



A LITTLE LESS
AND
A LITTLE MORE

A little more smile, a little less frown;
A little less kicking a man when he's
down;

A little more we, a little less I;
A little more laugh, a little less cry;
A little more flowers on the pathway
of life;
And fewer on graves at the end of the
strife.



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Heart Disease in General Practice

Harris McPhedran, M.B., Toronto.

(Address in Medicine delivered at the 72nd Annual Meeting of the Medical Society of Nova Scotia, July 1st, 1925.)

IT is the purpose of this paper to deal with the commoner heart diseases as met with in general practice. Reasonable prognosis and sound treatment are founded on sound diagnosis. With that in mind it has seemed advisable to deal with the conditions necessary for a diagnosis of the commoner diseases of the heart.

What are some of these conditions? Parfitt,¹ in a recent paper on tuberculosis, said that 80% of the diagnosis was the history. That is as true of the majority of cardiac cases as it is of pulmonary tuberculosis. In fact, in Angina Pectoris, the history contains, in some cases, the only information on which a diagnosis can be made, as in these cases nothing abnormal is found on physical or laboratory examination. One cannot stress too often and too emphatically the desirability of the physician writing down the history and the findings at the time of the patient's examination, not only for future reference, but also because, as he writes, fresh questions, demanding answer, arise in his mind, and often a new light shines in on the case, rendering the obscure bright as day. In this way, and in turn, there are investigated the age, occupation, habits, environment, the worries and anxieties and the family history of the patient; a complete record of any previous illness is made, and last, but not least, the patient is examined and cross examined as to his present complaint and illness, not neglecting to make inquiry into those systems which seem not to be diseased. All this is a great art, and is only perfected through long experience.

It is perhaps desirable at this point to dwell for a short time on those symptoms which frequently, but not necessarily, denote disease of the heart. They are mostly evidence of a failing heart muscle—(1) Shortness of breath. (2) Swelling of the feet and legs. (3) Pain over the heart. (4) Conscious action of the heart. (5) Pain and soreness over upper abdomen. Shortness of breath, the first symptom noticed in the great majority of uncomplicated heart cases, is a relative term, and when a patient complains of such a symptom one should seek to determine the degree of his distress. For example, the effort that would produce this symptom in a clerk would not produce it in a coal miner. The questions can be put in some such way as this—(1) When did you first notice this symptom? (2) Did it come on gradually or suddenly? (3) What effort or work put out you of breath at first, and what now? In that way one gets the progress of events and

1. Parfitt, Canadian Med. Journal, Vol. XIV, Pg. 1046-51, Nov. 1924.

as accurate an estimate as it is possible to secure of the present power of the heart muscle of this patient.

Swelling of the feet and legs is the next symptom most frequently noted. It is first noted about the ankles and shins. The lesser degrees of it which have escaped the patient's attention, and may easily escape a physician's cursory examination, can be best demonstrated by putting on pressure over the shin bones. As the heart muscle gets weaker, the skin, peritoneum, lungs, liver, kidneys, etc., become oedematous and we get the general anasarca so well known to you all.

Pain in the chest, over the heart, is always a cause of great concern to a patient and to the physician. It is often the symptom that drives the patient to seek advice. In his or her mind it always means "heart disease," and consequently worry and mental depression. To the physician pain over the heart (lungs or local chest disease being excluded) by itself suggests two conditions—(1) The most important symptom in that syndrome known as Angina Pectoris. (2) The outstanding symptom of nervous exhaustion. This calls for serious investigation. If the pain is retrosternal, in middle aged or old people, and radiates into the left neck and left arm, or it may be both arms, is accompanied by choking or strangling, comes on after a full meal followed by little or no great effort, and makes the patient breathe shallowly, stand still or stop work until it passes, it usually means Angina Pectoris. Add to this a positive Wassermann in the middle aged, and hard arteries, with raised blood pressure, in the aged, and the picture is complete. If, on the other hand, the patient is young, of the nervous type, likely a female and married, the victim of prolonged incessant worry, with consequent loss of sleep and loss of appetite, and has pain, not sternal but mammary, which may be excruciating and radiates into the left neck and arm, and whose subsidence is followed by prostration and polyuria, the pain here is but a manifestation of general exhaustion of muscular and nervous systems, a cheerful prognosis can be given, and surely but slowly the victim will recover. This is the Secondary Angina spoken of by the late Sir James MacKenzie. Pain over upper abdomen especially in right epigastrium with tenderness here is often very distressing and is due to engorgement and swelling of the Liver.

There is no "conscious action of the heart" in the healthy individual. Frequently, however, when the heart itself is diseased, and in various debilitating disorders, the heart's action becomes noticeable. There is not time to go into all the conditions that give rise to disordered action of the heart, but attention should be drawn to the most frequent—(1) Sinus or respiratory arrhythmia; (2) auricular fibrillation, paroxysmal or continuous; (3) extra systoles; (4) paroxysmal tachycardias; (5) heart block, partial or complete; (6) rapid heart. Of sinus or respiratory arrhythmia, the patient is usually unconscious, but the physician is upset by finding an irregularity in the pulse. It most frequently occurs in young people, is of the type where the pulse

quickens in inspiration and slows with expiration. It disappears when the heart rate quickens, e. g. with exercise, is due to stimulation of vagus and its inhibitory action on the sinus, is found with a perfectly normal heart muscle and needs no treatment.

Extra systoles are the most common cause of irregularity of heart action. You will recall that the normal stimulus for contraction of the heart muscle arises in the sino—auricular node at the mouth of the superior vena cava, spreads through the auricles, causing their contraction, down the bundle of His, and to the right and left ventricles, causing them to contract synchronously. At any place in this path an extra stimulus may be interjected, giving rise to the sinusal, auricular, auriculo-ventricular and ventricular extra systoles. The sensation produced by the extra beat of the ventricles is described as a "thump," or a "turning over of the heart." followed by a sense of the heart having stopped, this causing apprehension, and sometimes, if the pause after the extra systole is long, a feeling of faintness. They are very common after adolescence, appear frequently in nervous people, and may be associated with digestive or emotional disturbances. They are associated with acute and chronic diseases of the heart. Unless associated with acute disease of the heart, in the young they may be regarded as of no importance. In patients who have passed 50 they may have no greater importance, but, as Huchard justly said, any arrhythmia that appears in middle life should be investigated. When they arise during the course of a severe illness, typhoid, diphtheria, etc., they should arouse suspicion of acute myocardial degeneration. Their treatment depends on the cause. In nervous people they cause great apprehension and distress. The exhibition of bromides, coupled with the assurance that the distressing action of the heart is not dangerous, while it may not cure the disorder, will mightily relieve the mental distress of the patients and make their lives happier. Other treatment depends on the cause, and something will be said of this later.

The third common cause of irregular heart action is auricular fibrillation. This irregularity has been so much to the fore of late years that it seems scarcely necessary to say anything regarding it. Vaquez calls it "complete arrhythmia." Into the various explanations of fibrillation of the auricles I do not purpose entering, except to say that clinically it is always associated with myocardial disease and is but a symptom of myocardial change. Desirable as it might be to know the exact method of the production of the quivering action of the muscle of the auricle, what mostly concerns us as physicians is to be able to recognize the condition. Clinically, where we have complete irregularity in the heart's action, rate 110 or 120 or more at the apex, and 20 or 30 beats less in the wrist, it may generally be said the case is one of auricular fibrillation. If, in addition, there is a history of rheumatic fever and a present mitral stenosis, the diagnosis is certain. An Electrocardiogram will, in doubtful cases, e. g. very frequent extra systoles, clear up the diagnosis and make for rational treatment.

Of paroxysmal tachycardia I need say little. Occasionally you see a case where suddenly, for no apparent reason at all, a heart begins to run rapidly—160-200 per minute, and after a time, varying from several minutes to sometimes several hours or days, just as suddenly stops, without, in the majority of cases, one having been able to, apparently, influence the course of the paroxysm. The pulse is regular and the paroxysms never at widely varying intervals.

Another disordered action of the heart is one in which, search high, search low, no adequate cause, such as hyperthyroidism, tuberculosis, etc., can be found for a persistent increase in the pulse rate, and one begins to wonder if a rate of 90-100 in such an individual is part of the make-up of the individual. ²Parkinson says "It is a persistent simple tachycardia, lasts for months, increases on excitement or exertion, is reduced by rest, digitalis does not control it and we do not know how to stop it." The tachycardia is the only positive clinical sign, or it may be combined with an easily produced sense of exhaustion. Several of these cases are under observation at the present time. Curiously enough they are all young women. Bradycardia (slow heart) is come upon not infrequently. It may be a normal condition for an individual, it may be due to feeble extra systoles, or to complete heart block, i. e. a condition in which the stimulus, arising normally at the sino, auricular node and spreading over the auricle, cannot pass the bundle of His to the ventricles. In this case the ventricle takes on a regular rhythm of its own and the electrocardiogram shows the auricles and ventricles beating utterly independent of one another. An electrocardiogram clears up the diagnosis and helps one to give rational advice.

So much for the history and the outstanding symptoms connected with heart disease. The next important step in arriving at a satisfactory diagnosis is the physical examination.

