Clinical Investigation, **Volume 31**, 1056-1063, December, 1952.

The authors present controlled observations on the hormonal levels in the normal and toxemic pregnant states and the non-pregnant state. No change in serum antidiuretic activity was detected in normal or toxemic pregnancy. Chorionic gonadotrophin excretion was over five times higher in toxemia than in normal late pregnancy. Total urine corticosteroid was increased slightly during late pregnancy and more markedly in toxemia. A fraction of the total cortiscosteroid which was poorly water soluble showed a greater proportionate increase in toxemia than the freely water soluble fraction. There was suggestive evidence obtained by the use of paper chromatography and by the effect of supplementary injections of desoxycorticosterone that the poorly water soluble corticosteroid contained a substance structurally similar to desoxycorticosterone.

Although desoxycorticosterone is a synthetic hormone (rather than a naturally occurring one) which is highly active in causing the kidney to retain salt (and is in some ways antagonistic to cortisone), they have recently added a naturally occurring minerocorticoid isolated by Grundy and co-workers from beef adrenal. This substance is also highly active as a salt retainer. Lloyd and co-workers speculate regarding the possibility that excessive minerocorticoid secretion may be the cause of the salt and water retention and even the vascular changes found in eclampsia. Increased secretion for other corticoids may represent efforts at compensation by the body.

This paper is a further contribution along a line of great current interest, as applied to the urgent problem of toxemic pregnancy.

W. I. MORSE, M.D.

W. I. MORSE

PHYSIOLOGICAL EFFECTS OF MECHANICAL EXSUFFLATION OF EXPERIMENTAL OBSTRUCTIVE BREATHING IN HUMAN SUBJECTS. Reuben M. Cherniack, Charles A. Gordon and Fred Drimmer. Journal of Clinical Investigation, **31**, 1028-1035, December, 1952.

This paper reports experimental observations on obstructive breathing, a problem constantly before the physician in the form of broncho-spasm with pulmonary emphysema. The authors studied the effect of obstructive breathing in normal human subjects while breathing through a 3 mm. orifice. They demonstrated the following changes by the use of suitable instruments: (1) a diminished rate of air flow during inspiration and expiration, (2) inadequate ventilation of the lung alveoli, (3) a lowering of the peripheral venous pressure and (4) an abnormal negative pressure in the respiratory tract during inspiration. The last 2 observations reflect the high negative intra-pleural pressures during inspiration which favour the development of pulmonary congestion.

Relief of subjective dyspnea and a return toward normal of the objective findings was accomplished while obstructive breathing continued by the use of a conventional tank respirator, the performance of which was modified. A negative intra-tank pressure of 40 mm. Hg. developed over a two-second period by a motor blower unit attached to the respirator, was followed by a rapid return to atmospheric pressure in 0.06 seconds by means of a swift opening valve. One valuable feature of this technique was the rapid movement of air from the lungs, i.e. exsufflation. Possible clinical applications of the technique under study—with or without modification—are apparent.

W. I. MORSE, M.D.

Classification of Pulmonary Tuberculosis

Extent of Pulmonary Lesions

Minimal. Slight lesions without demonstrable excavation confined to a small part of one or both lungs. The total extent of the lesions, regardless of distribution, shall not exceed the equivalent of the volume of lung tissue which lies above the second chondrosternal junction and the spine of the fourth or body of the fifth thoracic vertebra on one side.

Moderately advanced. One or both lungs may be involved, but the total extent of the lesions shall not exceed the following limits:

Slight disseminated lesions which may extend through not more than the volume of one lung or the equivalent in both lungs.

Dense and confluent lesions which may extend through not more than the equivalent of one-third the volume of one lung.

Total diameter of cavities less than 4 cm.

Far advanced. Lesions more extensive than moderately advanced.

Extent of Pulmonary Lesions Following Therapy

In the case of temporary collapse, the extent of disease existing immediately before the collapse shall be continued in the classification until re-expansion permits reclassification.

In the case of permanent collapsed or pulmonary excision, the extent of disease in a lung existing immediately before excision or collapse shall be continued in this classification through life, except, that such extension or new deposits of disease as appear any time postoperatively in this or the contralateral lung shall be additions to the preoperative classification. The form, site, and duration of the procedure shall be added in parenthesis to the classification of extent of disease.

In other cases the classification of extent will be changed as the change in the extent of the demonstrable lesion warrants. Once the diagnosis of pulmonary tuberculosis has been established, however, the extent of the lesion cannot be classified as less than minimal even when clearing on the roentgenogram appears to be complete.

Location of Lesions

It may be useful to classify the extent of lesions in each lung separately. When this is done, however, the combined extent for both lungs should always be designated.

The location of lesions may be further designated by bronchopulmonary segments. The terminology and classification of Jackson and Huber*have been adopted upon the recommendation of the American Association for Thoracic Surgery.

