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# Cancer of the Rectum

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Dr. R. M. BENVIE, Stellarton, N. S.\*

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**D**URING a recent visit to London and Edinburgh, I was surprised at the number of patients who had carcinoma of the rectum. On investigation, at least one author was found (G. Bychovsky), who placed this type of cancer third in his cancer incident.

- 1st. Cancer of the Breast.
- 2nd. Cancer of the Stomach.
- 3rd. Cancer of the Rectum.

On account of its relative frequency, it is therefore necessary for one to be always "on guard."

As in other tumours of this type, the patient is generally beyond middle age, yet it is often found in comparatively young people. One patient was 27 and others were well under 40 years of age.

The symptoms are: 1st—change in the bowel habit. The patient finds that although formerly regular, he is beginning to have constipation accompanied by slight cramps, and the condition is progressive, finally ending in obstruction. Blood is found in the stools.

On arising in the morning, there is an immediate evacuation of the bowel, the stool consisting largely of mucus.

Another complaint is "piles." A patient suffering from haemorrhoids, whether he be in the cancer age or not, should have his lower bowel carefully examined. I know of a young man of 35, who came to the operating table for the purpose of having a haemorrhoid operation, when it was found that he had an extensive cancer of the bowel, which had invaded the prostate. Pain in the left hip with marked constipation was the picture in another patient.

Apart from the symptoms, the diagnosis is established by rectal examination with the finger, the proctoscope and sigmoidoscope. If the tumour be rectal, an absolute diagnosis can always be carried out by this method. A portion can be readily removed by the cautery knife for microscopic confirmation and to some extent its degree of malignancy can be determined. As the tumour is daily traumatized by a hard faecal column, the danger of doing harm by removing a part is practically nil.

Except in the young, whose tissues are active (and even in them) these tumours are usually slow of growth and generally are of a year's duration before coming for treatment.

\*Read at the Annual Meeting of the Medical Society of Nova Scotia at Digby, July, 1930.

When the doctor is sure his patient is suffering from carcinoma of the rectum, what procedure shall he advise?

At present, surgical removal of the rectum is the best hope. However, cases treated with radium have been reported to have survived a five year period free from symptoms. Only half of the patients with the disease are fit for surgical intervention. Young patients survive the operation, but the disease recurs. Short fat patients are poor risks. The thin spare patient of 60, when free from other ailments, is the best surgical risk.

In regards to operative procedure one has to choose from:

1st. Simple Colostomy to relieve obstruction.

2nd. Colostomy with the insertion of radium.

3rd. Colostomy with the later removal of the rectum by the perineal route.

4th. The abdominal-perineal operation in two stages.

5th. The abdominal-perineal operation in one stage.

In the present state of rectal surgery the operation of colostomy with the later removal of the rectum by the perineal route is the one most widely used, the abdomino-perineal being reserved for selected cases.

There is no doubt that the abdomino-perineal resection, as done by Mr. Edgar Miles, of London, is the ideal operation, but the initial mortality in other hands than Mr. Miles is extremely high. Mr. Miles carefully selects his cases, does the operation in one stage, and has excellent results, his initial death rate being no higher than when done by the perineal route.

To determine the condition of his patient, he uses what he calls the energy index. This is determined by dividing the pulse pressure by the systolic pressure. If the resulting quotient be between .25 and .75 the patient (other things being equal), should survive operation. The majority of British operators use the perineal route.

*Anaesthesia:* Ether anaesthesia was most frequently used, but spinal gave excellent results. The patient was narcotized with morphine or veronal previously, 1 cc 10% novacaine, or .07 cc stovain was injected into the spinal canal, five to seven minutes before the beginning of the operation. One cc of Ephedrin hypodermically was used to prevent the marked fall of B.P., which results from spinal anaesthesia. This gave perfect analgesia without the uncomfortable symptoms which follow the use of ether.

*Colostomy:* The operation of colostomy is frequently life saving, and in many instances following the drainage of the bowel and relief of obstruction, there is a vast improvement in the physical condition of one's patient, who may be changed in a few weeks from a poor to a fair, and even a good operative risk.

In doing this operation, the technique varies with the individual surgeon. Mr. Miles, of the Cancer Hospital, first makes an incision slightly to the left of the midhypogastrium, sufficiently long as to

allow the introduction of the hand. The abdomen is then explored—its upper portion first. Should metastases be present, especially in the liver, all hope of removal of the growth is abandoned. In the neighborhood of the tumour, the glands are always enlarged, yet may not contain cancer cells, the enlargement being inflammatory and so does not necessarily mean “inoperable.” Many “fixed growth” also can be safely removed.

Exploration being complete, if found necessary the sigmoid is mobilized; generally the cutting of one peritoneal band, which is attached to the brim of the pelvis, is all that is needed. The site of the colostomy, about two inches to the left, is selected, and the skin picked up by a pair of forceps. One sweep of the knife cuts away an oval portion. The fascia is incised, the rectus split, and a stab wound made through the peritoneum—the opening being large enough to readily admit the index finger. With a pair of forceps an appendix epiploicae is seized and a loop of sigmoid drawn through the wound, care being taken to have the proximal bowel drawn tight. A mattress suture of cat gut is placed through the mesentery of the loop. The purpose of this is to cause some obstruction of mesenteric circulation and bring about oedema and more or less “mushrooming” of the exposed bowel and so prevent retraction, and fecal matter passing the colostomy opening to the rectum below. (Mr. Miles has a specimen, removed by himself, in which faeces became impacted in the lower bowel and the pouch became a solid tumour, filling the whole pelvis, necessitating excision).

The spur is anchored by a few interrupted sutures and the appendices epiploicae are removed. Either end of a strand of S. W. gut is sewed into the anterior longitudinal muscle band (like the handle of a basket), which marks the site where the bowel will be opened in 48 hours.

The exploration wound is closed in layers, but 5 or 6 strands of S. W. gut are placed longitudinally beneath the skin sutures. These act as a drain and are removed at the first dressing. Sheet rubber is placed over the bowel, followed by a dry dressing.

Other operators, Lockhart, Mummy and Mr. Gabriel of St. Marks, Prof. Pannet of St. Mary's, Prof. Fraser and Prof. Wilkie of Edinburgh, make but the one, left rectus muscle, splitting incision, utilizing a portion for the colostomy. To prevent retraction of the spur, a glass rod is commonly used, except at St. Mary's, where Prof. Pannet makes a semicircular flap of skin in the mid portion of the wound, which he sews beneath the projecting spur of bowel.

When by the exploration done at the colostomy operation, it is found that the case is one suitable for perineal removal, the second and major operation is undertaken in one to three or more weeks later, depending on the patient's condition. In the meantime some surgeons (notably Prof. Wilkie of Edinburgh) endeavour to raise the resistance of the subject against infection by injections of a B. Coli and streptococci serum.

*Perineal Excision:* The position in which the patient is placed for perineal excision of the rectum, again, depends on the surgeon—the left lateral with the knees well drawn up to the abdomen, lithotomy or the reversed Trendelenburg. The latter position—the patient being in the shape of a reversed V gives the easiest approach.

■ In the male, some surgeons first tie a catheter in the urethra. The patient is then placed in position and the anus sewn over with silk. An elliptical incision from the mid-perineum encircling the anus and removing  $\frac{3}{4}$  inch of skin around the sacro-coccygeal joint is then made. The structures attached to the coccyx (gluteus maximus, external sphincter, levator ani and coccygeus) are incised and in most instances the coccyx is disarticulated and removed. By finger dissection the ischio-rectal fat is dissected and severed at the sides. The inferior haemorrhoidals are ligated and cut or vice versa. The index finger of the left hand is hooked above the levator ani muscles from behind forward and the muscles divided with scissors. Their anterior fibers, in the male, connect the rectum with the urethra, forming the recto-urethratis muscle. This is next severed, care being taken to avoid the urethra. The finger is then passed up between the prostate and the rectum. Should the growth be adherent to the prostate, its capsule is also removed. (Radium is in such cases later inserted into the gland). The fascial attachments and middle haemorrhoidals are ligated and cut as high as possible. The peritoneum is now divided around the rectum. This permits the bowel to be easily brought down. The superior haemorrhoidal is ligated and cut as high as possible. The bowel is then clamped with two clamps at least two inches above the growth and removed with the cautery, and the lower end sewn over. Prof. Wilkie of Edinburgh, in his removal incises the muscular coats of the bowel down to the mucous membrane. This is ligated and burned off. A purse string suture is placed around the bowel, three quarters of an inch above the incision and by steadying the gut with Allis forceps the raw end is invaginated and the purse string drawn tight.

The peritoneum is now sutured with a running suture and the rectal stump fixed in the suture line.

The large cavity which is thus formed, is either packed with gauze inside rubber dam, or simply drained by a large tube. A few skin sutures are also inserted.

*The Abdomino-Perineal:* This operation I saw done by Mr. Edgar Miles (its greatest exponent), and Mr. Gabriel—the former in one stage, the latter in two stages.

The patient is placed in the dorsal position. An incision is made slightly to the left of the midline in the hypogastrium from the umbilicus to the pubes. The abdomen is explored for metastases, the hand being first passed to the upper portion, so as not to carry any contagion from the tumour. The sigmoid is drawn to the left and the inferior mesenteric artery isolated, ligated high and cut. The peritoneum is

incised on either side of the rectum, down to the bladder reflection in the male. This is also cut and the ureters located.

By blunt dissection, the bowel with its surrounding fat is lifted from its bed downwards to the lower end of the sacrum. This is usually a bloodless procedure.

Where the operator wishes to sever the bowel is crushed with a heavy "Miles Crusher" and then severed either with the cautery or knife. The ends are covered with caps of rubber dam.

The rectum with its growth is packed in the cul-desac and the peritoneum sewn over, forming a complete diaphragm at the pelvic brim. To facilitate this, some operators remove the greater portion of the free rectum, leaving only the stump at the lower end. A colostomy wound is made as previously described and the bowel end covered with rubber dam is drawn through and anchored to the skin by a few silk sutures. The abdomen is then closed.

In the two stage operation this, after establishing drainage either through the vagina in the female or by lateral stabs at the sides of the anus, completes the first stage. The rectum is removed a week or ten days later.

Mr. Miles advocates and does the operation in one stage.

The patient is turned on the left side with the knees well drawn up. The anaesthetist does a sacral block and the assistant sews over the anus.

The first incision is a short transverse one through the sacrococcygeal joint. The second goes forward encircling the anus. The coccyx is disarticulated and removed. The levator-ani, etc., are cut and the rectum removed in a very few minutes. The large cavity that is thus formed is filled with gauze inside rubber dam. A few skin sutures are inserted and a dry dressing applied.

The patients have to be catheterized regularly and a common complication is cystitis.

The pack is removed in 48 hours and each day the cavity is irrigated with dilute Hydrogen Peroxide followed by Bichloride and Saline.

Should the colostomy contract, it is dilated frequently by the gloved finger. The patients usually leave the hospital in six weeks.

The operative mortality in Mr. Miles series compares favourably with the other types, being 10% to 15%. I personally saw him operate on six cases, all of whom did well.

About 40% are cured.

In no instance was any attempt made to restore the continuity of the bowel or to preserve the sphincter.

Recurrences are commonest in the perineal tissues. These are treated by insertion of radium needles. Small doses are used over a period of 7 to 10 days.

Radium was used in inoperable cases in the abdominal cavity, both with and without colostomy.

It is felt that up to the present time surgical removal gives a better chance for cure than does radium.

# Orthopedic Symposium

## On Complications frequently attending Industrial Bone Injuries.\*

By Dr. M. D. MORRISON, Chief Medical Officer, Workmen's Compensation Board.

THE present medical age being heralded as the era of "Preventive Medicine" it may not prove inopportune if, at this Annual Meeting of the Nova Scotia Medical Society, I occupy your attention for a short time while making a plea in favor of the more general adoption, by the members of our profession, of active measures in the early treatment of bodily injuries that may obviate the necessity for subsequent orthopedic attention. The desirability, and even urgency, for such a plea has been forcibly presented to me during the past twelve years while engaged in my present position as Medical Officer of the Workmen's Compensation Board.

At the very outset let me state emphatically that the orthopedic work which has come under my observation during this period was performed by skilful, competent, and painstaking practitioners; yet, in many cases, the results have been unsatisfactory and disappointing so far as the removal of industrial disability is concerned. Many of our back cases, especially, developed the most distressing forms of neurasthenia; while other claimants of this class are perfectly happy to put on weight, encase themselves in their orthopedic corsets during the day, and smilingly assure those interested in their welfare (including the Compensation Board) that they absolutely cannot do any kind of work.

Our experience in this respect has forced me to the conclusion that too much attention to many such cases in the way of orthopedic appliances may be a mistake, and this for two reasons. First, in the tendency to create a mental attitude in the claimant, favoring chronic invalidism: secondly, in the prevention of measures that would develop the spinal muscles as soon as the natural effects of the original injury were controverted. It can be easily understood that such measures are impossible while the movements of the body are absolutely restricted by the rigid and closely-fitting apparatus supplied by the orthopedic surgeon. At this stage in the treatment the patient is, as a rule, not accessible to the specialist and thus is necessarily deprived of accessory

\*Presented by Dr. Morrison at the Annual Meeting of the Medical Society of Nova Scotia at Digby, July 2nd, 1930.

influences that would mitigate these deleterious effects. And what I have just said with reference to spinal cases is also applicable, though to a less degree, to other parts of the body. We have had a correspondingly unfortunate experience with steel braces applied to the lower limbs. These are early discarded, especially by the miners, on account of the weight and awkwardness; and if there is not complete removal of all pain and inconvenience the claimants prefer to get back on Compensation and do nothing.

But my purpose is not to indulge in any animadversions on the reparative work of orthopedic surgeons who, in too many cases, are called upon to rectify morbid conditions that have passed beyond the stage of satisfactory amelioration when the cases are submitted to them for treatment. Also owing to the failure of subsequent co-operation on the part of either the patient or the local physician, or of both, the greater part of the initial work by the orthopedic specialist is often rendered nugatory, and so the end-results anticipated at the commencement fall short of realization. Condemnatory reflections on these results have, therefore, no abode in my mind on the present occasion: My aim and purpose is rather to take advantage of this opportunity to respectfully suggest to the general practitioner the advisability of the early adoption of simple remedial measures in connection with one or two types of specific industrial injuries that may be attended by very beneficial results to the patient, increased prestige to the medical attendant, and, incidentally, avoidance of burdensome financial obligations by the Workmen's Compensation Board.

And, first, I would refer to the more moderate strains or injuries of the back from which, often, annoying and persistent pain develops. While these lesions have not all the detrimental influences that are claimed for them, yet that they do exist and cause symptoms I firmly believe. The seat of the trouble may be in bone, cartilage, synovial membrane, ligaments, fascia, blood vessels, nerves, or muscles. For the more thorough knowledge of these conditions that obtains to-day we are, no doubt, indebted to the painstaking investigations conducted by patient and competent clinicians and pathologists during the Great War, and since then carried on in various rehabilitation institutions. I am firmly convinced that all these cases should receive immediate attention and treatment, and that the more severe ones should be subjected to spinal manipulation in the first instance, and immobilization for a short period after—to be immediately followed by massage and active movements. Apropos of the ordinary sore back I may say that when engaged in active practice I invariably made it a rule, when consulted by a patient complaining of a persistent or continuous sore back of recent origin, to place him prone, on a low table or on a bench, and getting astride his body run down the whole course of his back with a closed fist on each side of his spinal column through which I communicated to him, in rapid successive stages, the full weight of my own body. I was often rewarded in hearing a crepitation or



distinct click during the manipulation, and an expression of relief from the patient when he again assumed the upright posture. Then a series of straps of adhesive plaster gave him the comfort and assurance that promoted speedy recovery. When recent, the injury in many cases, was probably the result of a partial luxation of a lateral articular facet; in more prolonged cases the underlying pathology was possibly the tearing of a few muscular or ligamentous fibres, producing a little hemorrhage and followed by the formation of fibrous tissue which causes pain when it is stretched.

Another type is the so-called "low back" pain and located in the region of the lumbo-sacral and sacro-iliac joints. Of late years, a good deal has been written about this class of injuries and a recognition of the frequency of their occurrence, especially in mining localities, has forced itself upon our Board. The X-Ray is seldom of any service in making the diagnosis except to confirm the absence of gross lesions. A partial differentiation between the two affections is that in the sacro-iliac cases points of tenderness are localized to the posterior superior iliac spine and just below it; while in the lumbo-sacral cases the tenderness is localized accurately to the lumbo-sacral junction in the mid-line and just to either side of it. Then in the sacro-iliac cases the patient has difficulty in bending forward, while in the lumbo-sacral cases flexion is free (being carried on at the intervertebral joints above the lumbo-sacral junction), but hyperextension is usually painful. Finally, on straight leg-raising we readily elicit pain in the sacro-iliac joint when that portion of the pelvic bony structure is affected. The general history is that of feeling something to give way in the back while taking a heavy lift in a bending position and with the legs spread apart, and the sudden appearance of pain in one or other of the regions indicated above. My experience has been that these cases are exceedingly prone to become chronic unless they are promptly dealt with shortly after the alleged accident; and the most recent effectual treatment seems to be that of spinal manipulation under an anaesthetic. The purpose of the procedure is to restore the normal range of spinal movements, and to break down fibrous adhesions. Rest in bed is imperative for a week or so after this manipulative performance; then massage and exercise are calculated to bring about a condition of improvement within a few weeks that otherwise might not occur in as many months.

Let me next direct your attention to the matter of injuries to the shoulder joint. The number of working people who, every year, become dependents on the Compensation Board for many months, following injuries to the shoulder girdle, is somewhat startling. The chief disabilities complained of are stiffness and pain; and when examined the disablement is most frequently found to be due to the existence of adhesions or to osteo-arthritis. Injuries to the circumflex nerve, the brachial plexus, and the axillary vessels are also encountered, but are comparatively rare.