This should be thorough, not only that the physical condition of the heart may be ascertained, but also that disease of other organs may be excluded or detected, particularly diseases of the lungs and kidneys. When more than one system is involved then the task becomes more difficult, and it is not infrequently impossible to say whether, in a given case, the heart or the kidneys were the primary seat of disease. Inspection, palpation, percussion, auscultation of the heart, examination of the arteries, veins and capillaries should be done in turn, with the patient in a comfortable position and in a good light. In palpation, the whole hand should be placed on the precordium, fingers toward the left, in order to detect any thrills present to determine the presence or absence of heaving pulse and to localize the punch of the apex of the heart during systole. How often has an apex far out in the axilla been missed because this "punch" was not sought for along the various interspaces with the finger tip. A large

2. Parkinson, Canadian Med. Journal, Vol. XIV, Sept. 1924.

mammary gland, thick muscles, narrow interspaces and a feeble heart muscle, separately or collectively, are a handicap to successful localization, but even under these circumstances, if the patient leans forward and forces all air possible out of his or her lungs, the "punch," though feeble, may be detected. This is the most reliable individual sign of the position of the apex of the heart, and this manoeuvre should be carefully and diligently practiced. Confirmation of the position of the apex is obtained by auscultation, and sometimes indeed successful determination in very obese people is achieved physically only through this means, that point being nearest the apex of the heart where farthest down and to the left the first heart sound is heard best. If one is sure of the position of the apex what a flood of light is thrown at once on both pulmonary and heart conditions. Its localization obviates the necessity of spending much time on percussion, particularly of the right border. The edge of the lung over the heart should, for very obvious reasons, always be obtained. This is easily done, and, for that reason, keeping in mind the aversion the ordinary individual has for doing the easy thing, is usually neglected. It is very difficult and, in my judgment, usually impossible to determine with any degree of accuracy, either the right or left border of the normal heart in the adult. That we get changes in sound as we come to a certain line to the right or left of the sternum is largely a matter of prejudice since we have in mind the anatomical position of the heart. It does succeed where the heart is large from hypertrophy or pericardial effusion is present. That is in the cases where the lung is pushed aside, and should not be neglected, but its value has been over emphasized, much time wasted and needless discomfort to the patient has been caused through failure to make use of other and more easily demonstrated signs. One should always seek to determine the width of the aorta. You will fail to demonstrate it unless there is considerable dilatation of the arch and pushing aside of lung tissue, but percussion along the 1st interspace on either side may be done with advantage in any case, keeping in mind disease of the lung, dilatation of the arch of the aorta or mediastinal tumor, any of which may give defective lung resonance on one or both sides. In every day practice, having located the apex, next obtain the position of the edge of the lung over the heart; try for the right border in the 4th right interspace, then the aortic arch, and, without further delay, pass on to the next phase of the examination.

Of other methods of examination just a word. Where there is any doubt as to the position of the heart, the size of the aorta or the condition of the mediastinum, an X-ray of the chest should be taken. It is a most valuable aid and is the only means by which the size and position of the heart and aorta can be accurately determined. It is the only means by which a small or medium sized aneurism can be detected, and in those showing a positive blood Wassermann, with a possibility of luetic infection some years ago, it should be taken even

in the absence of symptoms or signs that would point to dilatation of the aorta in any part of its intrathoracic course.

A Wassermann reaction should be done as a routine in hospital work and in private practice. Where there is the slightest room for doubt, syphilis should be excluded. Of the mechanical devices used as an aid in diagnosis, just a word. The blood pressure should always be taken and recorded. Where there are irregularities in the heart's action an electrocardiogram is of the greatest aid. For the elucidation of some irregularities it is a necessity; for the purposes of record it is valuable for all irregularities. Fortunately the most common irregularities in heart action can be diagnosed accurately clinically. The extra systole, auricular fibrillation, paroxysmal tachycardia and complete heart block fall in to this class in the majority of instances, but I must confess to a great feeling of relief when I see a diagnosis even of any of these commoner arrhythmias, confirmed in black and white by the fibre of the electrocardiograph. Blood cultures should be more frequently done. They are of both negative and positive value. A urinalysis and W. B. C. are of course done as a routine, and, if it is considered at all advisable, a blood sugar and urea N. are done.

Now, diseases of the heart, as met with in general practice, fall naturally into the two classes (1) Acute, and (2) Chronic. Of these only the commoner diseases will be dealt with. In the class of acute diseases we have (1) Rheumatic fever; (2) Pneumococcus and other pus infections; (3) Subacute bacterial endocarditis. In the class of chronic diseases we have (1) Rheumatic fever, with its late manifestations in mitral stenosis and aortic stenosis or regurgitation, and fibrosed muscles. (2) Luetic disease of heart and aorta. (3) Cardio-arterio-renal sclerosis, in which the picture varies, sometimes the cardiac, sometimes the renal picture dominating the field.

What are the signs and symptoms that in a given case indicate acute disease of the heart in the acute illnesses that have been mentioned? In rheumatic fever the first evidence of disease is one of myocarditis, manifested in dilatation and in increased rate of the heart, with, first, a slight distant blowing systolic murmur at apex that becomes rougher as time goes on and that does not, in the course of time, disappear as the dilatation disappears and the apex returns to its normal position i. e., increased rate, dilatation, a changing and persisting mitral or aortic murmur would indicate myocardial and endocardial organic disease. Of pneumococcus disease of heart (by this I do not mean the degeneration of muscle that accompanies any pneumonia) but the active inflammatory disease that involves endocardium, myocardium and perhaps pericardium, the evidence occurs late and the picture is one of septicaemia. A male, in the forties, was ill with lobar pneumonia. He did well, and had his crisis about the usual time. The next day there was a slight fever, and on the succeeding days the temperature became septic, pulse was rapid and there was drenching sweats. The lung affected appeared to be clearing and there was not

the usual evidence of an empyema. Seen at the end of second week of his illness he had petechial hemorrhages on the neck, on the back and in the palpebral conjunctivae. The heart showed some dilatation was rapid, and there was a slight distinct murmur of aortic regurgitation. He had a septic endomyocarditis, of which you know the outcome. A blood culture in another case of this kind showed pneumococci, even though there had been a distinct crisis and the lung, before death, had cleared.

Subacute Bacterial Endocarditis,—a disease of the young, often engrafted on an old, unrecognized rheumatic endocarditis, manifesting itself by (1) fever of low grade; (2) enlarged spleen; (3) subconjunctival or subcutaneous petechial hemorrhages; (4) blood in the urine, due to infarcts in the kidney; (5) enlarged and usually palpable spleen. (6) anaemia; (7) aortic regurgitation. This disease is often mistaken for typhoid or tuberculosis in the absence of distinct heart murmurs. The diagnosis is eventually cleared up by blood culture or the development of bruits that, along with other findings, leave no room for doubt as to diagnosis, even in absence of positive blood cultures. I shall say nothing of pericarditis. It is often overlooked, and for easily understood reasons when one considers the extent of the pericardium. The signs are well known to you all.

Of the *chronic diseases* just a word. The most common are those that I have just mentioned, the late effects of rheumatic fever (particularly mitral stenosis), luetic disease of heart, manifested by aortic regurgitation or aortic aneurism, and that most common of them all, the cardio sclerotic heart, and perhaps one should mention the *cor bovinum*, a result of adhesive pericarditis. Unless evidences of these conditions are discovered on a routine examination, for life insurance it may be, the diagnosis is not made until signs and symptoms of myocardial failure begin to manifest themselves. In the great majority of cases the early symptoms are (1) dyspnoea (2) swelling of the feet (3) pain over the heart (4) conscious action of the heart. A careful investigation of these four outstanding symptoms of heart failure, as indicated earlier in this paper, will usually put one on the track of the degree to which failure has advanced and give one some inkling as to what may be expected from treatment.

Again I plead for a careful investigation of the symptoms of which the patient complains and of other symptoms, which we have learned from experience, may be present, so that we may be in possession of the fullest information regarding his illness. Let us not disregard a symptom because we cannot readily explain it or fit it into a text book account of a disease. Take the facts as they are, record them, and perhaps you will find new facts or new groups of facts which help you and others to recognize disorders and diseases of the heart. The diagnosis will only be complete when history, physical, laboratory, X-ray and mechanical findings are all considered, and from such consideration one will be able to proceed to the prognosis and treatment.

A word as to prognosis in acute disease of heart. (1) In pneumococcus or other pus infection of the heart giving rise to carditis virtually, it is fatal. (2) Streptococcus viridans infection, giving rise to the disease called subacute bacterial endocarditis, is usually fatal. ³The writer had one case recover, the others that have been encountered have invariably died. May I here draw attention to the work of ⁴Oille, Graham and Detweiler in 1915, in which they point out the value of blood cultures and show that "a large number of persons showing symptoms of the neurasthenic type are really suffering from a subacute streptococcic endocarditis, from which recovery eventually takes place," these patients, however, not showing "the malaise fever of all grades, chills, progressive emaciation, weakness, anaemia, haematuria petechia, embolism, enlarged spleen," of subacute bacterial endocarditis. ⁵Later they report that out of 23 persons so diagnosed in 1915, 20 are still living, 4 are in good health, 14 are fairly well, 1 is gradually losing strength and weight, and 1 is a chronic invalid. With the exception of two cases they state that all have shown unmistakable evidences of endocarditis. This is an important piece of work from the standpoint both of diagnosis and prognosis. (3) The acute rheumatic heart in the adolescent or adult has, in my experience, gone on to a chronic condition. ⁶In the child the outcome in the individual case cannot be predicted. Recovery from the attack often takes place but on the other hand, the symptoms of infection may continue to a fatal termination. ⁷Ledford reviews 250 cases of acute endocarditis in Massachusetts General Hospital and reports that 150 gave a definite history of rheumatic fever. In reviewing his figures the writer found evidence of all but 30 being what one might fairly consider rheumatic in origin. In the whole series the prognosis was as follows:—Immediate mortality 16%; below the third year it was 30%, below the 5th year 23.7%; between the fifth and thirteenth years 13.7%. This indicates that the immediate prognosis is worse in younger than in older children. Pericarditis occurred in 32 patients, of whom 17 died. The tragedy of the rheumatic heart in so many instances (some writers say as high as 50%) is that the first evidences of disease are symptoms of failing heart muscle years after infection has first taken place. That means that the initial endocarditis has been so mild as to cause no alarming symptoms of illness, and we do not see these cases until signs of myocardial failure occur and we have to do with the chronic heart.