CLINICAL CLASSIFICATION

The following definitions, subject to the interpretation of the physician, apply regardless of the type of treatment given. Collapse therapy or pulmonary excision in effect at the time of classification will be indicated under extent of pulmonary lesions. The status of activity of lesions from a roent-

genologic, symptomatic, and laboratory standpoint is designatd first; the status of a patient in terms of exercise shall be designated next.

Roentgenologic, Symptomatic, and Laboratory Status

Inactive. Lesions as observed in serial roentgenograms must be stable except for extremely slow shrinkage, and there must be no roentgenologic evidence of cavity. Symptoms of tuberculous origin must be absent. Sputum, if any, must be found negative for tubercle bacilli repeatedly, not only by concentration and microscopic examination, but also by culture or animal inoculation. When a patient is not raising sputuum or when there is any question concerning the authenticity or adequacy of expectorated sputum specimens, the fasting gastric contents or pulmonary secretions which have been aspirated from the tracheo-bronchial tree should be examined by culture or animal inoculation.

These conditions shall have existed at least six months. The period of inactivity shall be designated, if known; for example, Inactive (6 months), Inactive (2 years), et cetera.

Arrested. The symptomatic and roentgenologic requirements of this group are the same as for "inactive," but the laboratory requirements are different.

When sputum specimens or gastric contents have been found negative by repeated microscopic examinations of concentrates but not by culture or animal inoculation, such patients cannot be classified as "inactive" but must be classified as "arrested."

Patients may also be classified as "arrested" even though culture or animal inoculation may be positive and, among many concentrated specimens of sputum examined, an occasional positive is found microscopically.

These conditions shall have existed at least three months. The period of arrest shall be designated, if known; for example, Arrested (6 months), Arrested (2 years), et cetera.

Active. Lesions as observed in serial roentgenograms are usually progressive or retrogressive but may be stationary. Symptoms of tuberculous origin are commonly present but may be absent. Sputum and gastric contents almost always contain tubercle bacilli although, in some instances, tubercle bacilli cannot be demonstrated even after repeated cultures and animal inoculations. With rare exceptions the tuberculin test is positive.

The period of activity shall be designated, if known; for example, Active (17 months), Active (3 years). The designations Active, *Improved*, or Active, *Unimproved*, may be used after an adequate period of observation or treatment.

Activity Undetermined. When activity has not been determined from adequate roentgenologic and laboratory examinations, the disease must be designated temporarily as "Activity Undetermined." If a provisional estimate of the probable clinical status is necessary for public health purposes, the terms (a) "Probably Active" or (b) "Probably Inactive" should be used. Every effort should be made to classify cases and to avoid this category.

Exercise Status

The exercise status of a patient shall be designated:

I The patient is not ambulatory.

II The patient has been ambulatory for less than one hour daily.

III The patient has been ambulatory for one hour daily for a period of two months.

IV. The patient has been ambulatory for at least two hours daily for a period of at least two months.

V. The patient is living under ordinary conditions of life.

The exercise status of a patient shall be designated following the designation of the roentgenologic, symptomatic, and laboratory status; for example, Inactive (6 months) III.

Correspondence

Suite 718,
Medical Arts Building,
Montreal 25, P.Q.
April 23rd, 1953.

Dr. H. G. Grant,
C.M.A., Nova Scotia Division,
Dalhousie Public Health Centre,
Halifax, N. S.

Dear Doctor Grant:

You are undoubtedly aware that T. C. A. offers a reduced fare for groups of 10 or more members and their families.

Several Montreal doctors are flying to Winnipeg for the Annual Meeting in June, and if the members of your Division who plan to attend wish to join our group leaving Dorval June 14th they may benefit from this reduction.

Should you be interested in this plan and like to send us a list of the doctors requiring plane reservations, we would be pleased to forward these to the Travel Agency here who are making the arrangements.

Yours sincerely,

G. W. HALPENNY, M.D.,
Honorary Secretary.
Quebec Division, C.M.A.

NOTE:—It is recommended that through tickets to Winnipeg be purchased through the Halifax office.

COURSE IN POSTGRADUATE GASTROENTEROLOGY

The National Gastroenterological Association announces that its Fifth Annual Course in Postgraduate Gastroenterology will be given at the Hotel Biltmore in Los Angeles, Calif., on 15, 16, 17 October 1953.

The Course will again be under the direction and co-chairmanship of Dr. Owen H. Wangensteen, Professor of Surgery of the University of Minnesota Medical School, who will serve as surgical co-ordinator and Dr. I. Snapper, Director of Medical Education, Cook County Hospital, Chicago, Ill., who will serve as medical co-ordinator.

Drs. Wangensteen and Snapper will be assisted by a distinguished faculty selected from the medical schools in and around Los Angeles whose presentations will cover all phases of gastrointestinal diseases and problems.

One complete session will be devoted to a Clinic at the College of Medical Evangelists at Loma Linda.

For further information and enrollment write to the National Gastroenterological Association, Department GSJ, 1819 Broadway, New York 23, N. Y.

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