On the other hand, adhesions are exceedingly common and are responsible for much disability. The explanation is not far to seek. Fractures of the shoulder are frequently treated with the arm bandaged to the side, a pad in the axilla, and the forearm supported in a sling across the chest, this fixation being maintained for an indefinite time before movements are begun. At the same time disuse of the arm is attended by muscular atrophy and eventually by muscular shortening. With such treatment adhesions are almost bound to develop, particularly in and around the lower and front part of the joint. These adhesions produce painful limitation of movement, and interfere greatly with the function and usefulness of the joint. There should never be much difficulty in diagnosing the condition. As soon as the examination is commenced, it shall be observed that movements are restricted in two main directions, namely, in raising the arm upwards from the side, and in rotating it outwards—that is to say, the movements of abduction and of external rotation. Other movements are performed with more or less readiness. If there is limitation in other, or in all, directions we at once think of osteo-arthritis, and this can be confirmed by X-ray.

The best way to prevent such adhesions is by gentle, supported, passive movements begun as early as possible—say, at the end of three weeks in cases of a complete fracture, and at an earlier stage in less severe cases.

Another joint that has acquired great pathological significance, in the experience of the Compensation Board, is the ankle. I think I am safe in saying that no fractures are responsible for more disability than those of the ankle joint. Bad results are, in fact, so common that a feeling exists among many practitioners that a degree of disability is inevitable after these fractures. The most persistent and disabling of these cases, that have come under my observation, could be classified under three heads: mal-union of the fragments, traumatic flat-foot, and osteo-arthritis.

To prevent the first-mentioned unfortunate effect of a fracture at the ankle joint it is always wise to have such fracture reduced under an anaesthetic. No matter what complications exist there is always the probability of a good re-adjustment being effected by manipulation while the patient is under the relaxing influence of ether or chloroform. And the earlier the displacement is absolutely and accurately reduced the less danger of future mental disquietude and physical distress.

Traumatic flat-foot is a rather common sequella to a fracture of one or more of the bony structures that enter into the formation of the ankle joint. This fact may be due, in part, to the rupture of contiguous ligaments or to nerve injury followed by muscular atrophy; but the most prolific cause is premature and unguarded weight-bearing which allows the immature callus to yield, and so leads to the valgoid displacement of the foot. Therefore, the prevention of this disabling and painful condition is procured by a thoughtful abstention from

using the foot until bony union of the fragments is good and firm, and until the weight of the body is absolutely sustained by the new structure. When the flat-foot is an accomplished fact the only effectual treatment lies in the hands of the orthopedic surgeon, who must put forth his best endeavours to remove muscular spasm, to break down adhesions, and to restore the arches of the foot.

One word about osteo-arthritis following fractures about the ankle joint. Orthopedic surgeons are practically unanimous in opinion today that many of such cases can be attributed to incomplete reduction of displacement. The joint line is broken, and rough ends project into and irritate the joint, and osteo-arthritis is the result. Such a condition causes a marked disability, the parts being swollen, stiff and very painful.

Lastly, I would call attention to injuries of the elbow joint. Disability from a stiff elbow is a very frequent result of fractures of this region, namely, the lower end of the humerus, the upper end of the radius, and the coronoid process of the ulna. The limitation of movement may be produced by adhesions or by excessive callus formation. Modern teaching insists that these fractures, after any displacement is reduced, should be put up with the elbow in full supination and in as much flexion as is consistent with a free circulation. The position is to remain undisturbed for about three weeks when gentle active movements are commenced. This precaution in delayed resort to movement and manipulation is an exception to the general rule in the treatment of joint injuries, and for the reason that the elbow is an *exceptional* joint by reason of the well-known tendency to the excessive formation of callus in this region. Early movement naturally throws a strain on the young callus and leads to further overgrowth of it with resulting progressive limitation of motion. For the same reason massage, especially vigorous massage, should be avoided.

In connection with the matter of physical disabilities arising from injuries about the elbow joint it would be well to keep in mind that the ulnar nerve frequently sustains damage in fractures involving the internal condyle of the humerus. It may be accepted as practically true in nearly all cases that the loss of function in this nerve, detected at a later date, originated at the time of accident and was caused by the original injury rather than by subsequent pressure of either a fibrous or bony character. In all elbow cases, therefore, the integrity of this nerve should be tested so as to avoid needless operations, at a later date, based on an erroneous pathology.

The great advantage and opportunity I have had, during recent years, of observing the serious effect of specific injuries, sustained in various parts of the body, and caused by accidents occurring in different parts of the Province, and subjected to diversified methods of treatment is my only excuse for the presentation of this hastily-prepared paper, and asking for it the kind consideration of the Society.

## Disorders of the Thyroid

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THE June issue of the *Bulletin* of the Academy of Medicine, Toronto, gives an abstract of an address given by Dr. George S. Young as one of the Post-Graduate Afternoon Lectures given last fall under the auspices of the Academy. With this acknowledgement we know that both the *Bulletin* and Doctor Young will be pleased with our making the following quotations:

**Diffuse Colloid and Nodular Goitre Without Hyperthyroidism.** The simple goitre problem is very important on account of this possible sequence:—Diffuse begets nodular goitre and nodular goitre before it is finished begets toxic adenoma, the end of which is myocardial failure. Prophylactic treatment by small doses of iodine at puberty will sweep simple goitre with its consequences out of existence. The responsibility at present is on the shoulders of the physician and should remain there. Wholesale treatment by the state involves some risks, at least in the light of present opinion. It is thought that even minute doses of iodine may convert the simple adenoma into toxic adenoma. Hence the treatment of simple goitre without nodules should be small doses of iodine up to the age of twenty, and after that, small doses of thyroid, whether nodules can be felt or not. The simple nodular goitre as a rule should not have surgical treatment unless there are pressure signs.

**Pseudohyperthyroidism.** There is often considerable difficulty in distinguishing between hyperthyroidism and tachycardia with certain nervous symptoms. In the latter cases, which are variously labelled "irritable heart," autonomic imbalance, etc., the resemblance to hyperthyroidism may be very close. The heart rate is rapid; on the neck may be the patchy shifting erythema so common in hyperthyroidism. The thyroid may happen to be somewhat enlarged. The patient is apprehensive of goitre and the basal metabolic rate if not done repeatedly may be slightly elevated. The following points are valuable in differentiating the two conditions. The hyperthyroid practically never has cold hands; they are warm and moist. The nervous case has cold, clammy hands. The pulse rate if taken by some one at the patient's home when she is asleep or in the morning before getting up, may be found to be almost normal. In the doctor's office the patient's pulse may show great fluctuation—and especially in a downward direction if her attention is distracted by an interesting story; while in hyperthyroidism the pulse rate is more uniform and is rapid even during sleep. In civilian life these nervous cases are more common in the second decade; the hyperthyroid cases are more often seen after the age of, say, twenty-five.

**The Overdriven Thyroid.** Occasionally one sees a young woman who presents a picture of mild hyperthyroidism which is apparently dependent on her living at too high a level, emotionally or otherwise. The stress of business life for a young ambitious girl may make too great a demand on the endocrine system and fatigue may be masked by over-activity of the glands of internal secretion. Here is a girl who takes a position in an office. She is bright and quick in mastering the routine of her work. Her employer gradually unloads his own work on her shoulders. The girl speeds up and finally does the work of two ordinary girls. After a while she finds that she is not sleeping well and cannot sit still. The doctor finds some fine tremor and a rapid pulse, perhaps some eye-signs and a full thyroid. Three months' rest in the country will probably restore her to health and a frank discussion of the case with her will probably prevent a repetition of the trouble when she goes back to work.

It would be interesting to know how far these cases would go if left alone. Would the final result be a typical exophthalmic goitre? It is not easy to say, but it is a fact that not infrequently it will be found on careful inquiry that surrounding the onset of a typical exophthalmic goitre, there is a setting of extreme mental, emotional or physical strain.

**Toxic Adenoma.** Note this common history: Simple goitre in early life. It might have been prevented. Goitre apparently disappeared but a nodule was cunningly hidden behind the sterno-mastoid attachment. In the fourth decade, nervous symptoms and "palpitation" attributed to the menopause. Gradual improvement with occasional return of symptoms. At sixty, myocardial failure. The proper diagnosis is now made, but many years too late. In such a case, absolute rest in bed for weeks or months and digitalis in adequate doses may bring the patient to a point beyond which there can be no farther progress. Then the patient must decide between a life of invalidism and the risk of operation. If the patient pulls through the operation, there is a fair prospect of a moderately active life. Most patients will take the risk. It cannot be repeated too often that the only cure for toxic adenoma is surgery, but it should be invoked long before auricular fibrillation occurs.

**Exophthalmic Goitre.** The older physicians have seen many cases recover without operation. I believe that where economic and environmental factors are favourable, where the patient has not reached the age of forty and where the disease has not existed long, medical treatment for three months is advisable. The patient should be most of the time in bed on a liberal high carbohydrate diet. She should be protected from everything that might affect her emotionally. She should have carefully planned mental occupation. It is in such details that general practice becomes a fine art. Sedatives may be necessary, but should be given with discrimination. Some caution should be used

in discontinuing Lugol's solution at any time lest a thyroid storm should be precipitated. It must be admitted that economic and environmental conditions do not often permit prolonged medical treatment of the ideal sort, so that, at the present time, surgery largely has the field.

**Conclusion.** Two types of hyperthyroidism have been sharply differentiated, but as a matter of fact between these pure types there are many cases which partake in varying degree of both. Clinical diagnosis is often corrected by pathological findings. Even the origin and nature of the so-called adenoma is not definitely known. In spite of all this, it is helpful to have some clarifying hypotheses such as those presented, viz., that hyperthyroidism may show itself in two distinct entities, which may exist apart or together; and that in exophthalmic goitre there is a two product secretion, one part of which is normal, the other deficient in iodine."

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This year a medical student is again President of the Dalhousie Students' Council, Mr. J. W. Denoon of Halifax having been elected to this responsible post. Last year Mr. F. C. Jennings of Saint John was the President. Both of these gentlemen are now in the final year, of the medical course.

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Mr. T. L. Farmer of Kinkora, P. E. I. has been elected President and Mr. J. H. Budd of Halifax Secretary of the Dalhousie Students' Medical Society.

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The BULLETIN readers are under deep obligation to Dr. W. H. Hattie for the very interesting report of the recent Winnipeg Medical Convention. To the few Nova Scotians who were present its reading will pleasantly refresh their memories, to those unable to attend it will be suggestive of a greater effort another time to be one of those present. The BULLETIN thanks Dr. Hattie for you, one and all.

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**Is it Nearly True?** Once more attention is called to the fact that the best medical treatment goes to the rich and the poor, while those of moderate income get only what they can afford to pay for. (*Toronto Mail and Empire*).

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**Not in Nova Scotia.** Interne: "Jones is badly shocked, Nurse, give him a coffee enema." Young Nurse: "Mr. Jones, do you take cream and sugar in your coffee?"

## State Medicine

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The following is a summary of the Address given by Dr. K. A. McKenzie of Halifax at the Third Conference on the Medical Services in Canada held at Ottawa in November, 1929.

**M**R. Chairman and gentlemen, I have been asked to introduce the section dealing with the Therapeutic side of State Medicine. There are several reasons why I should be brief. The first is that some things concerning this subject have already been mentioned by previous speakers. The second is that we in Nova Scotia have not touched at all on the therapeutic side of State Medicine. It has never been discussed in our medical societies nor in other circles, nor has the Government of the province discussed it so far as I know. It is not a live question in Nova Scotia. I, therefore, have nothing to say about the therapeutic side of State Medicine from the point of view of experience. The third point is this, and it is the most important of all that some of the speakers who are to follow me come from the West: and they have studied this question in great detail and are therefore much more competent than I to give you information of interest. Any observations I make, therefore, will be of a very general nature.

It seems to me that in our present system there is a distinct evil or defect which requires a remedy. That evil may be briefly stated, as I have often heard and seen it stated, as follows: that in our present system a certain class of people cannot get what medical science has to offer them at the market price. Medical science, as we all know, has made tremendous strides in the last twenty-five years and the problem of diagnosing a case correctly and treating it efficiently is an expensive business.

If I wish to investigate a case of obscure fever or obscure abdominal pain, it is necessary, after making a careful examination, to refer to various diagnostic procedures such as the X-ray, laboratory tests and so on. The result is that the expense connected therewith is very great.

Now, the poor man gets this service in the public hospital for nothing or next to nothing. On the other hand, the rich man is well able to pay for it at the market price. But about sixty per cent. of our population, I should say, belong to the class whose earning powers are small and in order to balance their budget they cannot afford these expensive forms of diagnosis and treatment. They are too proud to accept them for nothing, and they are intelligent enough to want to get the best that medical science can offer.

Now, if there is an evil there must be a remedy and that remedy, as I see it, must be some form of distribution of cost among the people at large. That brings us to the term "State Medicine."

I do not think anybody means by "State Medicine" a complete service such as we had, say, in the army, where everybody comes under a certain law. It calls for some form of disposition of cost for those services which cannot be paid for by a large percentage of our population.

We have in a measure some forms of State Medicine now. We have the State supported hospitals, we have the Workmens' Compensation Board and the Sick Mariners' Fund. These are examples of State Medicine. Some industries have a local form of State Medicine. In Nova Scotia in the colliery districts we have also what is equivalent to a form of State Medicine. So that any scheme which may be evolved will simply be an extension of some of the things which are already going on in our country.

I must confess, myself, that I cannot see the solution of our difficulty clearly. But I was very much interested during my recent trip to Western Canada in observing the activities of the people out there. We read with great interest what they have done in British Columbia, Alberta and Saskatchewan and I think that the work which was started out there, and which may develop into something worth while, will gradually filter through to the more conservative East. I have faith that the medical profession will solve this problem, and in the end solve it well.

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### STATE MEDICINE

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(Under a title "Panel Doctor" the Aug. 11th, 1930 issue of *Time*, the weekly magazine, has the following Editorial, which is quoted as an intelligent lay opinion of the situation from the medical and public viewpoints).

**I**N the dusty brick headquarters of the American Medical Association in Chicago, there is a large office file on the subject of paternalism in medicine. President William Gerry Morgan of the Association has excerpts from that file in his fashionable offices on 1 Street, Washington. Some evenings he takes them to his home around the corner to study, or to his office at Georgetown University, where he lectures on diseases of the digestive tract.

The records show a gradual spread of institutional medicine in the U. S., of doctors working for hire—for clinics, insurance companies, factories, labor camps, government agencies. Especially does government interference with medicine annoy Dr. Morgan and his A. M. A. associates. They insist that the Government should abstain from conducting, controlling or subsidizing any form of medical treatment "excepting such service as is provided by the Army, Navy or Public Health Service, and that which is necessary for the control of communicable diseases, the treatment of mental diseases, the treatment of the indigent sick, and such other service as may be approved and



administered under the direction of or by a local county medical society, and are not disapproved by the State Medical Society of which it (the county group) is a component part."

In other words, the A. M. A. wishes to control the practice of medicine in the U. S. It wants each doctor to develop his own clientele through his own ability and personality. It wants patients to have the freedom to seek personally preferred medical attention. It does not want U. S. doctors regimented, as in England, and Germany, where doctors are listed on panels like jurymen. In England some 39,000 doctors are so paneled. To each is allowed up to 1,000 of the population. The sick under the insurance plan must go to one of these doctors. He willy-nilly must attend to them at a fixed sum from the government.

The English profession dislikes its situation as much as the U. S. profession dislikes its prospect. In the headquarters of the British Medical Association in Tavistock Square, London, there is a file similar to the A. M. A.'s file. Like Dr. Morgan, President A. H. Burgess of the B. M. A. has excerpts in his offices at Victoria University, Manchester, where he is professor of clinical surgery.

Dr. Burgess' associates are a more compromising group than are Dr. Morgan's. Last week London despatches reported how they are dealing with their situation.

For the *prevention* of disease they would have the family physician educate and advise the public, school doctors educate children, public health authorities handle health propaganda and sanitary services.

For *treatment*, every individual would be in voluntary contact with a general practitioner. The general man would guide the patient when necessary to a specialist or an institution.

For *payment*, the individual would pay all costs where at all possible. Some would pay the doctor for his house visits and have voluntary insurance to pay for hospital treatment. A third group would get their family doctor paid by national insurance, the hospital by voluntary insurance. To the very poor, all medical service would be free.

Wrote a colleague of Dr. Burgess to the American Medical Association: ". . . . . The scheme outlined has been brought forward because the British Medical Association regards this extension of medical socialism as inevitable and wants to be early in the field, so that the change shall be, as far as possible, on lines acceptable to the medical profession."

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The wealthy old lady was very ill and sent for her lawyer to make her will. "I wish to explain to you," she said, weakly, "about disposing of my property." The lawyer was sympathetic. "There, don't worry about it," he said, soothingly; "just leave it to me." "Oh, well," said the old lady, resignedly, "I suppose I might as well. You'll get it anyway."

## The Story of Anaesthesia

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SOME months ago, more than we like to say, Dr. J. J. MacRitchie of Goldboro sent the BULLETIN a clipping from the Montreal *Standard*, giving an abstract of a lecture delivered at the Mechanics Institute, Montreal, on *Anaesthesia* by Dr. Wesley Bourne of McGill. This was at a time when considerable publicity had been given to several deaths resulting from or at the time of the administration of an anaesthetic. After all these months, the writer has finally made the time to present some of the material in such a form as may be used by medical men in addressing clubs, institutes or other bodies who can offer no resistance to an invited speaker. In order to give Doctor Bourne due credit we will use some quotation marks, but we will call our literary effort,—*The Story of Anaesthesia*,—so our staid scientific confreres need not waste their valuable time in giving it reading attention.