The prognosis in chronic heart disease is beset by a multiplicity of difficulties. As we do not see the great majority of cases until signs of failure manifest themselves, the question that confronts us

3. Harris McPhedran, Canadian Med. Journal, Vol. XIII, Pg. 669-70, 1923.
4. Oille, Graham and Detweiler, J. A. M. A. Vol. LXV, Pg. 1159.
5. Oille, Graham and Detweiler, Transactions of the Association of American Physicians, 1924.
6. McCulloch, Nelson's System, Vol. IV, Pg. 200-201.
7. Ledford, American Journal, Diseases of Children, Pg. 21-139, 1921.

in a given case is on what findings can we base a reasonable prognosis? The chief points to be considered are—

1. Age and the cause of the disease.
2. Family history.
3. Occupation and environment.
4. The number of break downs.
5. Response to effort—under sudden strain.
—under prolonged strain.
6. The valves involved—mitral stenosis.
—aortic regurgitation.
—pericarditis.
7. The progress of dyspnoea and oedema.
8. Response to treatment.

(1) The age and cause of the disease. These two factors are closely linked. Young people with chronic hearts are, as a whole, victims of rheumatic fever. Usually they do not survive the fourth decade of life. This varies somewhat of course on the age at which infection first took place, the number of valves involved, the degree of damage to myocardium, the number of attacks of rheumatic fever, and the care the patient can take of himself or herself.

In people of middle age with chronic heart disease and aortic regurgitation lues is the common cause. ⁸Rendle Short says "the expectation of life is five years from onset of symptoms in the luetic heart, and it is worse if there is an aneurism."

In people beyond middle life sclerosis is the commonest cause of chronic heart disease, and the prognosis is a matter of (1) what care these patients can take of themselves (2) the family history (3) whether to what degree the kidneys, liver and arteries are involved.

2. The family history is very important. We are only what our progenitors were, and given a person in the late forties or early fifties showing signs of failure from cardio sclerosis, with, a history of parents, brothers and sisters dying of heart failure, apoplexy or high blood pressure, one can predict rather well the course and duration of the life of the patient.

3. The care that patients can take of themselves, and the conditions under which they live, have obviously a marked influence on the prognosis.

4. Response to effort is important, not so much the response to sudden effort, e. g., toe touching or running upstairs, as the response to the strain necessitated in the ordinary day's routine. This varies with each patient, as I have noted before, and gives very definite information as to the capacity of the heart to respond to the work usually demanded by the individual, and the rapidity with which failure has taken place.

5. The number of breakdowns. ⁹MacKenzie says "In the vast majority of cases the heart recovers from its first breakdown and usually from many subsequent attacks. Indeed, after one attack I have known

8. Rendle Short, Index of Prognosis, Pg. 260.

9. McKenzie, Diseases of the Heart, Pg. 333.

patients go on for 20 years and more with no further trouble beyond a slight limitation in the field of response to effort."

6. The presence of adhesive pericarditis greatly embarrasses the heart in its work, leads to cor bovinum, and materially shortens the life of the individual. Two valve lesions deserve special mention. (1) mitral stenosis; (2) aortic regurgitation. Both seriously handicap the heart muscle—mitral stenosis the right heart and aortic regurgitation the left heart. Mitral stenosis is considered to be rheumatic in origin. In early life aortic regurgitation is usually rheumatic (in young men it may be luetic), in middle life it is luetic usually, and in advanced years luetic or cardio sclerotic. The prognosis in any given case is such as has been already indicated under the various chronic diseases enumerated.

7. The progress of dyspnoea and oedema. As these, in nearly all cases of heart disease, are the initial symptoms of failure, a history of them gives the most definite information as to when the heart muscle began to fail and the course of events since. When these two symptoms, in a well marked case of heart failure, do not disappear, or nearly so, at the end of a week with rest in bed and other appropriate treatment, the outlook is bad. These cases may drag on for months, but useful activity on the part of the patient is at an end.

8. Cases of auricular fibrillation, which demand large doses of tincture of digitalis to reduce the heart rate and to maintain it somewhere near normal do badly. The writer has had two such cases recently. The history of one is as follows:—

Miss M., age 48, cardio sclerosis. Father dead at 62 from dropsy; shortness of breath since fall of 1924; heart apex in mid axillary line, rate at apex 160, at wrist 120 fibrillating.

Date	Heart Rate	Dose of Digitalis in 24 hours.	Course
May 2/25	160	$\frac{1}{2}$ ounce	General anasarca. Liver large.
" 3	140	$\frac{1}{2}$ ounce	Oedema.
" 4	120	2 drachms	"
" 5		3 "	Vomiting. Oedema better.
" 6	92	$\frac{1}{2}$ drachm	Nauseated.
" 7-9	84-92	40 minims	Nauseated, liver still large. oedema of abdominal wall only.
" 10-19	88-100	1 drachm	Oedema of feet again.
" 19 June 13th	88-80	1 $\frac{1}{2}$ drachm	Oedema disappearing in legs. Still free fluid in abdomen.
June 13-17	80-76	1 $\frac{1}{2}$ "	No oedema of legs—oedema of abdominal wall, free fluid in abdomen, liver large.
" 24			Death.

A degree of failure necessitating tincture of digitalis in the doses indicated above from May 2nd to May 9th to bring the heart rate from 160 to 92 per minute, with oedema still present, made for a bad prognosis. The patient went gradually back and death occurred on June 24th. During the last week there occurred jaundice, tympanites, increase of oedema and a heart rate of 120-130 in spite of increase in daily dose of digitalis.

A degree of failure necessitating tincture of digitalis in doses of *M XX* four times a day from May 19th to June 19th, to bring the heart rate from 100 to 80 per minute, and the presence still of oedema, make for a bad prognosis.

Treatment. This may be taken up under the following headings:—

(1) Nursing (2) Rest (3) Diet (4) Drugs.

Of nursing and its value I need say nothing in these days. The services rendered by a competent nurse are invaluable to the patient and to the physician. It is certain then that one's orders are being carried out accurately and intelligently, and an accurate daily record of events kept for reference.

Rest in bed either for the acutely or chronically diseased heart is essential. Where there is dyspnoea the patient should, by preference, be on a Gatz frame. In the more severe degrees of oedema and dyspnoea more comfort may be had by the patient sitting up in a large chair with a head rest suitably arranged in front. Perhaps only by this means can these unfortunates secure any comfort and sleep. There should be freedom from all worries, and the well intentioned cheerful, but talkative, friend should be excluded from the sick room as rigidly as the bore. The question always arises with both acute and chronic cases, how long should the patient stay in bed. The acute case should show for a period of at least one month before getting out of bed (1) absence of fever (2) normal pulse rate (3) good quality to heart muscle sound (4) return of heart to normal position, or, (5) if there has been dilatation and hypertrophy, a forcible apical impulse (6) other systems normal. Chronic cases should show for at least three or four weeks (1) nearly normal pulse rate, even though irregular (2) absence of oedema of legs abdomen and lungs (3) capacity to sleep in usual position in bed. In either acute or chronic cases getting about should be accomplished gradually, care being taken then and even afterward to do nothing that causes breathlessness. That is their index of what the heart muscle can stand.

Sleep is essential. Usually some form of hypnotic is required, for in the chronic cases the night starts, occasioned by Cheyne-Stokes respiration, made for nights dreadful and days wearisome. This can be prevented by the exhibition of hypnotics, of which the most useful seems to be the old fashioned mixture of bromide and chloral hydrate, giving Grs. XV of each (any of the bromides) in a two drachm mixture one half hour before the usual bed time. This may be repeated during the night. One may get equally good results with Luminal, grs. $1\frac{1}{2}$,

at bed time, or Trional, grs. XX, but for continued use the first mentioned has been found the best. For a few nights morphia, gr. $\frac{1}{4}$ repeated as required, may be necessary to secure rest. In the hopeless cases it is our sheet anchor.

Diet. In cases of oedema restriction of fluids and the salt intake is necessary. Till oedema disappears, or materially lessens, the Carrel diet may be used, and after that such kinds and quantities of food as are sufficient to make up the basal diet of the patient. This is increased as the convalescence is established and the patient gets up and around. Attention should always be paid to the likes and dislikes of the patient, if for no other reason than to make the period of a tedious illness as easily tolerable as possible.

Drugs. Some of the drugs necessary in the treatment have already been mentioned. On the use of three I would like briefly to dwell. (1) Tincture of Digitalis (2) Quinidin (3) Novasurol.

Digitalis, in the form of the B. P. Tincture, finds its chief field of usefulness in cases of auricular fibrillation. It acts through depressing the conductivity of the bundle of His, principally through the stimulation of the vagus nerves. It also increases the force and magnitude of ventricular systole, at least in the presence of a failing heart. The preparation used is chiefly the fresh standardized B. P. Tincture. The writer has used it solely for some years and it has never failed. There are other preparations, but it is well, when you have a good familiar weapon and reliable, to stick to it. The taste is unpleasant and sometimes you will find a patient who can take one manufacturer's preparation better than another. Occasionally, if there is vomiting from other causes than heart failure, it is necessary to give a few doses by rectum.

The dose—(1) If the case is not urgent then one may use the small dose method, i. e. giving M XX of the tincture four times daily until the desired effect is obtained. This will take a week or ten days (2) If one wants rapid digitalization give as follows:—zi of the tincture every 6 hours for the first 24 hours, zss every 6 hours for the second 24 hours, and continue at this dose until full digitalization is secured, when the daily amount can be reduced to suit the needs of the patient. Larger doses may be given, and for some time, in the more urgent cases of fibrillation, I have used 15 cc's per pound of the body weight for the first 24 hours and half this dose for the 2nd 24 hours, that is a person of 150 pounds gets 22.5cc, or 7.5 drachms in the first 24 hours, $3\frac{1}{2}$ in the second 24 hours, and further dosage according to the heart rate at that time, dropping it gradually until one finds the dose that will keep the heart rate near 70. This dose varies in different individuals, but usually it is found that 15 to 25 minims a day is sufficient. These patients should be taught to measure the tincture in a graduate and not be allowed to gauge the dose by the drop method. They soon learn what dose best suits and that the drug is as necessary as food for their well being, and indeed very existence, which is prolonged

years through the lowered rate of the ventricles. The patient, during the administration of large doses, should of course be in bed and some one should be in charge who can count the heart rate at the apex and report on first symptoms of digitalis poisoning.

Quinidin. This is the dextrorotatory isomeric of Quinine. It is soluble in ether and alcohol, less so in chloroform and benzol, and very slightly in water. The sulphate is the usual commercial salt used.

The dosage—gr. 3 repeated in 4 hours, should be given the first day, and signs of susceptibility to Quinine looked for, for example, headache, dizziness, buzzing in the ears, scarlatiniform rash, gastric disturbances. If none of these symptoms appear then the dosage, according to ¹⁰Vaquez, should be as follows:—"10 gr. on the first day and 15 grains on the 2nd day, 20 grains on the third day. Usually the normal rhythm returns when the patient has ingested 45-60 grains of Quinidin. If there is no effect by the 6th day there is no use in continuing." The writer has been in the habit of following this plan mainly, but carrying the dose to 40 or 45 grs. a day. ¹¹Eggleston uses very heavy doses as follows:—10 grs. on the first day. If this is well borne, 4 grs. every four hours for 4 doses and a fifth dose at midnight. This dosage for 4 days. If no effect is produced, 6 grs. five times in the day in the above manner and continued for 4 days and if still no effect is produced, 8 grs. similarly five times a day for 4 days. Most workers favor the smaller dosage. ¹²Burwell and Dieuaide review 600 cases reported in the literature and find normal rhythm restored in 55.9% of the cases. The period during which normal rhythm remains after the drug is withdrawn varies from weeks to several months. The longest I have had one stay normal is 1½ years. The question arises in connection with those restored to normal rhythm whether one should keep up the drug. I have under observation at the present time a patient in his twenties, a fibrillator following rheumatic fever whom we can keep with normal rhythm only by giving gr. XVI per day of the drug. We have repeatedly let him out from the drug's influence, but invariably found that at the end of from 1 to 2 weeks he began to fibrillate again. The future alone can decide whether in these cases one should use Quinidin as one uses Tincture of Digitalis i. e. continuously. With paroxysmal fibrillation, where the paroxysms are of short duration, a few hours to one or two days, no treatment seems necessary except rest and some sedative. In a case of mitral stenosis in a young married woman of 26, now under observation, where, since November, 1923, attacks have increased in frequency from one in three months to one every two weeks and sometimes oftener, it seems that the drug will have to be used continuously. Taking gr. XV a day for one week seemed not to lessen frequency, but it did, apparently, the duration of the attack. She is now on gr. XX a day but is still having a couple of short paroxysms a week,

10. Vaquez, Diseases of the Heart.

11. Eggleston—Nelson's System, Vol. IV, Pg. 491.

12. Burwell and Dieunaide, Baltimore, Archives of Internal Med, Pg. 518, 1923.

and the drug has been increased to XXV gr. a day. There is no contra indication to the combined use of digitalis and Quinidin. In any case of fibrillation, particularly of the more serious degrees, the first duty is to slow the rate of the ventricle by digitalis, and then one may seek to control the rhythm and rate by the exhibition of Quinidin in the doses indicated. It is my conviction that, in properly selected cases, i. e., in younger people, early fibrillators with a good heart muscle, the drug can be given without fear of untoward results in the way indicated by Vaquez. The patient should of course be in bed, and in private practice, in charge of a nurse by preference. In older people and in all where the heavier doses are being used, the patient should be in hospital, where careful observations can be made and frequent electrocardiograms taken.

Embolism and sudden death have occurred during the course of Quinidin therapy. A good many of these accidents are probably coincidences. We can understand that, on the return of the auricular rhythm, a more active contraction of the auricle may break up and loosen clots, and so embolism occurs with the establishment of the normal rhythm. It is foolish to give fibrillators with advanced myocardial degeneration any drug, such as Quinidin, that is depressing to the myocardium. These cases do better on digitalis, which not only controls the rate but strengthens systole.

Novasurol—the double salt of sodium mercurichlorophenyl oxyacetate with diethylbarbituric acid and contains 33.9% mercury. This drug is given in doses of 1 to 2 ccs of a 10% solution intramuscularly or intravenously two or three times a week in cases of cardiac dropsy. It was first introduced by the Germans in the treatment of syphilis, being a preparation that could be given intravenously with Salvarsan. It has been noted that it has a marked diuretic effect in the doses indicated, and the best results have been obtained in dropsies due to cardiac disease, especially those in which digitalis has failed. Reports on it so far are few but favorable.

¹³Crawford and McIntosh state that marked diuresis followed the doses indicated above, the maximum effect being reached in from 3 to 9 hours and its action passing off in 24 hours. The total output of chlorides in the urine was increased, urea and ammonia remaining unchanged. They used it in severe cases of heart failure, in which digitalis failed to relieve oedema, with marked improvement and no ill effects following the treatment. We have just begun its use and cannot speak from experience of its value, but it seemed wise to mention it here.

In conclusion, let us remember to treat the patient and not the disease. No two cases are alike and success in management will be ours in proportion to the degree we study the individual.

13. Crawford and McIntosh, Proc. Soc. Exper. Biol. and Med. 21; 253, 1924.

Pioneers of Medicine

(By the late Dr. D. A. Campbell of Halifax, and published in the
Maritime Medical News 21 years ago,—1904).

PART II.—BRITISH SETTLEMENT.

THE chief events affecting the population between 1749 and 1775: were the beginning of English colonization at Halifax; the arrival of the Germans; the deportation of the Acadians; an extensive settlement of New Englanders; the influx of Ulster people; the repatriation of the Acadians; the Yorkshire immigration; and the arrival of the first batch of Scottish Highlanders in 1773.

These various race stocks settled in different parts of the province, and they did not mix to any great extent.

THE TOWN OF HALIFAX.—Halifax was founded in the year 1749, at the expense of the British Government, and under the direction of the "Lords of Trade and Plantations," and was named in compliment to George Montague, Earl of Halifax, then at the head of the Board.

The inducements offered to settlers were—grants of land; free transport; maintenance at the public expense for one year; arms and ammunition for defense; and implements for clearing the land, erecting dwellings, and prosecuting the fisheries. These offers proved attractive, and soon afterward a fleet of transports under the command of the Hon. Edward Cornwallis, sailed for Chebucto Bay.

The total number of immigrants was 2,576, and of this number 1,546 were adult males. But one death occurred during the voyage. This small death rate was attributed to the care of the Board of Trade and Plantations in providing ventilators and air pipes for the transports, a new invention then lately introduced.

In the same year, 1749, in consequence of the evacuation of Louisburg, several New England families who had settled there during the English occupation, accompanied the troops to Halifax. Other settlers came directly from New England, and this movement continued for two or three years.

The New England people soon formed the basis of the resident population and are the ancestors of many of the present inhabitants. They were better settlers than those who came with Cornwallis and they soon secured the business of the place, and filled many of the most important positions in the Colony.

The list of the settlers who came out with Governor Cornwallis contains a surprisingly large number of medical men, out of all proportion to the number of immigrants. I have picked out the following names from the list, 28 in all:—

Alexander Hay, wife and two children, surgeon's mate; Georgius Phillipus Bruscowitz and wife, surgeon; M. Rush, doctor and surgeon; Robert Grant, surgeon's mate; Henry Menton and wife, surgeon's mate; John Willis, wife and one child, chymist and surgeon; Fenton Griffith and wife, surgeon's mate; Thomas Wilson, surgeon; Thomas Lonthion, surgeon's mate; Charles Paine, surgeon; William Lascelles, surgeon's mate; William Grant, surgeon; Robert White, surgeon; Matthew Jones, wife and one child, surgeon; John Steele, lieutenant and surgeon; Patrick Hay, surgeon; Augustus Caesar Harbin, assistant surgeon; John Wildman and wife, surgeon; John Inman, surgeon; John Wallace and wife, surgeon's mate; Daniel Brown, surgeon's mate; John Grant, surgeon's mate; Cockrane Dickson and wife, surgeon; James Handeside, surgeon; Harry Pitt and two children; surgeon; Joshua Sacheverell, surgeon; Archibald Campbell, surgeon's mate; David Carnegie, surgeon. To this list may be added—Robert Throckmorton, surgeon, pupil at St. George's Hospital, and one Alexander Abercrombie, who is described as an apothecary's mate.

It is probable that many of the above list were engaged to accompany the expedition as surgeons or physicians, but the majority, no doubt, came with the intention of settling in America.

In 1752, three years after the settlement of Halifax, a list of the families who had settled in the city since the year 1749 was prepared, and the document is extant. It contains only three of the names of the medical men who came in 1749, viz: Dr. Robert Grant, Dr. John Steele, and Alexander Abercrombie. In addition, there is the name of Dr. Jonathan Prescott, who came with the New Englanders from Louisburg.