We believe that to-day, more than ever before, both the medical and dental professions are endeavouring to make safe the giving of anaesthetics to their patients. Certain we are that the publicity given to deaths from or during anaesthesia has resulted in creating a demand by the public that the anaesthetist should be a specialist in this particular field. Another lesson learned is that a special examination of every patient should be made before an operation is arranged.

Doctor Bourne intimated that Divinity sanctioned Anaesthesia when He caused a "deep sleep" to fall upon Adam for the painless excision of a rib. (For particulars see The Bible, Book 1,—Genesis, Chapter II and verse 21).

"Time out of mind man has sought means to assuage human pain and suffering, and, it is probable that primitive man produced anaesthesia by compression of the large blood vessels of the neck, which is done to-day by some aboriginal peoples, and was the practice of the ancient Assyrians before performing the operation of circumcision. Curiously enough the liberal translation of the Greek and Russian terms for the carotid is 'the artery of sleep.' At the dawn of civilization (more than 3000 years before Christ), pressure applied to an arm or a leg was practiced, as is shown by Egyptian carvings illustrating the method.

"Cuneiform inscriptions show that nepenthes or sedative draughts made from Indian hemp, the juice of the poppy, mandragora, and other drugs were used to cause drowsiness before a surgical operation. The 'sorrow-easing drug' mentioned in the fourth book of the 'Odyssey,' as given by Helen to Ulysses and his comrades, probably consisted of such substances. It is stated that she learned of them from an Egypt-

ian queen. 'The wine of the condemned', spoken of by the prophet Amos, was likely a preparation from these materials given on a sponge, such as was offered to Jesus before he was nailed to the Cross. Pliny relates that the Egyptians applied to painful wounds powder Memphis stone moistened with wine, which is the first record we have of local anaesthesia with carbon dioxide gas.

"The most important of the ancient anaesthetic agents was mandragora, about which a voluminous mythology arose. The actions of this were due to the presence of chemicals which are now known to be atropine, scopolamine and others which do definitely produce sleep and alleviate pain. The Chinese, the Babylonians, Egyptians, Hebrews, Arabians, Greeks and Romans used mandragora extensively. It is believed that an evil spirit dwelt in the plant; for, when uprooted, it was said to utter such frightful shrieks that no mortal man might hear them and live. To prevent this catastrophe, it was usual 'to gather ye mandragora at dead of night and take a dogge or other animal and tye hym wyth a corde unto ye plante. Loose ye earth round about ye roote, then leave hym, for in hys struggles to free hymself he wyll teare up ye roote, whych by its dreadful cryes wyll kyll ye animal.' All sorts of rites and ceremonies were performed in connection with the preparations of this plant and their uses. Dioscoridies (100 A. D.) was the first to recognize the distinct anaesthetic properties of this drug. Since which time very frequent mention is made of its employment by the physicians of most countries. Writers and poets of mediaeval romance in more than one instance allude to anaesthesia produced by drugs, notably Boccaccio in the story of Dionius and Shakespeare in *Romeo and Juliet*.

"Very few advances were made in the knowledge of anaesthesia over that of 3,000 years B. C. until the middle of the 19th century, although there have been attempts to introduce hypnotism, intoxication, compression of nerves and arteries, bleeding to the point of fainting and freezing with carbon dioxide, ice with salt and ether sprays.

"Thus from the dawn of creation anaesthesia for surgical operations had been practiced to some extent, but owing to the uncertainty of the potency and action of the powerful narcotics and palliatives administered, and the danger attending their use when exact science was unknown, the practice seemed likely to fall into oblivion. At last a series of brilliant discoveries in chemistry created a new epoch in the history of anaesthesia. In 1772 Joseph Priestly discovered nitrous oxide and other gases. Soon after Dr. Thomas Beddoes founded and endowed the Pneumatic Institute at Clifton, England, for the treatment of disease by the inhalation of various gases.

"While Sir Humphrey Davy worked at this place he found that nitrous oxide produced insensibility to pain and recommended that it be used during surgical operations. He allowed his friend Southey the poet to inhale some, who wrote the following to his brother: 'Oh

Tom! such a gas has Davy discovered! Oh Tom! I have had some. It made me laugh and tingle in every toe and finger-tip. It makes one strong and so happy! so gloriously happy! Oh excellent gas bag! Tom, I am sure the air in heaven must be this wonder-working gas of delight.' Thus it is that we have the expression 'laughing gas.'

"Faraday pointed out in 1818 that the inhalation of ether vapour produced similar effects to those caused by nitrous oxide. It is an extraordinary fact that, even in the face of such experiments as these, no one ventured further. For thirty-nine years these substances were used for experimental purposes, and even for amusements, without a realization of the great blessing to humanity that lay almost within grasp. Although Dr. Hickman (1800-1829) a country practitioner in England, worked both with carbon dioxide and nitrous oxide. The ridicule he received at home and the failure of his demonstrations in France so discouraged him that he died in poverty while still a young man."

It appears strange that the employment of ether as an anaesthetic was so long delayed, being first so used by Dr. Crawford W. Long of Georgia in 1842; then by Horace Wells a dentist of Hartford, Conn., in 1844, but his demonstration in Boston in 1844 was a failure. Then William T. Morton, a dentist, and Dr. C. T. Jackson, both of Boston, gave a successful demonstration in 1846. To Dr. Oliver Wendell Holmes falls the credit of introducing the terms Anaesthesia, Anaesthetic and Anaesthetist.

James Young Simpson introduced the use of chloroform for obstetrics in 1847. It is interesting to note that in March, 1848, chloroform was made by J. D. B. Fraser of Pictou, Nova Scotia, and successfully administered in Halifax. Perhaps few of our present generation are aware of this latter incident in the history of Anaesthesia.

Now here as elsewhere the giving of Anaesthetics is a specialty and every hospital, however small, should have at least one attending physician well qualified to give the same or competent to supervise its administration.

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S. L. W.

**Ages in Childhood.** In former days we spoke of the several ages of man from the cradle to the grave. The Bostonian youth has several age periods all at the same time according to the opinion of a Halifax lady visitor recently to that intellectual centre. This lady says she inquired of a somewhat mature appearing young lad, the son of her hostess, "How old are you?" "That is a difficult question," answered the young Boston lad, removing his spectacles and wiping them reflectively. "The latest personal survey available shows my psychological age to be twelve, my moral age four, my anatomical age seven, and my physiological age six. I suppose, however, that you refer to my chronological age, which is eight. That is so old-fashioned that I seldom think of it any more."

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## Health Publicity Committee

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**F**OR several years the Medical Society of Nova Scotia has appointed two or more committees each year to do something along health lines. For a time there was only the Public Health Committee, then there was added the Cancer Committee, then a Health Publicity Committee that in time absorbed the Cancer Committee, then Tuberculosis Advisory and recently others, all with quite well understood duties along the general lines of the health education of the people. On several occasions the chairman of one or two of these committees would really prepare a report about something that was not done but had been in mind. For two or three years a struggle has been made to add another to this list of paper committees and this year a Committee was named that of Historical Medicine. Strange to say, however, this Committee seemed to take its appointment seriously and has proceeded to action, the nature of its work will be announced to the readers of the BULLETIN as soon as possible.

But there is another Committee that has not functioned for a couple of years, namely the Health Publicity Committee, whose duty is to aid in getting information on health matters to the attention of the general public. We speak so glibly of the "General Public," especially in articles of this nature that one is tempted to abbreviate the term, but initials would be too suggestive, so we will use the word *public*, meaning all those who need knowledge on health subjects. As the newspapers are devoting a lot of space these days to all questions, relating to health and the work of the medical profession in research and prevention of disease, their readers are those whom we must address.

The modern newspaper is not wholly devoted to murders, auto fatalities, infractions of the old N. S. T. Act and continued bootlegging under Government Control, or to boat races or ball games or racketeer shooting. It has caused considerable remark as to the amount of publicity given in recent months to meetings of medical or surgical conventions, to the work of the American College of Surgeons, and many accounts of hospital meetings and articles on hospital administration. Then the health articles of more or less value are found in every paper, both dailies and weeklies. At the present time these articles may be of considerable value; with the passing of the McCoy material they can do little harm if they are appreciated in their true sense. They are not intended, primarily, to cure or prescribe for each individual, neither for one person or his ailment, but to give sufficient information to all persons that will enable them to use good common sense in caring for their bodies and in the prevention of disabling conditions. These articles now published in Nova Scotia lack one feature that can only be supplied by the Department of Health or the Medical Society of Nova Scotia. There should be very definite effort to have furnished promptly reliable information on all health matters that are of vital interest at the moment. When an epidemic is possible, or is present, is the time to give sound and sane information to the public. Nor do we believe that the newspapers would seek to make a charge for such articles if the service was general and efficient.

We always read at least two daily papers besides those published in the City of Halifax and it is wonderful the space these papers give to these subjects. One of these is usually an eight page paper of eight columns, usual width and length. Probably one-half the entire paper is given to advertising, notices and plate illustrated material, the remaining thirty-two columns are for straight news and reading matter. To our very great surprise we noted that fully six columns of space was filled with health material, such as,—Standardized Hospitals; Medical Education; the recent Congress of the American College of Surgeons; That Body of Yours; besides nearly a column and a half giving editorial prominence under the broad heading of—*Human Salvage*.

Surely the lesson is obvious, papers print what the people want to read or they will not buy or subscribe. It is quite plain that the burden of supplying the Press with this reading material rests upon the medical profession. The Society has always recognized this, hence its Committee. But the Society has never formulated the ways and means by which this object may be accomplished. Is it not time that an effort was made to have this phase of Medical Society work show some results. It is quite safe to assume that the Society will endorse the work of the Committee if they can see any effort to accomplish anything. Perhaps the wise course would be for the Committee to find out if any one has a plan for carrying out this necessary service in Nova Scotia.

S. L. W.

## THE CANCER PROBLEM

**I**N general, it may be stated that there are so many phases of the Cancer Question that the BULLETIN should possibly present something on the subject in every issue. Perhaps this would be the best way in which the official Journal of the Medical Society of Nova Scotia can best contribute to the campaign.

The importance or value of what is written on the subject depends largely upon the viewpoint of the reader. The same may be said of the speaker before a medical society or a mixed audience. There are two chief parties most vitally interested in this matter,—the doctor and the patient, and all educational propaganda must be directed to both parties. If we try to impress the public with the need of consulting the doctor upon the first sign of any physical abnormality, one would expect the consultant to be thoroughly conversant in recognizing the early stages of cancer.

At a recent conference of doctors at Johns Hopkins University, Baltimore, it was found that many were unable to interpret the X-ray pictures of cancerous bones. Doubtless, this inability is not confined to plates relating to cancer. One feels like suggesting that possibly the very excellent X-ray outfits in small hospitals are not of as much value as the public is apt to believe. Be that as it may, where a Cancer Clinic is established, the photograph may be mailed to the Clinic and an expert reading given, *without charge if necessary*.

But at this same conference it was brought out that there has been a monopoly in the manufacture of X-ray tubes that has resulted in almost prohibitive prices and has checked improvements by filing away useful patents that might have been of great service to humanity, especially in the field of the treatment of cancer by a more effective X-ray radiation. In this connection Dr. Ernst of St. Louis, president of the new Radiological Institute, boldly makes this charge and says:—

“There is no question but that the X-ray tubes can be materially improved and made more powerful. We now produce X-rays of from 6,000 to 250,000 volts and, if we went to 400,000 volts, we could get practically radium rays from an X-ray tube. We know results would be better. But we cannot go that high, for we lack the tubes to stand it, and so far no one has dared to tackle their development because of the patent monopoly.”

If this is a correct statement of the situation it would appear that there is an economic matter here to be quickly dealt with and that drastically, if necessary.

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THE BANTING MEDICAL INSTITUTE

**S**ELDOME is it the lot of a young man to attend the opening of an institution that may be termed his own Memorial. But, with the opening in Toronto recently of the Banting Medical Institute as

a part of Toronto University, Dr. Frederick G. Banting had this unusual experience. It was Lord Moynihan who said, on this occasion,—"His memorial is the gratitude in the hearts of millions of people (diabetics) who owe their lives to Dr. Banting. Am I not right, when I add, he wears with becoming humility the crown of immortality."

The weekly magazine *Time* then adds:—"Throughout the long day Professor Banting said scarcely a word. He may have been thinking, as many of his lauders were, of his sudden flight to prestige. Dates best mark that progress:—1919. Returned from the War, wounded, with a military cross, expert in surgery. 1921, Persuaded a great teacher, Dr. MacLeod, that he was on the verge of isolating pancreas hormone which promised to be the best treatment for diabetes. He needed laboratory facilities and opportunities for clinical experiment. Professor MacLeod secured him a lectureship in Pharmacology at the University of Toronto (pay \$1,000 yearly). For pocket money Dr. Banting cut out tonsils. 1922, Insulin was announced as the specific treatment for diabetes. 1923, Professor of Medical Research (Toronto); Nobel Prize (jointly with Professor MacLeod)."

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#### Moist Heat.

There never has been a time in the history of medicine when it was not apparent to the observant that the application of heat to local inflammatory conditions was not only beneficial to the disease process itself, but comforting to the patient. Modern scientific investigation has fully proved that at least one of the effects of moist heat to the skin is to induce hyperemia and reduce fever and inflammation by the action of fresh blood brought to the affected area.

This is only one of the reasons why Antiphlogistine is so effective in the treatment of sinusitis, bronchitis, otitis media, cholecystitis and other inflammatory affections. It forms an impermeable and protective covering as well and induces a heating effect which is sedative to pain and is most grateful. Antiphlogistine may be employed as an adjuvant to any physiotherapeutic heat-producing method and more than thirty-five years of successful applications have confirmed its value in all congestive and inflammatory conditions. Samples and literature may be obtained from The Denver Chemical Mfg. Co., 163 Varick St., New York, N. Y.

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**Cat and Dog Life.** Perhaps you have heard this before, but the New Glasgow *Evening News* gives it recent publicity:—

"The late Lord Balfour, who, as is well known, was a confirmed bachelor, was once sitting in the drawing room of a friend who was happily married. Before them on the hearth rug were a cat and dog lying together. Said the friend: "Why do people speak of a cat-and-dog life? See how happy these are." Lord Balfour paused for a moment, smiled and then said: "Tie them together."



## Notes and Comments

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### Attention of Senior Students and Recent Graduates.

The Council of the British Medical Association proposes to award in March, 1931, the prize of £25 for the best essay attempting to "describe and discuss cases illustrating the modern methods of diagnosis of early pulmonary tuberculosis." The essay must be written by a final year medical student for registered medical practitioner of not more than one year's standing; either of whom must be studying or must have studied at one of the medical schools in the British Empire outside the British Isles. The essay must reach the medical secretary, British Medical Association House, Tavistock Square, London, W. C. I., not later than January 12th, 1931.

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**The Latest.** What is the difference between castor oil and gin? Ask your nearest movie and talkie fan.

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The School of Medicine of Dalhousie University is, perhaps, the largest of the 8 or 10 different faculties, having 183 students out of a total of some 950 registered. A recent visitor to the city, a teacher in Medicine of Toronto University, expressed the opinion that the facilities offered to medical students and the conveniences for clinical teaching were unsurpassed by any University in Canada. It is well to bear in mind that the Medical School is such an important factor in the great work that the University is doing for Nova Scotia education.

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We never could understand why medical men have been so silent on the baneful effects of the wearing of high heeled shoes. It remains for a foreign visitor to make a comment on the subject and it goes the rounds of the country as a matter of news. Much of the income of chiropractors, osteopaths, posturists, and many faddists is due to disabilities caused or aggravated by the ungainly practice of wearing these unnatural shoes and slippers. Perhaps medical opposition would be futile when the doctor cannot tell his own daughters what they shall wear with any assurance of being obeyed.

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It would appear that a properly equipped Cancer Clinic will shortly be established in Toronto, being sponsored by the Provincial Government. There is one feature of work of this kind being carried on by the government that has its weaknesses, the tendency of many to, as far as possible, evade their proper financial obligations. We still lack the moral courage to make people pay what they can afford. We are the greatest sponsors of this *beating the game* custom of all members of Society.

*Dr. Collectum* writes the BULLETIN,—“Thanks very much for that very kindly little reference to the Association on page 518 of the September issue of the Nova Scotia Medical Bulletin. Your article suggests a course of procedure for which widows for years to come will have reason to thank you, Doctor Walker.” This helps a Business Editor in his lonely role and we wish some members of the Society would occasionally *do likewise*.

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**The Homewood Sanitarium** has distributed to the profession in Nova Scotia a new booklet giving considerable information about this very excellent institution located at Guelph, Ontario. The Medical staff consists of the Superintendent, Dr. Harvey Clare and three medical associates. Dr. Clare was Medical Director of the Reception Hospital for Mental Diseases, Toronto, 1914-1919 and, for the next three years, Director of all the Ontario hospitals for mental diseases. His three associates, Doctors Baugh, McKinnon and Cross are all war veterans. It is satisfactory to note that treatment is not marred by the exploiting of fads or the following of machine routine. Each patient is studied and treated individually. The institution is beautifully situated in the midst of forty acres of lawns and fields, of flowers and trees, just across the river from the City of Guelph.

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**The Prevention of Pneumonia.** Pneumonia may often be prevented by treating promptly and energetically any attack of bronchitis and grippe.

Pneumonia is easier to prevent than to cure. Notwithstanding the satisfactory results generally obtained by modern therapeutics, the mortality is still high, in spite of all our progress.

In a great number of cases pneumonia is a sequel to bronchitis, to an attack of grippe or even to a slight infection of the upper respiratory tract. It has been demonstrated that it is difficult for the pneumococcus to invade the normal bronchial and alveolar mucosae, but should resistance be weakened, following an attack of bronchitis or grippe, a pneumococcus invasion may cause pneumonia.