There may have been others, connected with the hospital, but no names are given in connection with the institution. There must have been a great deal of sickness. Akins, in his History of Halifax, says: "About this time (1749) a destructive epidemic made its appearance in the town, and, it is said, nearly one thousand persons fell victims during the autumn and the following winter."

On October 14th, the government found it necessary to publish an ordinance commanding all Justices of the peace, upon the death of a settler, to name so many persons, of the neighborhood or quarter to which the deceased belonged, to attend at the burial and carry the corpse to the grave. Anyone who refused to attend, without sufficient reason, was to have his name struck off the Mess Book and Register of Settlers, as unworthy of His Majesty's bounty.

Again in December an order was made commanding all householders to report their dead to the clergyman within twenty-four hours.

In 1750, a public hospital was erected, and was maintained by the government for several years. At about 1766, by request of the Magistrates, this hospital was granted for an alms house. The building stood at the northern part of the land now occupied by the Government House.

The first medical men who settled in Halifax were:

ROBERT GRANT.

Came out with Cornwallis in the "Charlton," frigate, and is described as a surgeon's mate, no mention being made of his having family. In the list of settlers compiled in 1752, he is mentioned as living within the town, and as having a household of six members. His lot was at the south-east corner of Prince and Granville Streets. He was "a leading man in Mather's Church." In 1756 he was appointed a member of His Majesty's Council. In 1756 his seat was declared vacant by absence. This he evidently resented, as in the following year, he sent to the Lords of Trade a protest, complaining of his removal from the Council on the ground of absence. The correspondence shows that he was on bad terms with Governor Lawrence. The cause of his quarrel with the Governor was probably the active part which he had taken in the agitation for a Representative Assembly. Nothing is known of Dr. Grant's subsequent career.

JOHN STEELE.

Came to Halifax with Cornwallis as a passenger on the ship "Beaufort." Surgeon by profession, he was also a lieutenant in Shirley's Regiment. In 1752 he was living in the south suburbs of Halifax, his family then consisting of four male members over sixteen years of age, and three females also over sixteen. This seems to indicate that he was then well advanced in years.

He probably removed to Annapolis at about 1759 to practice his profession there. His name, as Dr. John Steele, appears on the plan of the township of Annapolis as the proprietor of lot No. 53.

From 1761 to 1762 he represented Annapolis in the House of Assembly. He seems to have taken an active part in the proceedings of the legislature, especially in the steps taken to establish the Inferior Court of Common Pleas. He died in 1764 while still a member of the Assembly, his family probably returning to Halifax.

ALEXANDER ABERCROMBIE.

The following notice of Alexander Abercrombie in Latin appeared in the Nova Scotia Gazette of October 3rd, 1775. It was written by Jonathan Belcher, Chief Justice of Nova Scotia and President of Council:

"The epitaph of the most eminent Alexander Abercrombie, who departed this life 31st March, 1775, in the 48th year of his age.

Anxious wayfarer! What are you looking for among the tombs? Is it an example of life from engraven tombstones?

Stand here. Nowhere could you find any more worthy example; for under this sacred mound lies buried the most skilful Alexander Abercrombie, M. D., universally lamented, a man whom one could more easily admire than praise, a man distinguished for the character and lot of his life, his glowing love for country, and his benevolence; sacred in friendship and inferior to no one in prudence and courtesy; in the art of medicine skilled as a second Galen; practiced his profession with care, and in the issue, under God, with success. The cottages of the sick poor he visited of his own accord. He treated the sick conscientiously by his remedies.

If a conscientious, learned, trustworthy, benevolent friend should be lamented, pass on wayfarer! May you be like him in the work of your life! You will be equally happy in death, equally dear to and lamented by all. Oh Greif! Remains of a worth scarce ever too be properly valued, may you rest peacefully in holy repose up to the moment of resurrection and morning of the recompense for the blessed.

The president of the council of Nova Scotia, by Royal Appointment, and lately holding the position of Governor, thus grieving, devoted himself to the memory of a friend always loved by him, with a threefold and fourfold affection."

Alexander Abercrombie came out with Cornwallis, and was employed by the Government as apothecary. In course of time, and perhaps, by necessity, he became a practitioner of medicine, and was, no doubt, fortunate in securing the good-will and friendship of Jonathan Belcher. He obtained a large grant of land in the township of Windsor.

Here, I may observe, that very few of those who came to practice medicine in Nova Scotia during the 18th century, possessed a diploma, or what would now be deemed a legal qualification to practice. In Great Britain to some extent, and very largely in the older colonies of America, those who wished to become physicians or surgeons, obtained the requisite knowledge by being apprenticed for a term of years to prominent medical men. In, however, perhaps not a few instances, men deeming themselves to be endowed with natural gifts to practice the art of medicine, proceeded forthwith, without let or hindrance, to do so.

Very few medical degrees were conferred in America prior to 1800, those who possessed them, in most instances going abroad for the purpose.

DR. JONATHAN PRESCOTT.

Dr. Prescott's memory is perpetuated by his descendants, as well as by his ability and business enterprise. He was born at Concord, Massachusetts. He studied the profession of medicine, and at the siege of Louisburg in 1745, was not only surgeon but also a captain of engineers. After the evacuation of Louisburg he probably came to

Halifax and retired from the army. In 1752 he was living in the south suburbs of the town, his household numbering thirteen persons. He engaged in business in Halifax, and took a prominent part in the settlement of Chester, where he secured large tracts of land and built mills. He accumulated considerable wealth, but suffered much loss from the depredations of the Indians, who, on two occasions, burned his house and mills. He lived during the latter part of his life at Chester. In 1806 he died and was buried there.

Dr. Prescott was energetic and enterprising, kind and benevolent and took great pains to help and relieve the poor soldiers who had served with and under him at the siege and occupation of Louisburg. He was Justice of the Peace and Judge of the Inferior Court of Common Pleas for the County of Lunenburg, and he took an active part in the organization of the militia.

The practice of medicine was, no doubt, a secondary consideration with Dr. Prescott, but the necessities of the people, particularly in Chester, where there was no medical supply, would call for his intervention.

JOSEPH PRESCOTT.

One of the sons of Dr. Jonathan Prescott, engaged in the practice of medicine. Mrs. William Lawson, in her History of Dartmouth, says that he was "Doctor in the United States Army," and afterwards a physician in Halifax. From information gleaned from other sources, I am led to infer that he practiced about Windsor between 1790 and 1800, and that later he lived many years in Cornwallis, finally coming to Halifax.

Another son the Honourable Charles R. Prescott, was a merchant of Halifax. He amassed considerable wealth, and at about 1812 he removed to Cornwallis, where he devoted his wealth, energy and common sense to the development of pomological fruits.

He introduced the Golden Pippin, the Ribston Pippin, and the Blenheim, and had in his orchard over one hundred varieties of apples and fifty varieties of pears.

John Prescott, a third son, purchased and lived at Maroon Hall, Dartmouth, for many years.

Among the earlier settlers of Halifax were two gentlemen who at one time practiced medicine and for that reason deserve a passing notice.

LEONARD LOCKMAN.

Was a German. In early life he practiced medicine. He afterwards received and held the rank of major in the army in return for services rendered the British Government. He came out with the settlers in 1749, and eventually settled in the north suburbs.

He died at Halifax, in the 73rd year of his age, after a lingering illness. He was interred under the old German church in Bruns-

wick Street. The monument to his memory, with coat of arms, is yet to be seen in that church. Lockman Street was named after him.

REV. THOMAS WOOD.

Was Surgeon to Shirley's Regiment during the siege and occupation of Louisburg. He retired from the army and qualified for the ministry. He came to Halifax in 1752, and was appointed a missionary. In 1758 he was appointed Curate of St. Paul's. In 1763 he removed to Annapolis to take charge of the church at that place. He died in 1778. He had an excellent knowledge of the French and Mic-Mac languages, which rendered his services at times very useful to the Government. He was not unmindful of the wants of the sick in the poor and thinly populated districts which he visited.

THE GERMAN AND FRENCH PROTESTANTS.—In order to secure an additional number of immigrants, the Lords of Trade and Plantations caused a proclamation to be distributed in certain sections of Germany inviting settlers to Nova Scotia, and offering generous terms. A large number applied and secured passages for themselves and their families. They came in detachments during the years 1750-52 and were first domiciled at Halifax. Among them came about 453 French-speaking Protestants from Alsace. In 1753 the great body of these immigrants were removed from Halifax, and founded the settlement of Lunenburg. I can find the name of only one medical man in connection with the settlement.

To be continued

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NO. 7

WHILE it was hoped that the July issue of the Bulletin would deal very fully with the business transacted at the 72nd annual meeting of the Medical Society held at Bridgewater July 1st, and 2nd, it has been found impossible to do anything more than publish a few of the reports submitted. The failure of a quorum of the Executive to be present Tuesday evening, the special discussions relative to a newly organized Society and the claims of the old Society, together with the unbounded hospitality of the local committee, made it impossible to complete the business of the session. Two very important committees were however appointed, whose reports when prepared will call for an early meeting of the Executive of the Society, when the full business of the Session will be completed. The proceedings of this meeting will appear in an early issue of the Bulletin.

In the Minutes will be found reference to votes of thanks extended to the good people of Bridgewater and Mahone for their part in making the meeting a splendid success. The motto of the programme was 'Hospitality' and it was certainly exemplified during the entire stay.

Medical Society of Nova Scotia 72nd Annual Meeting.

REPORT OF ASSOCIATE-SECRETARY.

To The Executive of the Medical Society of Nova Scotia.

IN presenting this my fourth report at the Annual Meeting of this Society, I must advise that I have been unable to accomplish nearly as much as the aims of the Society required. It is very disappointing to see opportunities for service, and to be unable to obtain the time to embrace them. I beg, however, to present certain general matters for your information, consideration and such action as you consider best.

MEMBERSHIP.

Membership in the Provincial Society in 1922 was 100. For 1923 the active membership was 201 with 11 Honorary members, a

total of 212. For 1924 the total membership was 200. The 1925 membership is as follows:—

Active members 218 and Honorary members 11, making a total membership of 229. Of these 108 are also members of the Canadian Medical Association. Not only is our total membership higher than ever before, but our proportion of C. M. A. members is higher than any other Province. It is only fair to conclude that the profession in Nova Scotia appreciate the advantages of organization both provincially and federally. The General Secretary, Dr. Routley, has given expression to the appreciation of the C. M. A. Executive for our co-operation.

The problem is still before us to work up our own membership to 300, for only so can we fully carry out our programme. An assured budget of \$3000.00 would enable the provincial body to assist the different branches. This assistance is required to enable branches to hold better meetings, giving more attention to clinical work. If branch society meetings are made worth while, their membership will increase and the members can be canvassed for the provincial body.

This matter has engaged the attention of the C. M. A. through its Inter-Provincial Relations Committee. It is suggested that each local branch appoint one member to form a committee acting with the provincial representative on the C. M. A. Committee. This Committee would sponsor matters referred from branches to the provincial and through it to the C. M. A. Likewise matters of general interest could be passed from the C. M. A. to each branch. This Committee could make a special effort to increase our membership.

We have nearly 400 doctors in active practice, so about 175 are not members of the Society. It is pointed out that Branch Societies should be required to furnish the Associate-Secretary with a list of their members on or before December 31st. of each year. Perhaps then it would be better to make the annual draft only on those who are actual members of branches.

THE BULLETIN.

In accordance with instructions from the Society, the Bulletin has been issued monthly since the last annual meeting. The Wallace Advertising Agency was engaged to secure advertising to lessen the cost of publication. To get advertisements it was necessary to make a better appearing publication, and all will agree that it is now a credit to the Society.

The firm reports space sold in the April issue to the amount of \$81.20, less 25% commission. The printing bill for April was \$135.00. Space in the May issue was sold for \$93.20 less commission, being net \$69.90. The cost of printing for May was \$114.58. The June issue had about \$101.00 in advertising and the issue will likely cost \$130.00.

Beginning with July, the Bulletin will be printed at a cost of

less than fifty dollars per issue. If the Bulletin were increased to 64 pages and sent to the Doctors in New Brunswick and Prince Edward Island, it could be published for \$40.00 per month more. It would increase both the rate and the amount of advertising. A letter from the Agency on this subject will be submitted for your consideration.

IRREGULARS.

The Chiropractor appears to be in evidence a little more today than a year ago, if one may judge by newspaper advertisements. Digby and Middleton have had the services of a Mr. G. W. Bowlby for the past two years, but he is now reported as taking a four year post graduate course in Philadelphia. A Mr. Kennedy advertised as a "Drugless Physican" in Parrsboro. Dr. Ross Millar and Dr. C. S. Henderson were interested in this case, and it was hoped would secure evidence that could be used to convict him. Doctors Pearman and Hemmeon of Wolfville and Dr. Fales of Middleton used the local press to advise the public regarding the use of 'drops' in refraction work.

A man calling himself Dr. Herman, operated in a number of country districts in May 1925, extracting teeth, fitting eyeglasses, selling medicines and otherwise fleecing money from the people. Through the Deputy Attorney General's Office he was compelled to stop his dental work and his present whereabouts is unknown. Influence should be brought to bear on Municipal Authorities to prevent the issuing of licenses to such frauds.

While the Attorney General should conduct suits against Irregulars and while in default the Provincial Medical Board should prosecute, in any case members of the Medical Society of Nova Scotia, should secure the evidence.

THE OTTAWA CONFERENCE.

This Conference was attended by Doctors Reh fuss, Hattie, Jost and Walker, as representing Nova Scotia. The Report prepared by Dr. Hattie and published in the April Bulletin is herewith submitted for your consideration.

WORKMAN'S COMPENSATION BOARD.

The report of the Standing Committee is in hand for your consideration. Also letters from Dr. W. J. Kennedy, and Resolutions from Branch Societies.

OBITUARY.

As far as possible, mention has been made in the Bulletin of the death of members of our profession in this Province, or who were in some way known by or related to us as a provincial body. Since our meeting last year the following deaths have been recorded:

- JOHN C. CADEGAN, M. D., Bellevue Hospital Medical College 1882, Little Glace Bay, July 29th, 1924.
- JOHN A. FERGUSON, M. D., C. M., Dalhousie 1905, Dominion No. 6.—July 7th, 1924.
- VERNON H. C. MORSE, M. D., Harvard 1903 Paradise, N. S. July 8th, 1924.
- JOHN ST. CLAIR MACKAY, M. D., C. M., Dalhousie 1899, Windsor, N. S.—August 6th, 1924.
- ANDREW DEWOLFE BARSS, M. D., University of Edin. 1864, Wolfville, N. S. Honorary Member Medical Society of Nova Scotia.—August 22nd. 1924.
- GEORGE JOHNSON MCNALLY, M. R. C. S., England, 1897. L.R.C.P. London 1897, Berwick, N. S. August 8th, 1924.
- GEORGE ERASTUS DEWITT, M. D., Harvard 1872. Wolfville, Honorary Member of Medical Society of Nova Scotia, Nov. 17th, 1924.
- DUNCAN CAMPBELL, M. D., Tulouse University, Louisiana 1891. West Branch, River John, N. S., November 17th, 1924.
- JUDSON BURPEE BLACK, M. D., Dartmouth College 1890. In practice 1864, Windsor, N. S., Honorary Member Medical Society of Nova Scotia, December 9th, 1924.
- ELIAS NICHOLAS PAYZANT, M. D., Jefferson Medical College 1855. Wolfville, N. S., January 22nd, 1925. Honorary Member Medical Society of Nova Scotia.
- WALTER MALCOLM COWPERTHWAIT, M.D., M.C., McGill University 1900. Sydney, N. S., February 4th, 1925.
- JOHN McDONALD, M. D., C. M., Halifax Medical College, 1876. St. Peters, N. S., February 26th, 1925.
- HOWARD DOUGLAS WILSON, M. D., University of Pennsylvania, 1878. Barrington, N. S., March 5th, 1925.
- JOHN FERGUSON BLACK, M. D., College of Physicians and Surgeons, N. Y. 1868, Stone, Somersetshire, England, March 1925.
- JOHN WILLIAM GANNON M. D., C. M., McGill University 1918, Glace Bay, N. S., June 6th, 1925.
- LAURIE THOMAS W. PENNEY, M. D., C. M., McGill University, 1907. New Germany, N. S., June 20th, 1925.

The sympathy of the profession of Nova Scotia has been extended to families of these deceased practitioners by the Associate-Secretary and these messages have been acknowledged with much appreciation. In the case of the death of our Honorary Members or an elected Officer of the Society, should not a floral tribute be also sent.

BRANCH SOCIETIES.

While this Society has nine affiliated Branches, the affiliation and co-operation is not as complete as it should be. Regarding local meetings, the local press furnishes the only information available in most instances. Likewise we have no reports as to membership.

Reports have been received giving the following nominations to the Provincial Executive which should be confirmed:—

Valley Medical Society, Dr. M. R. Elliott, Wolfville, D. F. S. Messenger, Middleton, and Dr. W. F. Read, Digby.

Western Counties, Dr. A. J. Fuller, Yarmouth, and Dr. M. C. O'Brien, Wedgeport.

Halifax, Doctors S. R. Johnson, V. L. Miller, H. W. Schwartz, and G. W. Grant.

Cape Breton, Dr. J. J. Roy, Sydney, Dr. J. G. Lynch, Sydney, and Dr. L. W. Johnstone, Sydney Mines.

Perhaps the Nominating Committee might ascertain the nominees from other Branches and include the names in their report.

HONORARY MEMBERSHIP.

Our list of Honorary Members contains now eleven names, four having died since our last meeting. Fifty years of honorable practice should call for some recognition. This year completes 50 years of practice for Dr. Robinson Cox, all of which has been spent in Upper Stewiacke, Colchester County. Until very recently he attended Medical Society Meetings whenever possible, and is an active member of the Colchester-Hants Branch. He stands high in the estimation of the people whom he has served so many years. Our Society might show appreciation of Doctor Cox by electing him to Honorary Membership.

Attention is directed to the fact that there is residing near Bridgetown, Dr. Daniel Oliver Saunders, a Graduate of Harvard in 1869. He is 85 years of age and practiced for many years at Conqueral Bank, Lunenburg County. He is the father of Dr. R. McK. Saunders of Lunenburg. He retired from practice about 20 years ago. Should he not be extended the courtesy of Honorary Membership in this Society.

LOCUM TENENS.

Some better system should be adopted to assist Doctors in getting other Doctors to supply for them during temporary absences or while

sick. The Associate-Secretary has been of some service in several instances this Spring, but by co-operation with the Dean of the Medical College, this service could be more effective.

(This report will be considered as a whole at an early meeting of the Executive.)

REPORT OF PUBLIC HEALTH COMMITTEE.

President, Nova Scotia Medical Society.

THE Public Health Committee of the Medical Society beg to submit the following report.

1. At the Amherst Meeting of the Society a Resolution was passed as follows:—

“In view of the fact that a Conference between the Federal and Provincial Health authorities and representatives of the Canadian Medical Association and Societies is contemplated, your committee beg to suggest that this matter (the better reporting of Notifiable Disease) be placed by this Society on the Agenda of the Conference for discussion, with a view to the practitioners of this Province conforming in their actions with any which may be decided upon as a result of the deliberations of the Conference.”