By eliminating the congestion, by stimulating the superficial circulation, by favoring phagocytosis and by establishing a normal circulation in the bronchi and alveoli, the use of prolonged moist heat in the form of Antiphlogistine will assist in preventing the pneumonia, which may follow an attack of bronchitis or grippe. (Denver Chem. Co.).

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**Brucella Abortus.** Experimental evidence obtained by several investigators indicates that complete, carefully supervised pasteurization (143 to 145 F. for 30 minutes) will kill organisms of the *Brucella* group.

## The Winnipeg Convention

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Conjoint meeting of the British Medical Association and the Canadian Medical Association, August, 1930.

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**H**AD I realized how difficult it would be to report comprehensively, within reasonable space, on the Winnipeg Meeting, I would have been much less ready to comply with the request to review the proceedings for the BULLETIN. Now I can only deplore my inability to give an adequate report and submit what follows as evidence of a desire to make good my promise.

Much of the work of the Council of the Canadian Medical Association had been disposed of before I reached Winnipeg, but the reports of the various committees had been printed and from these one could gather some conception of the time and consideration given to the matters which had been referred to these committees. Several prolonged sessions of Council were devoted to the reports, and, as might be expected, diverse opinions were expressed and there were a number of keen debates. Dr. Primrose again demonstrated his skill and tact as chairman and, without restricting debate, kept the discussions well in hand.

The Executive Committee reported that an invitation had been received to hold the 1931 meeting in Vancouver, and that it was proposed to hold the 1932 meeting in Toronto at a time favourable to the organization of a post-convention tour to England, which would permit of attendance at the centenary meeting of the British Medical Association. A few changes in constitution and by-laws were suggested for the purpose of more clearly defining the duties of committees. The Health Education Department, financed for a year (\$6,000.00) by the Canadian Life Insurance Officers' Association, had accomplished much and a continuation of the subsidy was hoped for. The Periodic Health Examination Department, which came into being at the beginning of the present calendar year, had made definite progress to which reference will be made later. The Sun Life Assurance Company had renewed its appropriation of \$30,000.00 for extra-mural post-graduate work, which means the continuation of this activity for at least another year. The establishment of the Royal College of Physicians and Surgeons of Canada had been effected (November 20th, 1929). The Association had been admitted to membership in the Association Professionnelle Internationale de Medecins. Those appointed to represent our Association at a conference of voluntary health organizations held at Ottawa last November, reported it to be so worth while as to be worthy of repetition at appropriate intervals.

Notable among the accomplishments of the Department of Hospital Service was the successful negotiation of an arrangement with the Federal Government for the removal of duties on many articles required by hospitals, which promises an annual saving to Canadian hospitals amounting to some hundreds of thousands of dollars. The American Medical Association has suggested that this Department relieve it of the investigation of Canadian Hospitals which wish to be approved for internship.

The Committee on Public Health reported the preparation and publication of many articles for the public press and a weekly broadcast as part of the programme of the C. N. R. transcontinental hour. Nearly 1,500 letters had been received asking advice and had been suitably answered. A very full memorandum on Health Insurance, prepared by Dr. Fleming, was presented as an addendum to the report. As some of the Western Provinces are likely to adopt health insurance very soon, and interest in the matter is extending eastward, Dr. Fleming's memorandum should be read by every member of the profession. It will doubtless appear in an early number of the Journal.

The report presented by Dr. H. H. Murphy, on behalf of the Department of Periodic Health Examinations, showed that, in the few months of the Department's activities, nearly 1,300 requests for examinations had been received. An arrangement with several Canadian Life Insurance Companies has led to the establishment of this Department. A particular feature of the scheme is that the examination is made by the physician chosen by the policy holder—not by a Life Extension Institute official. The doctor's report is not seen by the Insurance Company concerned, so the interest of the policy holder is in no way jeopardized. The insurance companies expect to profit by prolongation of lives of their policy holders. It is hoped that the fee allowed the doctor for each examination (\$4.00) may soon be increased. The experience of the Department thus far is that about two-thirds of those examined needed either treatment or advice.  
*Verb. sap.*

The Post-Graduate Committee reported continued activity, a larger number of doctors having been reached by the lecturers than in any previous year. It is noted that Nova Scotia benefited in this scheme to the extent of 39 addresses given by 16 speakers to audiences which totalled 3,211.

For the calendar year 1929 the Association was the recipient of \$48,600.00 from various Canadian Life Insurance Companies, which was used in promoting the activities above noted. The ordinary revenue from membership fees, sale of advertising space in the Journal, etc., amounted to \$70,798.73. In addition, the Association is charged with the administration of Trust Funds (Lister Memorial, Osler Memorial, Blackader Lectureship, etc.) which at the end of 1929 amounted to \$28,881.90. It is evident therefore, that the administration of the financial affairs of the Association is in itself no small

matter. That this administration is good is very satisfactorily shown by one item in the balance sheet—Balance 31st December, 1929, \$38,349.60. It is scarcely more than ten years since we worried much over the state of the finances. The present happy situation and the confidence with which we now face the future is due to the devotion and sacrifice of the small group responsible for the excellent organization which has been effected.

Very encouraging reports were made by both the Editor and the Managing Editor of the Journal. Under Dr. Nicholl's guidance it continues to worthily represent the Canadian Profession. It may be said incidentally that at a luncheon, tendered by Dr. Ross Mitchell of the Editorial Board for Manitoba, the Editors of the British Medical Journal and the Journal of the American Medical Association both spoke of our Journal as one which has attained a foremost place among the leading medical journals of the world. It was, in part, in recognition of his splendid work on behalf of the Journal that Dr. Blackader was made Canadian Vice-President of this year's meeting of the British Medical Association.

The Committee on Medical Education had concerned itself mainly with a study of means of realizing one of the two purposes for which the Association was organized—"The establishment of a Central Board of Examiners, before which all candidates for license to practice medicine in the Dominion of Canada shall be examined." Its report indicated that the provincial medical councils were not unanimously in favour of making the Medical Council of Canada the only portal of entry by examination into all the provinces. A previous report had shown general willingness of the Universities to co-operate in a plan which would permit of diploma and license being secured by one examination. The Committee recommended that the Association should use its influence in every possible way to bring about the accomplishment of this objective, suggesting the adoption of a method somewhat similar to the British arrangement. In the debate initiated by the presentation of this report representatives of the Medical Council of Canada expressed the opinion that the proposed change could not be effected without amending the Federal and each of the Provincial Medical Acts, and they questioned the possibility of securing satisfactory amendments. Other speakers considered that no changes in the Act are necessary. The report of the Intra-Canadian Relations Committee, which was being discussed at the same time, recommended that the Association "refrain from any active step to interfere with the present systems of licensure." After much talk the latter recommendation was withdrawn and the report of the Committee on Medical Education adopted.

Attention was drawn by the Committee on Economics to the tendency to make general hospitals supported by public funds more open to all practitioners, and to the matter of Health Insurance. Speaking of British Columbia it was said that "there is a widespread

agreement among all classes that some system of Health Insurance is necessary, and it is more than probable that the next report of the Commission will have some definite recommendations. . . . It would seem advisable that in some way every medical man in Canada should be apprised of the stage proceedings have reached and the conclusions come to by the British Columbia Medical Association, which has been most closely connected with this, in order that the profession may be a united body with certain main principles that they would support and on which they would insist before allowing the profession to become a party to any system of Health Insurance. These principles are few and simple, and are, it is believed, for the benefit of the community as a whole equally with the medical profession."

The Study Committee on Nursing reported progress and submitted an interim statement by Prof. Wier, who is directing the survey of Nursing Education in Canada, which is being fostered jointly by the Canadian Medical Association and the Canadian Nurses Association. Prof. Wier expects to be able to submit his report about the end of next March.

The report of the Committee on Medical Services in Canada reviewed briefly the Proceedings of the Third Conference held at Ottawa in November last, and recommended that the Committee be continued as a standing committee empowered to arrange for future conferences.

The Committee on Pharmacy reported review of some material to be included in a proposed Hospital Formulary, particularly insofar as it overlaps work in hand by a committee which is preparing a Canadian Formulary that promises to be very useful to physicians. The appointment of a new Pharmacologist to the Federal Department of Health promises more rapid progress in the standardization of medicinal agents.

The Mariners' Committee reported success in their effort to persuade the Department of Pensions and National Health to provide fees for required specialist services and for a remuneration in a set schedule of fees. This Committee still presses for the uniform adoption of a separate contract for medical and surgical services as the renewal of existing hospital contracts will permit.

The Committee on Maternal Welfare has collected a large amount of information which is in the hands of the Association and available to interested persons. The Committee urges that members of the profession should assist all lay organizations in their efforts to educate the public in regard to maternal welfare. It recommended that the Post-Graduate Committee endeavour to arrange at least one meeting annually for each provincial and local medical society to be devoted to maternal welfare. It reaffirmed the necessity of giving every expectant mother adequate pre-natal care, and recommended that the Hospital Department be asked to submit to next year's meeting of Council a report on provincial inspection of maternity homes, lying-in homes and obstetrical departments of general hospitals.

It was very gratifying to learn from the report of the Committee on the Royal College of Surgeons of England that the first attempt to carry on the primary fellowship examination in Canada had resulted so successfully. Thus the efforts of several years to obtain this privilege for Canadians have been rewarded. Twenty-three candidates entered the examinations and nine were successful—the proportion of successful ones being higher than usual. As a second examination was held this year, early in September, it may be felt that this examination in Canada has been permanently established.

The report of the Osler Memorial Committee expressed disappointment that there has not been more general subscription to the fund. Edmonton is held up as an example of what can be done; eighty of the eighty-five practitioners of that city have subscribed. It is again suggested that each local medical society should specify one meeting day each year as Osler Day. The sum required for the proper establishment of the Osler Oration has not yet been secured and no progress has been made towards Osler Fellowships subscribed to by the profession. It is worth noting, however, that Mr. J. W. McConnel of Montreal, has donated \$6,000.00 to the Association, the interest on which is to be made available every third year to allow of special study to the student recommended by McGill University; and a like amount has been donated by a group of Governors of the Montreal General Hospital—the candidate, in this case, to be nominated by the medical board of the hospital. The Blackader Lectureship fund has nearly reached the objective set by the Association.

An outstanding report was that on a Medical Survey of Canada, undertaken by Dr. Harvey Agnew at the direction of Council. Based on 1400 complete replies to questionnaires this is a most interesting analysis of the conditions under which Canadian doctors carry on their practices. Only a few of the generalizations can be referred to. The average summer radius of the Nova Scotia doctor's practice is 11 miles; the average winter radius is 12 miles. Doctors resident in Nova Scotia towns average a radius both summer and winter of 8 miles; while for village doctors the average radius is 16 miles both summer and winter. These figures refer to ordinary practice. Of all Canadian doctors in practice 20% are over fifty years of age and 26% are not above thirty-five years old. In Canada there are 97 doctors to every 100,000 of population as compared with 127 in the United States and 24 in Mexico. In Canada 13.4% of doctors complain that they are not making a fair living. In Nova Scotia 14% make this complaint, while in New Brunswick only 5% are unhappy on this account. Besides such analyses the report deals with specialization, consultant service, hospital accommodation, laboratory and X-ray facilities, medical education and a variety of other interesting matters.

It is hoped that even so sketchy a summary may serve to give some indication of the way in which our national Association is endeavouring to deal with problems that associate with medical practice, and to

impress on those who are not of its membership, and who, consequently, will not see the full reports in the Journal, the value of the Association to the whole profession. When so much is being done with a comparatively restricted membership, what could be accomplished if every physician in Canada allied himself with the Association?

The meeting of the British Medical Association cannot be described properly in the space available in the BULLETIN. It was indeed a wonderful meeting. The arrangements made by the Winnipeg physicians were most complete and must have entailed months of arduous planning and preparation. Provision was made for the most varied entertainment, with special programmes for the ladies and juveniles.

The first day, August 26th, was mostly given over to formal functions. In the morning the retiring President, Professor A. G. Burgess, inducted the new President, Dr. W. Harvey Smith of Winnipeg, at a very picturesque and stately ceremony. The platform was filled with gaily gowned notables, and many of those on the floor of the auditorium were also gowned. After a number of interesting investitures, introduction of new Vice-Presidents (Dr. A. D. Blackader of Montreal and Sir Ewen MacLean of Cardiff), introduction of new Honorary Members and of delegates from Branches in various parts of the Empire and from foreign medical associations, the Presidential Address was delivered. This session was not only colourful, but was conducted with such vigour, precision and impressiveness as to win much approval.

In the afternoon the annual religious ceremony was held. This, too, was most impressive. The members, in academic costume, marched to the grounds of the Legislative Buildings, where the service was held in the open air. The Primate of Canada conducted the service, the Lesson (St. Luke vii, 1-10) being read by Dr. Harvey Smith. In the evening the President and Mrs. Smith held an enormous reception at the Legislative Building.

On each of the four mornings clinics were given at an early hour by eminent members of the Association. Beginning at ten o'clock on each, except the first, morning, the various sections (thirteen of them) carried on for about three hours. Then there were luncheons to attend. At two o'clock each day clinical addresses were given in the large auditorium of the Winter Club which were attended by the profession, while there were public addresses each evening. At these sessions the speakers were from Britain, but the chair was always occupied by a Canadian. The last evening meeting, at which Lord Moynihan delivered the Listerian Oration, was presided over by our own greatly loved Dr. John Stewart.

One of the outstanding features was an Indian Pageant. Seventy-five braves of the Plain Crees, with their families and ponies, had been brought in from their Reserve, and were encamped in 22 tepees on the prairie a few miles out from Winnipeg. At this pageant, where feathers and war paint were much in evidence, Lord Dawson of Penn was



formally inducted as a Chief of the Plain Crees. Chief Red Dog, son of a Chief and grandson of a Chief, according to his own proud declaration, had heard winter before last winter that the Great White Chief was on his death bed with his son at his side, but a great doctor had saved him. As Lord Dawson was the great doctor he admitted him as a Chief of his Tribe and named him *Chief Muskikiwiwiniw Kitchi Okimaw*, which may be translated freely as Big Medicine Man of the Great White Chief. Lord Dawson looked every inch a chief in the Cree toggery, and expressed much delight in his beautiful new name. Following this installation, Premier Bennett presented to the President-Elect of the British Medical Association, Dr. W. G. Willoughby, a magnificent buffalo head, saying that there had occurred recently in this country an upheaval which had prevented the gentleman who had conceived the idea from making the presentation—but that he had nevertheless picked out a very fine head which it was now Mr. Bennett's privilege to present. The head will adorn the Common Room of the Association's house in London.

There was much private entertainment and Winnipeg folk vied with one another in making the stay of the visiting physicians pleasant and profitable. Overseas visitors expressed themselves as overwhelmed with courtesies, and one confessed that he had barely been able to stagger from one city to another since he had landed in Canada. It was no small undertaking to arrange for such a large meeting, and our Winnipeg brethren are to be warmly congratulated on the splendid success which attended their efforts.

W. H. H.

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**Frightening People to Life.** This was a plea of Lord Moynihan in a recent address to the Canadian Club at Montreal. He was impressing upon his audience the need to heed the first warnings of Cancer. Now Lord Moynihan can speak this way, but let an acquaintance or confrere of mine or yours thus talk out in meeting and we knock or ignore him. Queer, isn't it? Not so queer; it is rather a state of mind peculiar to us, geographical or racial, and it is time we people of the Maritimes snapped out of it. Play the Game, Heads up.

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**Women Physicians.** Apropos of a recent article in the BULLETIN on Co-education in Medicine, it is noted that 5% of the total number of physicians in Germany are women, in all 2,562. These are chiefly located in cities only two or three practising in rural districts and this number is quite unlikely to increase. For the next few years the woman dentist has possibly better professional prospects than the woman physician.

# Department of the Public Health

## PROVINCE OF NOVA SCOTIA

### PROVINCIAL HEALTH OFFICER

DR. T. IVES BYRNE - - - - - Halifax.

### SPECIAL DEPARTMENTS

Tuberculosis	- - - - -	DR. P. S. CAMPBELL	- -	Halifax.
		DR. C. M. BAYNE	- -	Sydney.
Pathologist	- - - - -	DR. D. J. MACKENZIE	- -	Halifax.
Psychiatrist	- - - - -	DR. CLYDE MARSHALL	- -	Halifax.
Supt. Nursing Service	- - - - -	MISS M. E. MACKENZIE, R.N.	- -	Halifax.

### MEDICAL HEALTH OFFICERS ASSOCIATION

President	- - - - -	DR. W. F. MACKINNON	- -	Antigonish.
1st Vice-Pres.	- - - - -	DR. T. R. JOHNSON	- -	Great Village.
2nd Vice-Pres.	- - - - -	DR. M. J. WARDROPE	- -	Springhill.

### COUNCIL

DR. A. C. GUTHRO	- - - - -	Little Bras d'Or.
DR. A. E. BLACKETT	- - - - -	New Glasgow.
DR. F. E. RICE	- - - - -	Sandy Cove.

### MEDICAL HEALTH OFFICERS FOR CITIES, TOWNS AND COUNTIES

#### ANNAPOLIS COUNTY

Armstrong, M. E., Bridgetown.  
Braine, L. B. W., Annapolis Royal.  
Kelley, H. E., Middleton (Town and Co.).

#### ANTIGONISH COUNTY

Cameron, J. J., Antigonish (County).  
MacKinnon, W. F., Antigonish.

#### CAPE BRETON COUNTY

Tompkins, M. G., Dominion.  
Gouthro, A. C., Little Bras d'Or.  
(C. B. Co.).  
Poirier, G. J., New Waterford.  
MacKeough, W. T., Sydney Mines.  
McLean, J. A., Glace Bay.  
McLeod, J. K., Sydney.