In accordance with the above Resolution, the matter was considered at the Medical Conference held in Ottawa Dec. 18, 1924, and the following Resolution was there passed:—

“That this Conference suggests to the Canadian Medical Association the advisability of calling attention, through the Provincial and the Branch Societies to the importance of bringing about more accurate reporting of Notifiable Diseases, and, toward that end, the adoption of such courses of action as to each Provincial Society seems most advisable.”

Your Committee beg to present this matter for discussion, therefore, for such action as the Society is disposed to take. The importance of disease reporting as the first step in disease prevention need not be stressed.

2. Another matter brought before the above mentioned Conference resulted in the request being made the Federal Department of Health in Ottawa that in view of the serious extent of the losses met with in the Dominion in connection with childbirth, “it undertake a comprehensive inquiry in regard to Maternal Mortality in Canada.”

From a Provincial point of view such an investigation may well be urged. What might be considered a normal rate of loss is about two mothers per each thousand births. Our Provincial rate has never fallen below 3.26 per 1000 and last year it was over 7, which

indicates the death of about 60 mothers beyond what is considered to be practically inevitable.

Your Committee therefore beg to place this matter before you. Without the assistance of the members of the Society it will be impossible to secure data from this Province on which may be based any satisfactory conclusion, either respecting the causation of our excessively high rate or the means to be taken to reduce it. The investigation, it must be noted, is being conducted by the Federal Department of Health, and it is understood that preparations are now being made for the collection of the data required.

3. In addition to the above, note ought to be made of several matters which are of interest to your members.

During the year which has elapsed sufficient progress has been made in the study of Scarlet Fever to justify the opinion that the serum treatment of the disease is being placed on a firm basis. There are now being made a number of preparations similar to those used in the control, of Diphtheria, namely, an Antitoxin, a Toxin Antitoxin and Immunity Test. From the results met with in practice, it would appear that varying values are placed on these. The Antitoxin has been very favourably received, and is thought to have added very greatly to our methods of disease control. Concerning the other preparations, there appears to be a well marked difference of opinion, the majority of practitioners apparently not being convinced that the results up to the present obtained are meeting the expectations.

4. In connection with what must for a time be considered our greatest provincial problem namely, Tuberculosis, note ought to be made of the very evident support which is being given the Tuberculosis Clinics being arranged for in various provincial centres. If these have been of value, it is because of that support, and the members of the Society deserve the credit.

Antituberculosis work among the Indians of the Province is being more vigorously prosecuted. Though their numbers are small, (only about 3000) it must be recognized that our Indians are a very highly tuberculized part of our population, a large number of their deaths being due to this disease. Any strengthening of the measures being taken to improve their condition is then, sincerely welcomed. Your Committee, therefore, takes the liberty of requesting that the Society convey to the Department of Indian affairs its appreciation of the efforts they are putting forth to improve the health conditions of the Indians of our population.

5. It is a matter for congratulation that our losses from Tuberculosis have declined quite materially. What improvement there has been, however, has taken place almost wholly in respect of the Pulmonary form of the disease, our losses from other forms of Tuberculosis remaining almost stationary. An investigation will probably show that many cases of these other forms of Tuberculosis are due to

infection from the bovine type of bacilli. Unfortunately, there is not data from which we may hazard an opinion concerning the extent to which Tuberculosis affects the cattle of the Province. The advisability of suggesting some investigation along this line may well occupy your attention.

6. Your Committee also begs to direct your attention towards the matter of procuring treatment for drug addicts. There is not in the Province any institution where treatment for drug addiction can be procured under conditions considered adequate. Your Committee therefore requests consideration of this matter and if necessary the appointment of a special committee who may be asked to report upon the ways and means by which some facilities for adequate treatment might be secured.

Respectfully submitted,

Committee { A. C. JOST.
J. K. McLEOD.
EVAN KENNEDY.

REPORT OF PUBLICITY COMMITTEE.

MANY factors combined to hamper the Committee from accomplishing anything during the past year. Only two articles were broadcasted through the press of the province; one entitled "A fake Consumption Cure," and the other "A Warning to the Tuberculous." These were published in over 40 papers and were sometimes noted editorially. Some thirty papers come to the office of the Associate-Secretary, so it is easy to check up on publicity. Undoubtedly this educational work should be followed up and suitable articles published at least every month.

The Canadian Medical Association for several months gave a weekly publicity service of popular copyrighted articles. These were published in one of the Halifax daily papers.

It is very noticeable that the lay press devotes so much space to health matters. The 'Public Health Notes' issued by the Department of the Public Health of Nova Scotia is very often published by the provincial newspapers. It behooves us to take advantage of this evident desire on the part of the reading public and see that reliable information is published.

The Committee would appreciate your instructions to continue this work more efficiently.

On behalf of the Committee,

(Signed) S. L. WALKER,
Secretary of Committee.

REPORT OF THE COGSWELL LIBRARY COMMITTEE.

THIS report is necessarily brief. One meeting of the Committee was held at which routine business was transacted. No funds have been paid over to Dalhousie University during the year ending June 30th, 1925. All that can be reported, therefore, is information relative to the policy of the Medical Library Committee during the past year. The former librarian, Mrs. MacLean, having resigned, Miss McNutt was appointed in her place and has done very efficient work. An attempt has been made to reduce the congestion of the Library rooms by removing duplicate volumes to storage. A few current text-books have been purchased from the University funds, but the chief effort has been directed to obtaining complete files of some special journals required for research work, especially in the departments of Physiology, Biochemistry and Pharmacology.

It could be wished that the medical men of Halifax and of the Province generally would use the facilities of the Library more fully.

A. G. NICHOLLS.

Chairman of the Cogswell Library Committee.

June 30th, 1925

REPORT OF COMMITTEE ON MENTAL HYGIENE.

To the President and Members of the Medical Society of Nova Scotia:

ON behalf of the Committee on Mental Hygiene, I have but little to report.

The Committee was able to secure the co-operation of Mr. R. C. Robb, of the Department of Biology, Dalhousie University, who gave much time to a study of several families in which the transmission of mental defects is very noticeable. Mr. Robb prepared very complete charts of these families, which are available to the Society, and which your Committee feel will prove of much value in demonstrating the danger of continual neglect in the provision of means for preventing the propagation of the unfit. Mr. Robb's work in this connection deserves official recognition by the Society.

A meeting representative of various organizations which have shown an interest in mental hygiene was arranged under the auspices of the Society. A great variety of opinions were expressed, and it seemed unlikely that these opinions would be harmonized by further conferences. There was, however, unanimity in the opinion that the provincial government should proceed to the establishment of an institution for the feeble minded. Because of the near approach of a general provincial election, it was felt that it would be well to defer approaching the government until the new assembly meets.

Your Committee believe that if the representations of this Society to the Government were to be made independently of other organ-

izations, so that ample time would be available for the presentation of the medical phases of the problem, better results would follow than if we were to be merely represented on a composite delegation.

Respectfully submitted,

W. H. HATTIE,
Chairman.

Halifax, June 18th, 1925.

REPORT OF PROVINCIAL EDITORIAL BOARD, CANADIAN MEDICAL ASSOCIATION JOURNAL.

To the President and Members of the Medical Society of Nova Scotia:

ON behalf of the Provincial Editorial Board of the Canadian Medical Association Journal, the following report is respectfully submitted:

1. A year ago the policy of the Journal was changed to the extent that provincial boards were relieved of the duty of passing upon the suitability of papers presented by members resident in their respective provinces, and this duty has been assumed by the central board. Papers may now be forwarded direct to the Editor, and your provincial board cannot claim the credit of securing all the papers by Nova Scotian contributors which have appeared in the Journal during the past twelve months.

2. Regular monthly budgets of news items, and biographical sketches of deceased Nova Scotian physicians, have been prepared and forwarded for publication. Your provincial board would again appeal to secretaries of branches for references to local activities of general interest. The board has received no such assistance during the year, and consequently the monthly budgets have not been as representative of the whole province as is desirable.

3. The following contributions to the Journal, which have appeared during the past year, are from the pens of Nova Scotia physicians:—

- (a) Conclusions from Repeated Physical and X-Ray Examinations of Ex-Service Men, by Dr. A. F. Miller.
- (b) Role of Bone Marrow in Primary Blood Diseases, and
- (c) Some thoughts—New and Old—on Arterio-sclerosis, by Dr. A. G. Nicholls.
- (d) Erysipelas Successfully Cured by Subcutaneous Injection of Cow's Milk, and
- (e) Amaurotic Family Idiocy in an Infant of Non-Semitic Parentage, by Dr. T. A. Lebetter.
- (f) Surgical Headache, by Doctors A. R. Campbell and C. K. Fuller.

- (g) Vagitus Uterinus, by Dr. C. S. Morton.
- (h) Notification of Communicable Diseases, by Dr. A. C. Jost.
- (i) Treatment of Pernicious Vomiting of Pregnancy, by Dr. H. B. Atlee.
- (j) Historical Sketch of Dalhousie Medical School, by Dr. W. H. Hattie.

4. Of particular interest to Nova Scotians was the delivery of the first Listerian Oration, at the 1924 meeting of the Canadian Medical Association, by Dr. John Stewart. This oration was published as a special number of the Journal in October last.

5. Occasional editorials and book reviews have been prepared by members of your board.

6. On behalf of the incoming board we would ask members of the Society to assist in giving our province a worthy place in Canadian medical literature by contributing papers, case reports, items relative to local medical history etc.

Respectfully submitted,

W. H. HATTIE,

Chairman.

Halifax, N. S., June, 18, 1925.

REPORT OF WORKMEN'S COMPENSATION BOARD COMMITTEE.

Dr. S. L. Walker, Associate Secretary, Med. Society of Nova Scotia.

THE Workman's Compensation Board Committee had but one matter referred to them this year. It was the question as to who should retain permanently X-ray films, the hospital or the Compensation Board? Mr. Paton is now convinced that the permanent home of the films should be the hospital where they were taken and where they form an important part of the hospital's records. It is agreed that the Board should have access to any film required but return it to the hospital when through with it.

No other business was referred to your Committee during the year.

Respectfully,

Committee: { G.H. MURPHY, Chairman of Board Committee.
E. V. HOGAN.
M. G. BURRIS.

OBITUARY

JOHN WILLIAM GANNON, M. D., C. M., McGill University, 1918
Glace Bay, N. S.

On June 6th, there died in St. Joseph's Hospital, Glace Bay, C. B., John William Gannon, one of the rising young men of the Medical Profession in the colliery districts. His death, following a very serious operation for internal trouble, though not unexpected, yet came as a shock, and cast a gloom over the entire community.

Dr. Gannon was born at Glace Bay, thirty-five years ago. His father, the late Anthony Gannon, was for a number of years, Postmaster at Glace Bay. In his youth, Dr. Gannon attended St. Anne's School. Later on, he graduated from the Glace Bay High School; after which he attended St. Francis Xavier's College, Antigonish. After graduating in Arts from the latter institution, he entered the University of McGill, where he took up the study of medicine. In 1918 after graduating from McGill, he enlisted in the Army Medical Corps, and up to the end of the War, he was engaged in duty on transports from Halifax to England.

At the close of the War he was placed on the Medical Board of Military District No. 6, at Halifax, and given the rank of Captain. After receiving his discharge from army service, he went to reside at Reserve Mines, C. B., where he practised his profession up to the time of his death. In addition to his other duties he was the local representative of the D. S. C. R. Department in the colliery districts.

Six years ago he married Miss Margaret MacDougall, an overseas nurse, and daughter of the late Captain Alexander MacDougall of Antigonish. She and her son, Allister, survive him and reside at Reserve Mines. His mother and two sisters live in Sydney. The sisters are Mrs. (Dr.) O. Walsh, and Miss May. The latter is on the teaching staff of the Sydney Schools.

The deceased was a valued and active member of the Glace Bay Council of the Knights of Columbus, under whose auspices his funeral was held from St. Joseph's Church, Reserve Mines, at 9 a. m. Monday, the 8th inst. The large attendance of brother-physicians from all over the country and representatives of the Great War Veterans, as well as a great concourse of people of all denominations, that followed his remains to their last resting place in St. Anne's Cemetery, attest to the popularity and esteem with which he was held in the community.

At the regular monthly meeting of the Cape Breton Medical Society, the following Resolution of Condolence was passed:

Whereas it hath pleased Almighty God to call to his eternal reward, our esteemed and valuable fellow member. Dr. John W. Gannon of Reserve Mines, C. B.

Be it resolved that we, the members of the Cape Breton Medical Society, here assembled at our regular monthly meeting, express our extreme regret and sorrow over the loss of our esteemed member, and extend our sincerest sympathy and condolence to the deceased's bereaved widow and near relatives and friends.

And be it further resolved that a copy of this resolution be forwarded to his wife, one to his mother, and one placed in the records of this Society.

The death occurred at Yarmouth June 5th, of Mrs. Helen O. G. Webster, aged 87 years. Dr. Charles A Webster of Yarmouth, is a son of the deceased.

Mr. E. H. Culton, father of Dr. Alfred Culton of Wallace, died June 16th at his home in Stellarton.

After a long life of usefulness, greatly beloved, there passed away recently at her home, Mountain Road, New Glasgow, Mrs. Susan Forbes, widow of the late George Forbes. Dr. A. E. G. Forbes of Lunenburg, is a son of the deceased.

At her home in Englishtown, Victoria County, Mrs. Alexander Morrison died on June 3rd. after a lengthy illness. One son, Dr. J. C. Morrison of New Waterford was present when his Mother died. Another son is Dr. M. D. Morrison of the Workmen's Compensation Board, Halifax.

The death occurred in Halifax, on July 5th of Sir Frederick Fraser who for fifty years has devoted all his energies to the education of the Blind. He received his Knighthood in 1913 which was a signally happy instance of rendering honor where it was most rightly due. The older physicians will recall that Sir Frederick was the son of Dr. Benjamin DeWolfe Fraser, who practised in Windsor for over 50 years and was universally beloved throughout the whole countryside.

PERSONALS

Dr. and Mrs. G. E. Buckley of Guysboro, were recent visitors in Halifax.

Dr. Baxter of Halifax, is supplying for Dr. F. R. Davis of Bridgewater.

Dr. Prescott Irwin of Shelburne, has retired from the service of the R. M. S. P. "Chignecto."

Dr. L. L. Crowe of Bridgetown, spent the month of June in Toronto, returning by way of Boston.

Dr. F. H. Wheeler, who supplied for Dr. Barss of Rose Bay recently, has returned to Montreal.

Dr. H. N. Gosse recently addressed the Canning Women's Institute on general public health matters.

Dr. A. L. Wilkie a native of Antigonish, has been appointed Douglas Fellow in Pathology at McGill.

Dr. S. H. McLeod, who has been practising in Upper Stewiacke for the last two years, has removed to Saskatoon.

Dr. H. G. McLeod, Dalhousie 1922, who has been in Middle Musquodoboit, has removed to Cleveland, Ohio.

Dr. James Bruce and Dr. J. J. Roy of Sydney, were recent visitors to New York attending a Medical Convention.

Dr. John Bell of New Glasgow, attended the Congress of the Continuing Presbyterian Church recently held in Toronto.

Dr. Charles McMillan, Dalhousie 1925, practising in Newfoundland, spent a short vacation at his home in Dartmouth.

Dr. and Mrs. R. J. McDonald of Saskatoon, have been spending a few weeks in their former homes in Pictou and Cape Breton.

Dr. Frederick Schaffner and wife, of Winnipeg, were recent visitors in their former home in Melvern Square and vicinity.

Dr. G. A. Barss of Rose Bay, returned recently from a stay of three months in England. He was accompanied by Mrs. Barss.

Dr. Everett Muir of Eureka, Pictou County, has been taken on the staff of the Nova Scotia Sanatorium. He was a Dalhousie 1925 graduate.

Dr. Charles Beckwith, Dalhousie 1925, a son of W. H. Beckwith D. D. S. of Halifax, is now House Physician in the Glace Bay General Hospital.

Dr. Dan Webster a Dalhousie Graduate of 1924, is Ships Surgeon on the C. G. B. "Arras" which is equipped for medical service to the fishermen on the Brand Banks.

Dr. M. E. Armstrong of Bridgetown, accompanied by Mrs. Armstrong, attended the recent meeting in Toronto, of the General Council of the United Church of Canada.

The oral examinations of the Canadian Medical Council were held in Montreal this year. Doctors Hattie, Morton and Nicholls were examiners representing Nova Scotia.

Mr. Alexander McDonald, son of Dr. and Mrs. Dan MacDonald of North Sydney, has recently received the degree of Doctor of Philosophy, from the Catholic University, Washington.

Dr. Charles Spiro, Dalhousie 1924, who has been supplying for Dr. J. S. Brean of Mulgrave during his recent illness, is leaving for two and one half years special work in Eye, Ear, Nose and Throat Hospitals in New York.

Colonel H. M. Jacques, P. A. M. C. who has been A. D. M. S. in Military District No. 6, has been transferred to Ottawa and is now Director-General. His many friends among the profession in Nova Scotia will congratulate him.

Dr. C. S. Morton of Halifax, accompanied by Mrs. Morton and their son Harry, spent the greater part of June in a delightful motor trip, taking in Boston, New York, Albany, Detroit, Toronto, Ottawa, Montreal, and Quebec.

Dr. R. D. McLeod, Dalhousie 1925, has taken the place of Dr. H. G. McLeod in Middle Musquodoboit. After spending a short vacation at his home at Green Hill, Pictou, the latter goes for post graduate work at Cleveland, Ohio.

Mr. Percy J. Bentley, son of the late Dr. R. D. Bentley of Truro, has received a Degree of Master of Science in Engineering Administration, from the Massachusetts Institute of Technology. He graduated from the Nova Scotia Technical College in 1924.

Dr. W. D. Forrest of Halifax, with Mrs. Forrest, went to New York in the latter part of June to have treatment for their daughter Margaret. All are pleased to know the operation was successful. While away they visited the Doctor's brother in Rye, N. Y.

Four doctors were successful in the recent election,—Dr. B. A. LeBlanc, Arichat, Dr. John A. MacDonald, St. Peters, Dr. J. L. McIsaac, Antigonish, and Dr. W. N. Rehfuss, Lunenburg. Unless a Doctor is retiring from practice, one hardly knows whether to congratulate the winners or losers. The medical profession was well represented in the nominations by twelve of its members, showing that as a body we are interested in matters of State as well as Medical.

The Halifax Infirmary has just issued its 1925 Announcement. It is a nicely printed and illustrated brochure. The beginning of the hospital in 1886 is attributed to Doctors Edward Farrel, John Black and Fitzgerald U. Anderson, The members of the Advisory Board are:—

John Stewart, C. B. E., M. B. C. M., L. L. D.

William Tobin, M. D., F. R. C. S.

George H. Murphy, M. D., F. A. C. S.

Fitzgerald U. Anderson, M. D., M. R. C. S.

Victor N. Mackay, M. D., D. P. H.

“Why was the librarian roasting Doc Smith so bad?

“Doc took the appendix out of a book and then tried to collect \$200 from the library.”