O'Neill, F., Louisburg.  
Murray, R. L., North Sydney.

#### COLCHESTER COUNTY

Dunbar, W. R., Truro.  
Havey, H. B., Stewiacke.  
Johnson, T. R., Great Village (County).

#### CUMBERLAND COUNTY

Bliss, G. C. W., Amherst.  
Drury, D., Maccan (County).  
Gilroy, J. R., Oxford.  
MacKenzie, M. D., Parrsboro.  
Rockwell, W., River Hebert, (M. H. O.  
for Joggins).  
Withrow, R. R., Springhill.

**DIGBY COUNTY**

DuVernet, E., Digby.  
 Rice, F. E., Sandy Cove (County).  
 Belleveau, P. E., Meteghan (Clare Mcpy).

**GUYSBORO COUNTY**

Brean, J. S., Mulgrave.  
 Elliott, H. C. S., Guysboro (County).  
 McGarry, P. A., Canso.  
 Stone, O. R., Sherbrooke (St. Mary's Mcpy.).

**HALIFAX COUNTY**

Almon, W. B., Halifax, N. S.  
 Forrest, W. D., Halifax (County).  
 Payzant, H. A., Dartmouth.

**HANTS COUNTY**

Bissett, E. E., Windsor.  
 MacLellan, R. A., Rawdon Gold Mines,  
 (East Hants Mcpy.).  
 Reid, J. W., Windsor, (West Hants Mcpy.).  
 Shankel, F. R., Windsor, (Hantsport M. H. O.).

**INVERNESS COUNTY**

Chisholm, A. N., Port Hawkesbury.  
 McNeil, A. J., Mabou (County).  
 Ratchford, H. A., Inverness.

**KINGS COUNTY**

MacKinnon, H., Berwick.  
 Bishop, B. S., Kentville.  
 Burns, A. S., Kentville (County).  
 DeWitt, C. E. A., Wolfville.

**LUNENBURG COUNTY**

Davis, F. R., Bridgewater (County).  
 Donkin, C. A., Bridgewater.  
 Morrison, L. N., Mahone Bay.  
 Zinck, R. C., Lunenburg.  
 Zwicker, D. W. N., Chester (Chester Mcpy.).

**PICTOU COUNTY**

Blackett, A. E., New Glasgow.  
 Day, F. B., Thorburn (County).  
 MacKenzie, S. G., Westville.  
 Stramberg, C. W., Trenton.  
 Dunn, G. A., Pictou.  
 Whitman, G. W., Stellarton.

**QUEENS COUNTY**

Ford, T. R., Liverpool (Town and Co.).

**RICHMOND COUNTY**

LeBlanc, B. A., Arichat.

**SHELBURNE COUNTY**

Hatfield, G. M., Clark's Harbor.  
 Churchill, L. P., Shelburne (County).  
 Fuller, L. O., Shelburne.  
 Densmore, J. D., Port Clyde, (Barrington Mcpy.).

**VICTORIA COUNTY**

MacMillan, C. L., Baddeck.

**YARMOUTH COUNTY**

Blackadar, R. L., Port Maitland. (Yar. Co.).  
 Lebbetter, T., Yarmouth (Wedgeport M. H. O. and Town Yarmouth).  
 Siddall, A. M., Pubnico, (Argyle Mcpy.)

**INFORMATION**

The Provincial Public Health Laboratory provides free diagnostic services for the entire Province. It is, however, to be regretted that misunderstanding exists among physicians as to the scope of this work. Roughly speaking, free examinations are made of blood, cerebrospinal fluid, cultures, smears for gonococci, sputum, urine, faeces, pleural fluids, pus, water, milk, brain tissues for rabies, as well as throat, ear and prostatic swabs. Physicians desiring this service should address their communications to, Dr. D. J. MacKenzie, Public Health Laboratory, Pathological Institute, Morris Street, Halifax.

Physicians desiring serums and vaccines should address their communications to the Provincial Health Officer, Halifax, N. S.

### POLIOMYELITIS.

In a recent issue of the *Canadian Journal of Public Health*, appeared a paper entitled "A Clinical study of Poliomyelitis" by Dr. George A. Campbell and Dr. Samuel Mirsky of Ottawa. With respect of diagnosis the authors have this to say:

"The diagnosis in the pre-paralytic stage can be made clinically in well-marked cases which present the clinical picture described above. No sign or symptom, however, is pathognomonic.

Spinal fluid examination is usually helpful in the diagnosis, but renders no aid in differentiating poliomyelitis from encephalitis. The spinal fluid findings are as follows:

**Appearance**—Clear to faint ground glass and rarely turbid (depending on number of cells).

**Cells**—50 to 2,000; average 150-300. A pleocytosis of fifty per cent. multilobed cells on the first day changing rapidly to a ninety per cent mononucleosis is pathognomonic. The cell count must be made at the bedside as cytolysis of the cells rapidly occurs.

**Globulin**—considerably increased.

**Pressure**—elevated at first.

**Sugar**—Benedict's solution gives a normal reduction.

**Culture**—Sterile.

"The Welsback Mantle," so characteristic of the fluid in tuberculosis meningitis is usually absent.

The cerebrospinal fluid is normal in the abortive case and during the first febrile disturbance of the dromedary type. There is usually a leucocytosis of 15,000 to 30,000.

#### Differential Diagnosis.

A. **Before the Onset of Paralysis**—Since poliomyelitis is considered a systemic disease, early symptoms of any acute infection may simulate it. In the epidemic in Ottawa in 1929, cases of pneumococcus meningitis, cerebrospinal meningitis, pneumonitis, pyelitis, typhoid fever, otitis media, scarlet fever, rheumatic fever were suspected of being poliomyelitis. No difficulty was encountered, however, after routine, physical and laboratory examinations were made, in differentiating these diseases from poliomyelitis.

Tuberculous and syphilitic meningitis may require differentiation. Encephalitis is often confused with poliomyelitis. Encephalitis is characterized by marked drowsiness while poliomyelitis may be associated with drowsiness but this is never so profound, and the patient is quite alert when roused. The subsequent course makes the diagnosis evident.

The bulbar type of the disease with its initial febrile disturbance followed by hoarseness, dysphonia and dysphagia may present a picture of laryngeal diphtheria, hydrophobia or tetanus.

A culture of the throat in the former and the history in the latter will aid in the diagnosis.

A large group of cases that recover without paralysis, who have low spinal fluid counts and who present all the symptoms of acute poliomyelitis, are looked upon as "Abortive" cases.

Doubt often arises as to whether these cases are poliomyelitis. An absolute answer in the affirmative cannot be made. It seems quite reasonable, however, to accept them as such during the epidemic, since these cases occurred suddenly with cases that did develop paralysis and their incidence disappeared as rapidly when the epidemic subsided. If these "abortive" cases are not poliomyelitis we should have to assume that epidemics of two diseases, poliomyelitis and some other acute disease, occurred together. Such an assumption does not seem logical.

From experience in recent epidemics on this continent one may conclude that every febrile disturbance in children accompanied by headache, stiffness of the neck and spine, with gastro-intestinal symptoms, during the late summer months, should be suspected of being poliomyelitis. It may also be concluded that such a disturbance after the middle of November, in the temperate climate, is with equal probability not poliomyelitis.

**B. After the Onset of Paralysis**—Pain in the limb or diminished reflexes often precede the onset of paralysis. Muscle weakness may be detected at this stage by comparing both sides.

The detection of paresis is sometimes difficult, particularly if movement of the limb is painful. Under such circumstances one must keep in mind the possibility of other conditions which might prevent a child from moving its limb. Trauma, tuberculosis of a joint, osteomyelitis, rheumatic fever, rickets and scurvy have been mistaken for poliomyelitis.

The presence of flaccid paralysis following an acute febrile disturbance with meningismus and spinal fluid findings as described above is usually at once diagnosed as poliomyelitis. However, a flaccid paralysis may occur following diphtheria, in multiple neuritis myelitis, obstetrical injury and hysteria. The differentiation is a neurological problem and will not be dealt with here. Facial paralysis as a result of poliomyelitis must be distinguished from Bell's palsy, or involvement of the facial nerve as a result of mumps or middle-ear disease."

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**Public Health at Exhibitions.** Experience has shown that Exhibitions are of very considerable value in the matter of general education of our people as to our community resources and their utilization. We have heard the comment that there was nothing to gain from the public health standpoint in having a part in these annual functions at various points throughout the Province. This is an attitude quite foolish for any medical man or health worker to assume

and, moreover, it withholds due credit from those persons to whom the education of the people in health matters has been entrusted. In Nova Scotia we have entirely too much criticism and not enough co-operation.

The object of this paragraph was, however, to compliment Miss Margaret MacKenzie of the Provincial Department of Health upon the impression made upon the public by the Public Health Booth at the recent exhibition in Sydney. A half column report in the Sydney *Post* by a very discerning staff reporter is evidence that this work of Miss MacKenzie was appreciated, at least by those for whom it was made. Infant mortality, maternal mortality, the milk supply, the use of milk as a food and other kindred matters, were well illustrated in the booth by posters and much literature was distributed. The general health of the community will be improved only to the extent that the public learn what they must do to secure it. Then we repeat that it is incumbent upon the medical profession to aid in every possible manner all efforts towards this end, even in such little matters as have been indicated.

S. L. W.

Cases Reported by Medical Health Officers from Week Ending  
Sept. 10 to Oct. 15, 1930.

Disease	Sept. 10	Sept. 24	Oct. 1	Oct. 8	Oct. 15	Totals
Cerebro-Spinal Meningitis.....	2	1	....	....	....	3
Chickenpox.....	....	....	2	....	....	2
Diphtheria.....	4	6	4	11	11	36
Infantile Paralysis.....	1	....	4	6	5	16
Influenza.....	....	7	....	....	....	7
Lethargic Encephalitis.....	....	....	....	....	....	....
Measles.....	....	....	....	....	3	3
Mumps.....	6	....	....	....	1	7
Paratyphoid.....	....	....	....	....	....	....
Pneumonia.....	....	1	....	1	1	3
Scarlet Fever.....	17	5	25	11	14	72
Smallpox.....	....	....	....	....	....	....
Typhoid Fever.....	....	....	2	3	1	6
Tuberculosis-Pulmonary.....	....	3	....	2	2	7
Tuberculosis—Other Forms.....	....	1	....	....	....	1
V. D. G.....	....	6	4	2	2	14
V. D. S.....	1	....	2	1	....	4
Whooping Cough.....	5	7	3	6	....	21
Totals.....	36	37	46	43	40	202

**Errata.** In the October BULLETIN, page 559, last line, for the word "Blood" please read "Serum". This was a typographical error as all doctors would at once recognize.

**Brucella Abortus in Certified Milk.** A study has recently been made of certified milk supplied to the City of Detroit as to the presence of *Br. Abortus*. The only raw milk supplied by is five dairies. Milk from each dairy was examined and two only were given a clean sheet. 61 samples from one dairy gave 7 positives or 11.4%; 55 samples from the second dairy gave 1 positive and 40 from a third dairy gave 2 positives. The highest number of organisms found were 8 per cc. and the average for the 10 positive samples was 2 per cc. *Current Health Literature* then concludes,

"As a result of this investigation, all animals in these herds giving a positive agglutination with their milk of *Br. Abortus* were weeded out. A practical deduction from these tests proves that certified milk may be an active cause of the appearance in the human consumer of undulant fever, and lends emphasis to the arguments of many public health authorities for the pasteurization of *all* raw milk, particularly when eradication of infected cows in a herd is impracticable." (Federal Department of Health).

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**Country Clinics.** It is a matter of congratulation in our Health Work in Nova Scotia to note the many health clinics that are held from time to time in various towns and villages in addition to Government tuberculosis and Red Cross Crippled Children Clinics. Dr. D. F. McInnis of Shubenacadie with Dr. J. B. Reid of Truro, recently held a Tonsil Clinic at the Indian Residential School.

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**Want Operations.** An Austrian Professor in Diseases of the ear, nose and throat, recently commented on the tendency on the part of surgeons and the public to desire operation wherever possible. He says,—“And the American people all seem to want operations. It seems to be a fad with them. I don't believe there is a tonsil left in America, and an appendix would not feel at home in a man's body.” We do not believe the Canadian doctors cater at all to this frailty of the laity.

(This little comment was based upon a note in *Treatment*, a pamphlet issued by Rougiere, Freres of Montreal).

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**Old Medical Schools.** The Atlantic portion of the United States has a number of Medical Schools that have passed the Century Mark. The University of Pennsylvania, 163 years; Harvard University, 146 years; University of Maryland, 122 years; Columbia University, 121 years; Yale University, 104 years, also Jefferson; then the even century is reached by the Medical College of the State of South Carolina, by the University of Virginia and the University of Georgia.

## Hospital Service

### What About Brick Bats?

(From Hospital Management)

**H**OSPITAL administrators as well as saints should try to reach that degree in grace where they will not be flattered by a compliment or depressed by a criticism. A compliment is valuable to us when it brings to our attention some of the best features of our hospital administration and activities and causes us to continue to improve upon what has already been accomplished.

A criticism is valuable if it causes the hospital administration to inquire into the cause of the criticism and if the criticism is found to be just to immediately endeavor to correct the evil.

There is probably no institution more liable and more subject to criticism than a hospital. There are reasons for this. First, most hospitals are supported in whole or in part by taxation or public benevolence. The taxpayer or the voluntary contributor feels that he has the right to express his opinion and even make requirements of the institution he assists in supporting. Second, the patrons of a hospital are sick people or relatives of the sick. Sick people are often nervous, irritable and very hard to please, and sometimes the same is true of near relatives who are under the strain of suspense and anxiety. Sometimes such patients or their relatives, under the stress and strain, may point out to us a defect in our hospital which kind friends or more considerate patrons would have never called to our attention. Then sometimes such patrons, under the stress of suffering, of suspense and anxiety complain unceasingly and criticize unjustly the doctors, the nurses, the procedure and the institution that are bringing them back from sickness to health, from death to life. These complaints and criticisms we must accept with patience and forbearance.

Hospitals are judged and criticized from various angles. The good housewife judges the hospital by its housekeeping and culinary efficiency. The business man judges the hospital by its record of profits and losses. The doctor judges the hospital by its ability to meet his requirements in equipment and services. The patient and his friends judge the hospital by the courtesy, the kindness and the service given them. To secure the approval of the fastidious housewife who is a frequent visitor and of the thorough going business man who may be a member of the governing board and the efficient exacting doctor of the staff and all our patients and friends who come to us representing every phase of society, every variety of temperament and disposition is a task that might have caused Solomon with all his wisdom to pause and consider seriously.



No hospital will ever reach that degree of perfection in organization, in administration, in operation, where it will not be criticized. . .

Blessed is the man who can show us our defects and failures in our endeavor to develop and operate our hospitals and thrice blessed the man who can show us how to remedy those defects and failures.

The most exalted motive that can actuate us in our endeavours to perfect our hospital administration and operation is that we may give the best possible care and service to the sick. Until this consummation is reached let our friends and those who are not our friends continue nagging us by way of criticism.

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## Hospital Notes

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The wedding took place at Pictou, September 16th, of Miss Margaret M. Millman, V.O. Nurse in Pictou for the past three years, to Mr. G. M. Adamson of the old Shire town. After a motor trip to the bride's former home in London, Ont., the couple returned to and will reside in Pictou.

Miss Cora D. Harlow of Milton, Queens Co., a graduate nurse of the Nova Scotia Hospital, in recent years nursing in a private hospital in Liverpool, was married September 16th to Mr. W. R. MacDonald of Liverpool.

Nursing Sister Hubley, formerly of Cogswell Street Military Hospital, Halifax, now in London, Ont., spent a short vacation in September visiting her many friends in Halifax who were all delighted to see her looking so well.

The Payzant Memorial Hospital, Windsor, selects the week of the County Exhibition as Hospital Week with a drive for funds. The time selected is wise for this hospital caters very largely to the County rural districts. When, however, we see so many hospitals compelled to make drives, we are wondering if it is not time we were considering the question of municipal administration and maintainance. It is a community affair, why not have the community make themselves pay for it?

People of Kentville and vicinity were pleased to learn that Miss Dorothy Bluhm, V.O.N., who went on vacation August 1st and was unfortunately taken ill on reaching her home in Owen Sound, has fully regained her health. Miss McDonald of New Glasgow has been appointed in her place in view of the resignation of Miss Bluhm.

Western King's Memorial Hospital held graduating exercises October 2, 1930. The Superintendent, Miss Foster, administered the Nurses' Pledge; Mr. R. T. Caldwell, M.L.A., presented their diplomas, and Miss Hazel Ray, President of the Hospital Aid presented them with their pins. Dr. Atlee was the guest of the evening and spoke very entertainingly, drawing from the story of the origin of the Tales of the Arabian Nights, that Nurses should attend to the mental variations of patients. He urged the nurses to develop an interesting, courageous personality by training their minds and to bring cheer and courage into the sick room. This pleasant function was held in the local theatre. The graduates were:—Miss G. Troop of Belle Isle; Miss Strong of Berwick; Miss Cameron of West River, Pictou; Miss Sarsfield of Bridgetown.

From a communication addressed "To the Public" we conclude that Kings Memorial Hospital has financial difficulties like nearly all similar institutions. The Hospital Executive make this appeal:—

"The financial record you will note, shows a large amount of outstanding accounts. We do not think that any hospital can continue to run under the handicap of such a credit system. We are most anxious to make the hospital terms to our patrons as generous as it is possible. We know of no hospital that is running a lower rate. But your board feels that it is absolutely necessary that the present system of charging accounts must cease, and on the beginning of the new hospital year, October 1st, all accounts of \$5.00 and under must be paid in cash before leaving the hospital, and larger accounts must either be paid in cash, or, if this is impossible, settlement must be made by note approved by the Executive. . . . It should not be necessary for the Hospital to depend upon the Hospital Bazaar to pay its bills because patients have failed to pay up their accounts. . . . With fine patriotism and enthusiasm you have built this hospital, will you not see that it gets fair play in having its bills paid promptly?"

**Qualifications of Nurses.** More than 4,000 physicians recently replied to a questionnaire sent out by a committee on the grading of nursing schools, as to what qualifications a nurse should have; 65% of these physicians replied "skill in general care" was the requisite of a good nurse; 65% wanted one that could make the patient comfortable; 45% wanted one skilful in observing and reporting symptoms; 43% preferred a nurse careful in following medical orders; 34% said good breeding and attractive personality come first; 30% skill in handling people; 28% skill in asepsis; 27% familiarity with hospital routine; 21% familiarity with their personal methods; 15% ability to work under a heavy strain; 15% familiarity with a particular disease; 3% said she should be able to take care of the family and 3% that she should be a

mother's helper and houseworker. The study shows that the demand for practical nurses is dropping. Nine out of ten physicians reported that they were getting the nurses they wanted. The surgeons were the group most satisfied. (*Journal of the A. M. A.*)

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**Unemployment.** They say that in Oshawa, Ontario, the nurses are doing their part to lessen the business depression, by reducing their fees. For 12-hour duty the rate will now be \$5.00 per day, while for 20-hour duty the rate will be \$6.00 per day.

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**The Word "Hospital".** The word "Hospital" comes from *hospes* meaning a *guest*, having the same origins those charming words *hospitable* and *hospitality*. This means that the patient is a guest, not a case or a specimen, nor anything else but the object of whole-hearted hospitality, by hospitable and kindly hospital folk. *Host* is a kindred word, so every hospital worker is a host or hostess to every patient in the hospital. The spirit among workers in our hospitals must be the best if we are going to get and maintain good hospital morale.

(*Bey Barrington in the Sydney Post.*)

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Five student nurses recently completed their training at Saint Rita's Hospital, Sydney. The exercises began with a solemn and impressive celebration of High Mass in the beautifully decorated chapel. This was followed by a noon luncheon tendered by former graduates, an afternoon reception, a banquet at 6 p. m., and the presentation of pins and diplomas in the evening.

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Ten nurses were graduated from the training school of St. Martha's Hospital, Sept. 25, 1930. A number of the Clergy were present and took part in the speech making. Dr. J. J. Cameron gave the address to the graduates and distributed the prizes. Dr. W. F. McKinnon administered the Nurses' Pledge and Mr. D. C. Sinclair, president of the Aberdeen Hospital Board, gave the final address. Two of the prizes were donated by Dr. J. L. McIsaac. The valedictory was delivered by Miss Muriel McLeod of Truro, who was also awarded a degree from St. Francis Xavier University.

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The following hospitals in Nova Scotia were represented at the last conference of the Catholic Hospital Association:—Halifax Infirmary, Halifax; Lourdes Sanatorium, Lourdes, N. S.; Hamilton

Memorial Hospital, North Sydney; St. Rita Hospital, Sydney; St. Joseph's Hospital, Glace Bay; St. Mary's Hospital, Inverness; St. Martha's Hospital, Antigonish.

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The annual meeting of the New Brunswick Association of Registered Nurses was held at Bathurst, Sept. 9-10, 1930. In addition to routine business a number of addresses were given by members of the medical profession.

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The *Glace Bay Gazette* states,—“L. D. Currie, President of the Nova Scotia and P. E. I. Medical Association, left this morning by motor for Antigonish, to attend a meeting of the Executive of the Association.” For “Medical” read “Hospital” and at that Mr. Currie and his associates had many matters of importance to consider.

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Recently, another Royal Commission has been investigating in Ontario the entire field of what is generally understood as included in the term Public Welfare. The findings have been startling and we hope to make some references to the subject in an early issue of the BULLETIN. We note that one of the first results, and apparently they get results quickly in Ontario, is the appointment of a Director of Hospitals for that province. It might be well for us in Nova Scotia to watch carefully what happens in the premier province, there may be some lessons we need to learn.

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The BULLETIN notes that at the recent meeting of the Executive of the Hospital Association, the subject of the training of nurses in various hospitals was considered. It appears somewhat anomalous that it is proposed to place these training schools under the jurisdiction of the Department of Education. By a similar process of reasoning would it be desirable that Schools of Law and Medicine should also be placed under this Department? The BULLETIN invites an expression of opinion.

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**Virginia Medical Monthly.** Last month we mentioned the visit of a former Nova Scotia practitioner to his home province, Dr. H. G. Grant of Richmond, Virginia. In return for the BULLETIN he has sent us the September number of the *Virginia Medical Monthly*, which contains an article by Dr. Grant on “Diphtheria Control” of which we will make some reference at another time. Also in view of the hard times, unemployment and the high cost of living we propose to give another instalment of the relation of the public to the physician based upon an article by a Norfolk surgeon, published in the same number of this journal.

## Correspondence

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### The Dalhousie Refresher Course.

To the Editor,  
THE BULLETIN

Dear Sir:—

When submitting my imperfect report of the proceedings of the last Annual Refresher Course, I was led to make some introductory and concluding remarks, with here and there what appeared to me as pertinent comments, which, I am willing to admit, made the report a little top heavy. I was therefore not surprised when you asked me to present this portion of my report as a separate communication.

In complying with your request I must insist upon being regarded as a wholly unprejudiced observer, but intensely interested in what concerns the medical profession in Nova Scotia. My knowledge of local matters is but recently acquired but it has followed several years of observation and study in hospitals, colleges and laboratories in America, Great Britain and on the Continent. So much for my own introduction.

As intimated in my report it will always be to the credit of the staff of the Medical School of Dalhousie University, that ten years ago the necessity of a post-graduate refresher course for the great majority of the medical men in Nova Scotia was recognized, and steps taken to meet the situation. It is somewhat strange that post-graduate education, even in the largest medical centres, has but seldom been put on a practical basis for any considerable number of post-graduate students, until very recent years. The initiative displayed by Dalhousie in meeting this acknowledged need is rather remarkable, anticipating, as it has, similar procedure by larger universities.

The BULLETIN reporter was pleased to note a fairly large attendance and almost a record registration.

There is, nevertheless, a disposition on the part of many medical men in Halifax, as well as throughout the province, to entirely ignore this annual event especially staged for their benefit. It takes on the average 10 years for a doctor in general practice in Nova Scotia to put away enough money to pull up stakes and take a year's post-graduate. Generally, however, by that time he is so tied up by family ties that he cannot get away and so he sinks deeper into the rut, until it is too late, because the desire for knowledge has left him. This attitude of indifference is the hardest to overcome and the question may well be asked,—what steps are the Refresher Course Committee taking to increase general interest in these clinics and lectures?

In the first place the time to begin arranging for the next course is immediately upon or before the close of the current event. It takes

at least a year of nagging and reiteration to get Nova Scotia medical men sufficiently provoked to start talking or even to start knocking. In spite of this after every clinic lecturer has recited his little piece or given his little show, he retires to rest, knowing a Committee, some time during the dog days of summer, will send out the warning call for another continuous performance.

It may be presumptuous for a mere reporter to make any suggestions but when, such a one is also responsible to no one, he may venture to offer a few remarks.

Presumably the Committee, which must be congratulated upon the excellent fare furnished by the 1930 course, are having a meeting to check up their work preparatory to the usual hibernation. We hope they will review the recent session to ascertain possible defects, failures or omissions (if any such are in evidence), in the hope of avoiding the same next year. Then they should confer at least once each month all winter to study out how this is to be accomplished. Hitherto by the time the next event is staged, previous errors have been forgotten and are very apt to be repeated.

If there is one danger more than another to be avoided it is the deadly one of monotony. Because one session is very successful is no reason why it should be blindly copied in every succeeding session. Variety in methods and material should be featured. As no two days' work of a doctor is the same, the field, in which he appreciates a refresher course, is almost boundless in extent.

As regards the clinical features of this course, little variety is introduced, save as to the days upon which clinics are to be held, but all clinical teachers must be included. Why not lessen the number of clinicians and give them an opportunity to work out a more complete resume of material in their special field by a second or third clinic. If one of the imported lecturers is a prominent surgeon let him have both clinics and lectures on all four days of the course. Local surgical clinicians might to considerable extent give larger way to specialists, not only eye, ear, nose and throat, but the urologist, the skin man, the neurologist, even the psychiatrist, and above all the apostles of preventive medicine. Perhaps one of the visitors would be a prominent internist let him then conduct clinics and lecture on all four days.

Again one is tempted to inquire just what is Dalhousie doing along the lines of Preventive Medicine, which is what will be the greatest part of the work of two-thirds of the profession within a very few years. The Refresher Course appears to be somewhat weak along this line.

Again, why not have two or three evening meetings to which interested persons and allied organizations might be privileged to attend and take some part in the programme. Then should there not be a Dalhousie Dinner or some such distinctively University function during this week.

Why are not senior medical students compelled to attend these Clinics and Lectures?

Think it over.

X. Y.

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Guysboro, N. S., October 4th 1930

Dear Dr. Walker:—

Yours of the 1st received and I have thought over it carefully. I do not know when the first act was passed regulating the practice of medicine, but it was before my time. My great uncle, Dr. Avery was one of the very early M. D's., in Halifax making his calls on horse back. He also started the first drug store. Surgeons from the army, I think, did most of the very earliest practice in Halifax.

I, of course, knew many of the old doctors in this and Antigonish counties, but personal history is not what you want. Obstetrics was in the hands of midwives, so called, who never had any training. Bone setters in every settlement. The number of quacks was appalling. The wives of farmers laid in a stock of herbs every fall and were really skillful in managing all minor ailments. In one settlement poultices of fine clay were used in all cases where Antiphlogestine is now used and with excellent effect. In another place stewed earth worms were used as an application to stiff joints, but people were not all fools.

Dr. Jost has prepared a paper such as you want, but I do not know whether it covered the whole Province or only this county. He would not bother with it now. I think I have all the numbers of the *Maritime Medical News*, if of any service, but I believe you already have these. I have no old records and do not know where any would be available.

I had hoped to go to the Eastern Med. Society, at Antigonish, this month, where I would have seen two or three of the Committee, but I am still too much of a cripple to run any risks (from intracapsular fracture of hip).

If I can give any information about old doctors, in this county, I will gladly do it if that is wanted. The Committee have not an easy job on their hands.

With kindest regards

Yours very truly,

G. E. BUCKLEY.

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Dear Doctor:—

When Irradiated Ergosterol was placed before the medical profession a little over a year ago by various firms manufacturing under license from the Wisconsin Alumni Research Foundation, many

jumped to the conclusion that it was literally cod liver oil by the drop. This belief became rather widespread in the minds of the laity and many members of the medical profession as well, although numerous warnings were published from various authorities.

Increased emphasis has been placed on Vitamin A as a factor of great importance systemically and a marked inclination has developed to place Irradiated Ergosterol in its proper category as a specific in the treatment of rickets, tetany and osteomalacia rather than to use it as a substitute for cod liver oil.

Our advertisements and literature to the medical profession have consistently urged the wider use of Cod Liver Oil excepting in cases where Irradiated Ergosterol are specifically indicated and we believe this attitude has been fully warranted.

We are direct licensees in Canada for the manufacture and sale of Irradiated Ergosterol preparations and have no ulterior reason for discouraging its use, but we believe that many of your readers would be interested in a direct statement from you along the above lines. The adoption of increased standards of strength by the Wisconsin Foundation would indicate that a more extensive dosage will be employed from now henceforth and as this substance is rather well known to the public as an easy way of obtaining cod liver oil nourishment, it is only fair to them that this idea should be discouraged by their medical advisors.

Very sincerely yours,  
AYERST, MCKENNA & HARRISON LIMITED.

Dear Doctor:—

In angina pectoris and in other vascular diseases where it is desired to lower arterial pressure Erythrol Tetranitrate Merck is the remedy of choice.

Its action is more enduring than that of the nitrites and there is not the tendency to the establishment of a tolerance. Its better keeping qualities is no small advantage.

Erythrol Tetranitrate Merck is supplied as  $\frac{1}{2}$ -grain tablets in tubes of 24 and bottles of 100 and as  $\frac{1}{4}$ -grain tablets in bottles of 50.

The remedy is worthy of a trial.

Very truly yours,  
MERCK & Co., LIMITED.

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**Thanks The Bulletin.** A little pamphlet issued by the Medical Audit Association was inspired by a short paragraph in a recent number of the BULLETIN see page 518. That Association wrote and said so. Have you, dear reader, ever done so? If not, why not? We all like a little appreciation.



## Branch Societies

### HALIFAX BRANCH

**T**HE opening meeting of the Halifax Branch of the Medical Society of Nova Scotia was held at the Lord Nelson Hotel on Wednesday, October 15, 1930 at 8.00 p. m. The programme for the coming season is announced as follows:—

#### PROGRAMME—1930-31.

1930

- Oct. 15th.** Opening Meeting: Dinner at Lord Nelson Hotel at 8.00 p. m.; Presidential Address.
- Oct. 29th.** Clinical Meeting—Surgical; Victoria General Hospital.
- Nov. 12th.** Clinical Meeting—Nova Scotia Hospital.
- Nov. 26th.** "Recent Advances in the Bio-chemistry and Pharmacology of the Internal Secretions"; Dr. Young, Professor of Bio-chemistry and Dr. Dreyer, Professor of Pharmacology, Dalhousie University.
- Dec. 10th.** Clinical Meeting: Children's Hospital.

1931

- Jan. 14th.** "Some Problems of a Subscription Practice;" Dr. A. Calder, Glace Bay.
- Jan. 28th.** Clinical Meeting—Grace Maternity Hospital.
- Feb. 11th.** Dr. Mainland, Professor of Anatomy, Dalhousie University. Subject to be announced.
- Feb. 25th.** "Some Phases of Metabolism." Dr. Harry O'Brien and Dr. Clyde Holland, Halifax.
- Mar. 11th.** Pathological Meeting: Pathological Laboratory.
- Mar. 25th.** Subject and Speaker to be announced.
- April 8th.** Clinical Meeting: Medical; Victoria General Hospital.
- April 22nd.** Annual Meeting. Place of meeting to be announced.

Meetings will be held at the Dalhousie Clinic except where otherwise stated. Hour of Meeting,—8.30 p. m.

#### Officers

President . . . . .	Dr. W. L. Muir.
Vice-President . . . . .	Dr. F. G. Mack.
Sec'y-Treas. . . . .	Dr. N. H. Gosse.

## EASTERN COUNTIES MEDICAL SOCIETY

The following is the Programme of the Ninth Annual Meeting of the Eastern Counties Medical Society. It was held at Antigonish, October 14th, 1930, all the sessions being held at St. Martha's Hospital:—

## Programme

Tuesday, Oct. 14th, 1930.

1. 30 p. m.—Meeting to Order.  
Reading and Confirmation of Minutes.
1. 45 p. m.—Reading of Communications.
2. 00 p. m.—Paper. "Surgical Common Sense", Hon. G. H. Murphy, M.D., Halifax.
3. 00 p. m.—Paper. "Treatment of the Delayed Case of Labor," Dr. H. B. Atlee, Halifax.
4. 00 p. m.—Paper. "Treatment with Vaccines," Dr. Ralph E. Smith, Professor of Pathology, Dalhousie University, Halifax.
5. 00 p. m.—General Business.
6. 00 p. m.—Annual Dinner. St. Martha's Hospital.
7. 45 p. m.—Presidential Address. Dr. R. F. MacDonald, Antigonish.
8. 30 p. m.—Unfinished business.

Adjournment.

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We regularly read the Gaelic articles in the Antigonish *Casket*, and at times in the Glace Bay *Gazette*, so feel justified in asking these Journals to explain this newspaper item that had its start at Loma Linda, California, where there is a Sanitarium of very good standing, and which was noticed by the Journal of the A. M. A. in a recent issue, in the expectation of getting a reasonably acceptable explanation of an apparent phenomenal event:—

"When little Marie Skotnicki suddenly began to talk in a strange tongue, her parents called in a physician. That gentleman informed them that the child was speaking pure Gaelic. Marie had never been away from home or talked with anyone of foreign tongue. The only explanation offered is that she inherited the tongue from a grandfather, who died several years before she was born."

The same Journal also notes this incident:—

"A conscientious physician was called by a distressed mother, her child having swallowed fifty cents. The child having no symptoms at the time, the doctor suggested that the child be given a light diet and a purgative. The next morning the doctor called.

"How is the baby, madam?"

"Fine, doctor, but I have seen no change yet!"

## Bulletin Library

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### THE DALHOUSIE REVIEW.

NO publication coming to the desk of The Nova Scotia Medical Society BULLETIN is more welcome than this matchless Quarterly *Review* of Dalhousie, the October number of which is before us. The reading of Dr. Hattie's contribution on the distinguished French gentleman, whose early services the Pharmaceutical Association recently honored, was so pleasing to us that it is herewith quoted so that our readers may have the same pleasure. It is, moreover, a distinct contribution to the medical history of this province. We feel sure that the Review Publishing Company and Doctor Hattie will make no objection to its appearance in the BULLETIN.

### Canada's First Apothecary.

W. H. Hattie

Through a narrow gap in the North Mountain range, the tides of Fundy squeeze their way to form the singularly beautiful expanse of water known to us as Annapolis Basin. There is a measure of poetry in this name, but none in that which designates the portal—Digby Gut. One may now pass through this portal any day, in great comfort, to enjoy the varied delights of the countryside which bounds the Basin. No such comfort attended the first white men who ventured through the Gut. Wearied by long and strenuous weeks in the small, buffeted craft in which they had dared the treachery of wind and wave, Demonts and his curiously assorted company effected that historic passage early in the summer of 1604. There were rogues and ne'er-do-wells in the party, men who had known of nothing but deprivation and hardship, and there were gentlemen of culture and refinement whose very names are a heritage of which Canadians will ever boast. Some may have been more appreciative than others of the glory that greeted them when Fundy's turbulence had been left behind, and they floated on the placid waters of the Basin, rimmed by densely wooded hills broken by alluring gorges into which the tides could still find a way. But there was unanimity in approval of the peaceful beauty that had become theirs, and of the promise of comfort and plenty so generously unfolded. What more fitting than that such a place should be called Port Royal?

Many wished to go no farther, but Demont's commission was to explore as much as possible of the New World, and he insisted upon pressing on. And so it came about that the winter was passed at St. Croix, where defence against the dreaded native would seemingly be

easy, but where a much more formidable and unexpected foe was to be encountered. That was three centuries before the importance or even the existence of vitamins had been suspected, and nearly half of the party, victims of scurvy, were buried at St. Croix before the snows disappeared.

Port Royal was often thought of during that miserable winter, and in 1605 those who had survived returned thither to establish the second permanent European settlement in the western hemisphere. The site selected for the colony was thought to be safe against enemy attack, but between the date of founding and 1750 it experienced twenty-four military encounters of greater or less magnitude, while on two occasions during the American war for independence it was again the scene of hostilities. In such an historic setting, known since 1710 as Annapolis Royal, early in August of this year, the Nova Scotia Pharmaceutical Society erected a tablet to the memory of Louis Hébert, who joined the Port Royal colony in 1606, and was the first apothecary to come to Canada.

On this side of the Atlantic we are accustomed to a rather narrow interpretation of the term "apothecary", and to regard it as almost synonymous with "pharmacist". The earliest apothecaries doubtless limited themselves to the compounding and sale of drugs, but as time passed they gradually extended their activities to include prescribing and other medical treatment. Apothecaries and apothecary-surgeons were by no means uncommon in both England and France long before the time of Hébert. A Guild of Apothecaries was formed in France in the thirteenth century, the Masters of which were entitled, in the following century, to wear long gowns with wide sleeves and velvet facings. While many of those who assumed the title were thorough-going rogues, there were others who were of excellent character, some were good chemists, and not a few of the regular clergy took pride in being known as apothecaries. Of Hébert's standing in the Guild we are not informed, but he was engaged, in succession to his father, in the business of apothecary in his native Paris before coming to Port Royal. In the little colony he took place with those who comprised the famous *Ordre de Bon Temps*. For a short time he was entrusted with the administration of the affairs of the colony. And L'Escarbot wrote: "Our apothecary, Master Louis Hébert, a man who, besides his experience in his art, taketh great delight in the tilling of the ground." His enthusiasm in this last particular, and the stimulus he gave to others to emulate him, gained for him the right to be known as Canada's first agriculturist.

It would appear that the apothecaries, even those contemporary with Hébert, were not universally popular. They charged high prices, and mankind has ever been fond of indulgence in medicine. Our forefathers submitted to nauseous drugs with as much complacency as to discomfort in general, and perhaps derived from them even more satisfaction than we of to-day. Possibly their habits engendered a

greater sense of need for such artificial aids than we experience. Apparently they resorted to them with more diligence and enthusiasm than we do, and while their choice was more restricted, they made generous use of the mighty mixtures that were available. The stimulus given to exploration by the discoveries of Columbus resulted in the introduction and exploitation of a large number of new remedies which were welcomed with much acclaim by those whose drug-appetites had become somewhat jaded, and this proved of no small advantage to the drug-dealers. There is a subtle attractiveness in anything of oriental origin, and drugs from the East had a singular lure for many a year before trade in them could be carried on easily. In the sixteenth century Holland controlled the carrying trade between the north and the south of Europe, while the Portuguese held the secret of the sea route to India. After the Dutch learned that secret, there was fierce fighting for the control of the drug trade. Even the clove was responsible for much bloodshed, and Motley tells us that "the world's destiny seemed to have become almost dependent upon the growth of a particular gillyflower." The English struggled to gain a foothold in the drug marts, but for long had to be content with the occasional capture of a drug-laden Dutch or Portuguese ship. In time they effected a treaty with the Dutch which enabled them to set up an establishment at Amboyna, where, in 1623, despite the treaty, the establishment was attacked and destroyed, and several British were killed. So the apothecaries were able to suggest reasons for their high prices, but we can fancy, nevertheless, that good Queen Bess was startled when presented with Hugo Margon's bill, for one quarter, amounting to £83.7s.8d.—the equivalent in purchasing power of at least \$2,500.00 in our money. Included in this bill were such items as "a confection made like a *manus Christi*, with bezoar stone and unicorn's horn, eleven shillings;" "a conserve of barberries, with preserved damascene plums, and other things for Mr. Raleigh, six shillings"; "a royal sweetmeat with incised rhubarb, sixteen pence."

Then there was widespread suspicion that strict honesty did not characterize all apothecaries, and that substitution of inferior for expensive drugs was not infrequent. The arduous young were too often disappointed by the ineffectiveness of love philters for which they were charged large sums. Sensitive folk complained of concoctions which surpassed the witches' brew of Macbeth's time in disgustingness. And some shops were apparently but poorly camouflaged brothels. Such things accounted for the unpopularity of the apothecaries with the laity. The regular physicians did not love them either. As long as the sale of drugs had been in the hands of the grocers, the physicians were content, and for a long time the apothecaries merely carried on a branch of the grocer's business. There was contentment, too, during a period in which the apothecary was the physician's adjutant, a period when Chaucer could write concerning his "Doctour":

Ful redy hadde he hise apothecaries  
To sende him drogges and his letuaries,  
For ech of hem made oother for to wynn.

But when the apothecaries ventured into competition with the physicians, friction began. The physicians generally had been satisfied with modest fees, and the contrast between their relative impecuniosity and the opulence of their less well trained rivals became increasingly perturbing. After protesting without avail, they tried what stipulation would do. Thus William Bulleyn (obit. 1576) laid down twenty-one rules, of which a few are quoted:

#### The Apoticarye.

1. Must fyrst serve God, forsee the end, be clenly, pity the poor.
2. Must not be suberned for money to hurt mankynde.
13. That he neither buy nor sel rotten drugges.
15. That he put not in quid pro quo without advyement.
17. That he meddle only in his own vocation.
19. That he do remember his office is only to be ye physician's cooke.

Stipulation also proved unavailing, and the "cookes" continued to flourish abundantly and to flaunt their success. In Germany, insult was added to injury when apothecary shops came to be imposing structures with facades ornamented by stone figures of great physicians of the past. Wealth, of course, brought influence, and, in the year that Hébert came to Canada, James I granted a charter of incorporation to the apothecaries of London. While this was not seriously opposed by the physicians, it proved to be a factor in developing a wrangle which eventuated, some eighty years afterwards, in the establishment by physicians of free dispensaries for the sick poor—thus originating a system which has developed to an extent quite beyond the expectation of its originators.

All this digression may be put to account as offering an explanation for Hébert's decision to leave his business in Paris for an adventure in the New World. He was accompanied by the apothecary-surgeon Daniel Hay, who is generally spoken of as Canada's pioneer physician—although the writer has contended that there is evidence that a medical man of some sort was attached to the party that spent the winter of 1604-5 at St. Croix. The medical needs of so small a colony of hardy men could not have been great, and it may be assumed that one medical man would have sufficed at all times except when a party was detached to exploration. It is recorded that Hébert dressed the hand of Pontgrave's son, injured by the discharge of a misdirected gun in a conflict with Indians, and that five years later he attended the Sagamo Membertou in his last illness, but he could not have had an active professional life at Port Royal, and we cannot believe that his migration was in the hope of enlarging his business. That he was a man of parts and refinement is indicated by his acceptance to close

fellowship with Poutrincourt, Pontgrave, L'Escarbot, Champlain, and the other choice spirits of the colony, by the influence he wielded and the trust shown in him. We may therefore feel that he belonged to the better class of the apothecaries, but that he had other and greater interests.

When the colony, "its fair distances and the largeness of it, the mountains and hills that environ it" (as lovingly described by L'Escarbot), had to be abandoned in 1607, Hébert returned to France, but he came back to aid its re-establishment in 1610. Three years afterwards Port Royal fell to Argall's expedition, and Hébert once more returned to Paris where he resumed business as an apothecary, to be later (1617) persuaded by Champlain to accompany him to Quebec. With him came his wife and three children, of whom his daughter, Anne, became the first bride to be led to the altar in Canada. At Quebec he busied himself at gardening, urged others to similar activity, entered heartily into the social life of the community, and because of such things was distinguished as the Patriarch of New France. After ten years of untiring industry in his new home, he met with injuries which resulted fatally. His widow and children continued the cultivation of the garden, and we read that in the stressful winter which preceded the capitulation of Quebec to Kirke, in 1629, the garden was ransacked of every root and seed that could afford nourishment. On surrendering to Kirke, according to Dionne, Champlain asked the English commander to "protect the chapel of Quebec, the convents, and the houses of the widow of Louis Hébert and of her son-in-law Guillaume Couillard." To this Kirke agreed readily, and invited Madame Hébert and her family to remain at Quebec to enjoy the fruits of their industry under British allegiance. A few other families also remained, and it was in the Hébert home that the first Mass was heard after Quebec was restored to the French by the treaty of St. Germain-en-Laye.

The city of Quebec has possessed a memorial to Hébert for several years. It is fitting that at last an appropriate tablet should be erected at the scene of his first activities on Canadian soil. And it is especially fitting that the tablet should be erected by members of the craft with which Hébert was associated, and that a large number of them, assembled from all parts of Canada, should make a pilgrimage to the site of the ancient colony to participate in the dedication ceremonies.

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#### DEPARTMENT OF LABOR

The Ninth Report on Organization in Industry, Commerce and the Professions in Canada has reached the BULLETIN desk. As all know, it is the official publication of the Federal Department of Labor. That portion of interest to the BULLETIN readers is very largely a Directory of professional Associations but has some interesting information as

to medical organizations. We learn that the number enrolled on the register of the Canadian Medical Council is 2,630. The licensing bodies in all the Provinces, excepting Nova Scotia, are called Councils or Colleges of Physicians and Surgeons, while those registered are known as members. For instance, the licensing body in P. E. I. is known as the Prince Edward Island College of Physicians and Surgeons and its membership numbers 62. On the other hand, this same body in Nova Scotia is called The Medical Council of Nova Scotia and its membership is 15. The figures for all the other provinces probably indicate the number registered in active practice and total 9,630, not including the 15 members from Nova Scotia.

Then further discrepancies are noted in the Society membership. For instance the Council registration in New Brunswick is 260 and the Medical Society membership is stated to be 286, but according to Belcher's Almanac, there are only 267 entitled to practice in that Province. Then, if in Nova Scotia we claim from 75 to 80 per cent. of our registration as members of the Medical Society of Nova Scotia, we must play a low rate compared with New Brunswick which is about 108 per cent. strong.

We think a Federal Government publication could at least make a better job of membership statistics of the medical profession. If the same discrepancies are to be found in the so-called information for other provinces, besides N. S. and N. B., it is likely to be found in the tabulated information of other professions; and why not also of various statistics of Industry and Commerce. The BULLETIN proposes to furnish this Department with correct information for future issues.

There is a further suggestion that may be made at this time and it comes from noting the double machinery in every province in connection with its administration of general medical affairs. Indeed, in some instances it takes four or five bodies to discharge these closely related activities. It is not as if there were an income attached, there being little more than an honorarium for very few, but it appears to be such a waste of energy, this multiplication of Boards, Councils, Societies, etc. But perhaps reform is on the way, already some of the medical men in the West are beginning to talk as if we were over *Societyized*, to coin a word.

S. L. W.

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**The September issue** of the BULLETIN of the Alumni Association of Western Ontario Medical School came duly to hand. It featured largely the next meeting of the London District Association which was later held at London on Saturday, October 11, 1930. The following gave a good day's programme:—

10.00 a. m. Surgical Clinic at Victoria Hospital, Dr. A. T. Bazin, Montreal.



- 12.30 p. m. Alumni Luncheon, Presidential Address and routine business.
- 3.00 p. m. Foot-ball, Western versus Queens, Little Memorial Stadium.
- 7.00 p. m. Dance and Buffet Supper, Convocation Hall.

When we read of functions and events at other institutions and medical schools we always compare them with our own, but in matters of this kind we are unable to give any news.

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**Jew versus Scot.** In a clothing store in Glace Bay recently, there was a special sale where \$5.00 bargains were marked \$4.99. Ikey and Rebecca, with Ikey Jr. took a suit that fitted Ikey Jr. "just like ze paper on ze wall," and the five dollar bill was handed over the counter. Ikey Sr. left at once, but Rebecca remained for the one cent change, when Ikey calls out,—“Come on Becky, come on woman, do you vant the people to tink we are Scotch?”

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Amherst, N. S.

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## PRINTER'S INK.

The BULLETIN has constantly noticed what the public press has said about the medical profession and about matters of health. We have had occasion to speak very highly of the press in Nova Scotia for its publicity in matters relating to the prevention of disease and the promotion of health. We have also had occasion for fault finding particularly regarding advertising of fake remedies. It remains, however, for a contributor to a Daily Newspaper (not published in Nova Scotia) to claim that *Printer's Ink*, "the essential liquor of democracy", has accomplished more for the welfare of the people than all other agencies combined.

This claim was not allowed to go unchallenged. The burden of the claim very largely minimized the work of the medical profession, but the protest did not come from the doctors. It was a weekly newspaper, *The Casket*, of Antigonish, that comes out with a stinging reply that should be read by some papers that are published in Nova Scotia. *The Casket* has always been noted for its constant support of all matters aiming to improve the community, industrially, intellectually, physically and morally. We quote part of this reply by *The Casket* in the form of quotations and comments:

"It is printer's ink that scared the food fakers."

We did not know that. Not, surely, the food fakers who are paying the press great sums of money to circulate their lies.

"Printer's ink has prevented more tuberculosis than all the doctors have cured."

Perhaps so; but it has induced poor and sick people to pay millions of dollars for utterly worthless medicines on the understanding that they would cure tuberculosis.

"It has spread right ideas of sanitation; upset old mildewed superstitions; opened windows; lured people outdoors; flooded fearsome brains with truth; and despairing hearts with hope."

This is a lot. Some of it is true. Most of it is nonsense. It has done a great deal to kill truth and faith, and to replace them with stupid superstitions; for example, the superstition of Godless evolution. It has advertised both good and evil with a strong preference for evil, because evil is easier to sell, and pays more into the journalistic treasury.

"It has built hospitals and supports them."

When you are making a claim there is nothing like claiming enough.

And so the writer goes on:

"Cholera and small pox were conquered by it. Malaria and yellow fever fly before it."

We wonder if it was the pursuit of yellow fever that made so much of the press output so yellow.

"It is well enough to give an individual epsom salts or calomel, but what the public needs for what ails it is plenty of printer's ink."

But what does it need for the after effects of the printer's ink?

"There is some value in the medical profession, but also a deal of hocus-pocus, as there is in everything that becomes professionalized. The best part of the science of medicine is the part which can be told in plain language so that the common man can understand. Every newspaper ought to have its health department."

Most newspapers have one. They sell space to every faker in the country to boost his quack remedies "guaranteed" to cure anything, from erysipelas to rupture; all quackery, and often known to the newspaper to be utterly worthless. They assist in every sort of exploitation of the suffering poor and they do it for a price.

"The more truth they know, the less drugs they will take."

Not if their favorite paper can make them believe that the useless and harmful drugs that rascals advertise in the press will cure them.

"The less they will run after religious cure-alls and crazy fads."

The only sort of cure-alls that are here objected to are, it seems, those to which some sort of religious claim is attached. You may promise to cure paralysis, small pox, spinal meningitis, tuberculosis, hernia, dyspepsia, or bunions, and the press will, for cash in hand paid and received, undertake to carry your lies to every door sill in the land. But do not talk about curing man of any of his spiritual ills; else the press will begin to talk about cure-alls.

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The Federation of Medical Women in Canada is a part of the Canadian Medical Association or, at least, it holds an Annual Meeting at the same time and place as the C. M. A. It is the opinion of C. M. A. members that this Federation might be made very useful. It is a fact, not an opinion, that lady doctors do not take as active a part in medical undertakings as their numbers and special abilities would suggest as fitting. Nor do they assert any leadership along the lines of promotion of health for which their sex and sympathetic nature especially endows them.

As far as Nova Scotia is concerned, it did appear a few years ago that these doctors were desirous of organizing to aid community welfare in the matter of health. Dr. Mabel G. Paterson, of Dartmouth, is the Vice-President for Nova Scotia for this federal body. Should Doctor Paterson desire to line up the women doctors in Nova Scotia to give practical effect to the deliberations of that body in this province she may be assured of the support of the Medical Society of Nova Scotia and its official Journal THE BULLETIN

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Rougier Freres of Montreal have circularized the profession in Nova Scotia in the interest of the pharmaceutical products of F. Hoffmann—La Roche & Co., Ltd., Basle, Switzerland. The circular letter was accompanied by a neat appearing illustrated booklet.

## OBITUARY

FREDERICK EUGENE GULLISON, M.D., C.M., McGill University 1916, Yarmouth, N. S.

THE death of Dr. F. E. Gullison on October 3rd, 1930, came as a great shock to many members of the profession, for few knew that he had been in failing health for some months. Some five or six weeks before his passing he went to Boston for advice and treatment. He was barely able to return to Yarmouth in the care of his sister, Mrs. A. D. Parry of New York, who accompanied him home.

Doctor Gullison was born at Yarmouth Dec. 7, 1890 and was thus in his 41st year. He was a son of the late Captain Eugene A. Gullison, whose decease was noted in the August BULLETIN, and Mrs. Gullison, formerly Miss Josephine Corning of Yarmouth. As a lad, he accompanied his father on several sea voyages and saw much of the world. He, with his mother and sister, was with Captain Gullison on the Yarmouth steel barque, Bowman B. Law, when that vessel was destroyed by fire at Sourabaya, Java.

From the local schools Dr. Gullison attended Horton Collegiate Academy and then studied Medicine at McGill, graduating in 1915 and in 1917 he returned and began practice in his native town. Of him a friend writes:—"In the passing of Dr. Gullison the Town of Yarmouth loses one of its best citizens. He was a splendid type of man and, owing to his honorable character, his sterling integrity in dealing with his fellow men and his skill in carrying on one of the greatest callings which can come to man, was a person which any town might be proud to claim as a resident."

Dr. Gullison is survived by his widow, formerly Miss Hilda Ray of Yarmouth, one daughter and one son. As intimated, his mother and one sister also survive. To his immediate family the members of the Medical Society of Nova Scotia extend sincere sympathy.

He was greatly interested in his profession and was always a member of the local, provincial and federal medical societies. He was quiet and unassuming, but his participation in discussion at a meeting was always practical and to the point. He was prominent as a citizen, a Mason and an official of the Central United Church, from which church the funeral took place on Sunday, October 5th. After an impressive service the members of Hiram Lodge, A. F. & A. M. took charge and held their beautiful service at the grave in Mountain Cemetery. The pall bearers were his brother practitioners, Doctors, Fuller, Lebbetter, Campbell, Williamson, Webster and Phinney.

*Vale et Salve.*

Mr. Arthur Kent of Lower Truro, died August 8th, 1930, after a lengthy illness, aged 78 years. Beside his widow, a son and three daughters, he is survived by two brothers, Dr. J. B., Larchmont, N. Y., and Dr. H. V. Kent of Truro.

## Locals and Personals

**T**HERE is a very persistent rumor that Dr. H. A. Bruce of Toronto, Professor of Clinical Surgery, Toronto University, is to be appointed Canadian Commissioner to London. The members of the C. A. M. C. will recall the strenuous days of Colonel Bruce in Canadian Medical affairs in London during the war. It is a sure thing that he will give efficient service, even if he fails to please everyone.

A Post Card received at the BULLETIN office reads thus:—

**"Tetany**—does not occur in the presence of adequate Vitamin D.  
**Ostogen Solution**—Vitamin D. Irradiated Ergosterol "Frosst" supplies Vitamin D. Nursing infants 1 drop daily, bottle-fed infants 2 drops daily. (Signed) Charles E. Frosst & Co."

Did you read the one you received?

In the course of an address to the Sydney Rotary Club, in September, Dr. John K. MacLeod, City Health Officer, stated that Sydney had at that time a clean bill of health in respect of communicable diseases.

Among members of the British Medical Association who visited Halifax *en route* home from the Winnipeg meeting were Doctors Ballantyne and Paul, of Glasgow, and Dr. Price, of London.

An exceptionally dry summer caused a serious water shortage in many rural places in Nova Scotia, and many people were compelled to get their supply from sources liable to pollution. Several cases of typhoid fever have been reported from different parts of the province. Two cases in Halifax are attributed to the drinking of water of wayside pools when motoring through the country.

Medical officers who served overseas during the war will be interested to learn that Major-General Carleton Jones has returned to Alassio, Italy, and again taken up residence there.

Doctors Hart and Tisdall, of Toronto, were in Nova Scotia in September as lecturers under the Canadian Medical Association plan for post-graduate instruction, and addressed some of the branches of the Medical Society of Nova Scotia. Incidentally, they entertained some of the salmon of the Margaree River.

Dr. George H. Cox, of New Glasgow, well known for his fondness for antiques, recently addressed the Halifax Rotary Club on the "Search for Fossils," illustrating his talk with specimens which he had found in various places—more particularly Florida. His address was intensely interesting. Despite the fact that he makes frequent visits to Halifax, the city profession remains intact.

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## Viosterol in Oil- 250 D

(Solution of Irradiated Ergosterol)

Now replaces Viosterol  
in Oil-100 D

### AVERAGE DOSE

As a prophylactic for children:—5 or 6 drops daily, commencing at four weeks of age with 1 or 2 drops. For the premature and rapidly growing infant:—4 drops, three times daily. For the treatment of mild and moderate rickets:—4 or 5 drops, three times daily. In cases of tetany and rickets of long standing:—5 or 6 drops, three times daily. For the mother, during pregnancy and lactation:—15 drops daily.

In 5 c. c. and 40 c. c. vials.

A standardized dropper with each  
package

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## Activated Cod Liver Oil-10D

(Viosterol Cod Liver Oil)

Now replaces Viosterol  
Cod Liver Oil-5 D

Newfoundland Cod Liver Oil of the highest known Vitamin A potency, to which has been added Irradiated Ergosterol to increase the number of rat units of Vitamin D to ten times that of its natural content. The usual dose for infants and young children is  $\frac{1}{2}$  teaspoonful, two or three times daily; for older children and adults  $\frac{1}{2}$  to 1 teaspoonful three or four times daily.

In 4 and 16 fluid ounce  
bottles.



No change in quantity dosage.

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Late in September, Dr. Fulton, of Truro, removed a piece of glass from a lady's face which had been imbedded there since the date of the great explosion at Halifax in December, 1917.

When P. L. Herman, who spent a fortnight or so at Annapolis Royal when a travelling show was operating in that town, took out a license to sell candy and peanuts, he thought he was privileged to sell other things too. And when he undertook to examine people for visual defects and to sell spectacles, objections were raised and he was hailed to court. His claim that he had been president of the Nova Scotia Board of Optometrists seemingly did not convince the magistrate that he was entitled to practice optometry on so limited a license, and it was decided that he must either pay a fine of twenty-five dollars or go to gaol for thirty days.

Dr. A. Calder and Dr. John MacLean of Glace Bay have been appointed medical examiners for the personnel of the Cape Breton Flying Club.

Lt. Col. and Bvt. Col. H. A. Chisholm, C.M.G., D.S.O., C.A.M.C., has been awarded the Colonial Auxiliary Forces Officers' Decoration. We note also that Lt. Col. J. R. Millar, C.A.M.C. receives the same decoration.

**McKiggan-Howie.** A quiet wedding took place at Big Bras d'Or when Dr. John McKiggan of Dominion No. 6 was married to Miss Margaret K. Howie, on October 4, 1930. For several years the bride had been a valued member of the teaching staff of the local schools. Dr. McKiggan is a graduate of Dalhousie in 1921 and has practiced at Dominion ever since graduation. The doctor has also taken a very important part in local affairs and has represented the miners on many delegations. Congratulations.

**At Dalhousie.** One of the Professors in the Medical School, shortly after the term reopened this year, was one day unable to meet his classes and the BULLETIN Board carried the following notice:—"Dr.—, through indisposition, is unable to attend to his classes to-day." Shortly after an irresponsible member of the class erased a letter and the notice read "lasses" rather than "classes". By the removal of another letter from the same word, a Senior student expressed his opinion of the mental capacity of the classes concerned.

**Martyrs to Science** is the title of an article that will appear in the BULLETIN as soon as possible. While it was under preparation, the writer found an article in an Ontario newspaper entitled "Doctors in Politics," the concluding sentences of which were:—"No man sacrifices more to enter public life than doctors. Their business is a personal

**MEAD'S**  
**Viosterol**  
**in Oil,**  
**250 D\***

**Prevents**  
**and**  
**Cures**  
**Rickets**

**in proper**  
**dosage**

EFFECTIVE  
OCTOBER 1st, 1930

\*Mead's Viosterol in Oil is now designated 250 D because, in accordance with the provisions of the Wisconsin Alumni Research Foundation, we are now assaying the product by the Steenbock method. Before October 1, 1930, this same product was assayed by the McCollum-Shibley method and was designated 100 D. This was done in the belief that this method gave results comparable with that prescribed by the Wisconsin Alumni Research Foundation for its licensees. It was discovered, however, that when assayed by this method the potency of the product was virtually 250 D in comparison with products standardized by the Steenbock method. Mead's Viosterol in Oil, 250 D (Steenbock Method)—in normal dosage—is clinically demonstrated to be potent enough to prevent and cure rickets in almost every case. Like other specifics for other diseases, larger dosage may be required for extreme cases. It is safe to say—based upon extensive clinical research by authoritative investigators (reprints on request)—that when used in the indicated dosage, Mead's Viosterol in Oil, 250 D, is a specific in almost all cases of human rickets, regardless of degree and duration, as demonstrated serologically, roentgenologically and clinically. The change in Mead's Product is in designation only—not in actual potency. Mead's Viosterol in Oil, 250 D—in proper dosage—continues to prevent and cure rickets.

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one and absence means lost practice, which is difficult to rebuild." The would-be contributor was advised it was not necessary to include these in the special article referred to above. It was felt that the list in Nova Scotia would be too large to make the article readable.

It is stated that Dr. William Elliott of Wolesley, Sask., is to be the next Lieut.-Governor of Saskatchewan. Sometimes even the doctor gets his reward. When a doctor complained that doctors seldom had monuments erected as a memorial to their services, a friend replied, "Oh, doctor, think of our cemeteries."

Dr. W. G. Poirier of New Waterford spent a short vacation recently in Cheticamp and vicinity. We do not know about his golf, but as a mackerel fisherman, he is a high liner.

The wedding took place on October 4, 1930 of Dr. C. L. MacMillan of Baddeck to Miss Ethelyn Parker, daughter of Mr. and Mrs. E. T. Parker of Halifax. The wedding was held in the First Baptist Church, Rev. A. L. Huddleston officiating. After a wedding tour to Montreal, Toronto, Niagara and other Canadian cities the newlyweds will reside at Baddeck. Dr. J. W. Merritt of Halifax supported the groom. During the absence of Dr. MacMillan from Baddeck his practice was looked after by Dr. H. B. Whitman of Dartmouth.

**Unemployment.** When unemployment is noticeable in a community the medical profession very soon becomes aware of the straitened circumstances, both in the number of patients and in the readiness to pay for services. There are very good personal reasons that matters relating to such local economics should be fully studied by all physicians.

Dr. Robinson Cox of Upper Stewiacke, Honorary Member of the Medical Society of Nova Scotia received many congratulations on October 4th, on which he celebrated his 89th birthday. In these the BULLETIN would like to join; may he have as many as he can enjoy.

To know that we don't know is the first step towards knowing what we don't know.

The BULLETIN is glad to learn that Dr. J. J. Carroll, Dalhousie 1924, who has been in poor health for a number of months has regained his health and has resumed his practice at Antigonish.

Congratulations are now in order for Dr. Arthur S. Morton, son of Dr. and Mrs. C. S. Morton, Spring Garden Road, Halifax. After graduating in Science from Dalhousie in 1925 he did research work in Physiology and Bio-Chemistry under Professors Babkin and Young,

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The favored Hotel of professional men and those interested in our hospitals and colleges.

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## FERRO-CATALYTIC

FOR THE TREATMENT OF IDIOPATHIC LOW COLOUR INDEX  
ANAEMIA

Gratifying Reports continue to be received from Canadian physicians anent the satisfactory results from the administration of Ferro-Catalytic, originated in the Frosst laboratories, for the treatment of low colour index anaemia. These reports further confirm the careful clinical work which had previously indicated the value of this preparation in those cases of anaemia which did not respond to the ordinary accepted methods of treatment.

The results of preliminary experimental work with our capsules containing iron and copper, carried out by a member of the staff of the Montreal General Hospital form the subject of a report in the Canadian Medical Association Journal, Vol. XXII, No. 2, February 1930, from which the following paragraph is quoted:

"Cases of this disease of long duration were treated with a combination of iron and copper in capsules given by mouth. Prompt improvement followed in all cases, with restoration of the blood to about its normal level."

For use in cases where administration by capsules is unsatisfactory (as with children) Syrup Ferro-Catalytic is at the physician's service.

### FERRO-CATALYTIC

S. E. C. No. 82 "Frosst"

Ry	*Blaud.....	= 30 gr.
	Copper (as Carbonate).....	1/48 gr.
	Phenolphthalein.....	1/12 gr.

\*Approximately three grains of iron in the Ferrous state.

Dose:—One capsule three times daily after meals.

Boxes of fifty capsules.

### SYRUP FERRO-CATALYTIC

No. 36 "Frosst"

Ry	Iron Glycerophosphate.....	14 gr.
	Copper (as Sulphate).....	1/48 gr.
	Syrup q. s. ad.....	2 dr.

Dose:—Infants and children— $\frac{1}{2}$  to 1 teaspoonful, three times daily.

Adults:—2 teaspoonfuls three times daily.

In common with iron preparations in general, syrup Ferro-Catalytic tends to cause constipation. It is suggested that a suitable laxative, such as fluid extract cascara or phenolphthalein in small doses be given to offset these effects.

*Charles E. Frosst & Co.*

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MONTREAL

and in 1927 received his degree of Master of Science. Since then he has studied in London and has now secured his M.R.C.S. (England) and his L.R.C.P. (London). He is now about to undertake two years of Post-Graduate work in London and on the Continent. His many friends extend congratulations.

The doctors of Halifax observed the last day of September with what has come to be an annual event,—a Golf Tournament, a Dinner and an evening of Good Cheer. Instead of a group picture of the contestants, McRitchie of *Herald* and *Mail* fame, and wider, depicted the most picturesque participants in the afternoon programme. One wonders if the redoubtable Fergie is going to hit the pill or hit where he is looking. Dr. Kinley scored the lowest net score and Dr. Curry the lowest gross score. The keenest competition was for the "Booby" prize for which Doctors Marshall, Doull and Gorssline were tied, and in a thrilling playoff Major Gorssline emerged victorious. The entire event was most enjoyable.

Lieut. S. Marcus, C.A.M.C. is attached for duty to the Lunenburg Regiment as from June 20, 1930. Capt. T. M. Sienievicz, C.A.M.C., is attached to the 6th Machine Gun Battalion as from June 18, 1930.

Dr. and Mrs. Killam of Woodville, Kings County, motored to Toronto the latter part of September accompanied by their daughter, Kathleen, who has entered Toronto University.

Dr. H. V. and Mrs. Kent of Truro, returned the first of October from their motor trip to Toronto, New York and other places. A portion of the time was spent with Dr. Kent's brother, Dr. J. Bryden Kent of New York. Their daughter, Miss Margaret, remained in Toronto where she is taking the Library Course at the University.

Dr. Clyde W. Holland has returned to Halifax after a year spent as Rockefeller Fellow in Internal Medicine at the Peter Bent Brigham Hospital, Boston. He is located at 119 Spring Garden Road, Halifax.

In addition to Golf it has been suggested that a riding contest Medical Society of Nova Scotia. This, in view of the fact that a number of doctors have recently been granted certificates of "Proficiency in Riding" in M.D. No. 6. The entrants expected would be Dr. H. R. Corbett, Kentville; Dr. Gerald R. Burns, Halifax; Dr. W. G. T. Poirier, New Waterford; Dr. G. R. Forbes, Kentville; Dr. P. S. Cochrane, Wolfville; Dr. J. W. Sutherland, Amherst, Ready! Go!

Dr. D. W. N. Zwicker, Chester, accompanied by Mrs. Zwicker, left for New York the latter part of September, for two months post-graduate.

*in cystitis and pyelitis*

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Phenyl-azo-alpha-alpha-diamino-pyridine hydrochloride  
(Manufactured by The Pyridium Corp.)

*For oral administration in the specific treatment  
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Sec. Treas. and Actuary, Bernard Lockwood, F.F.A.

**Attachments.** The undermentioned officers of the Canadian Army Medical Corps are attached for duty, as Medical Officers as stated:—

**King's Canadian Hussars.** Lieut. G. R. Forbes, 6th June, 1930;  
Lieut. P. S. Cochrane (supy) 7th June, 1930.

**2nd (Res.) Regt.** Major A. S. Burns, from Medical Officer,  
1st Regt., 6th June, 1930.

**Cape Breton Highrs.** Lieut. W. G. J. Poirier, (Supy) 14 June, 1930.  
(M.O. 358, 1930).  
(District Orders No. 324).

Dr. W. H. Robbins of New Glasgow took his vacation by motoring to Niagara and other Canadian cities. Mrs. Robbins accompanied him to attend the National Convention of the Council of Women.

Dr. G. W. Whitman of Stellarton recently enjoyed a motor trip to New York, accompanying several prominent Pictou County citizens.

Dr. M. D. Morrison, Medical Officer to the Workmen's Compensation Board, recently gave an interesting address before the Halifax Rotary Club. For a number of years Dr. Morrison has been in the habit, after hearing a prominent speaker, of writing down his impressions of the speaker and the subject matter presented. From these notes he gave graphic word pictures of Professor Stephen Leacock Sir George Foster and Mrs. Philip Snowdon, to the great pleasure of all present at the Luncheon on September 16th.

**1930 Tourists.** It appears to be generally admitted that the tourist business of 1930 was not up to expectations. A provincial weekly's correspondent from a celebrated summer resort says the tourist season was much shortened and was "marked by a decided decrease in the influx of American Visitors." The reason assigned was the great disappointment in "that there has been no Government liquor store opened in the town." One is puzzled to know why 1929 was such a wonderful tourist year in this district? This community presumably then was dependent upon Medical prescriptions for the supply, or was there another source?

"I have heard to-day your son was an Undertaker, I thought you told me he was a physician." "Not at all. You misunderstood me. I said he followed the medical profession." This is quoted by the *Evening News* of New Glasgow, but here is another in response to the "You Tell One" heading.—45 years ago my father did the largest business in headstones of any firm in Nova Scotia. Four years later I was licensed to practice medicine.