VOL. XXX No. 7

The Nova Scotia Medical Bulletin

Official Organ of The Medical Society of Nova Scotia Canadian Medical Association Nova Scotia Division.

JULY, 1951

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Published on the 20th of each month and mailed to all physicians and hospitals in Nova Scotia. Advertising forms close on the last day of the preceding month. Manuscripts should be in the hands of the editors on or before the 1st of the month. Subscription Price: $3.00 per year.

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Some Later Thoughts On Cancer

By H. B. Atlee

DOES cancer bore you? It did me, too, until I realized that I was not so much bored as frustrated. The opportunities for cure seemed so limited that my ego was constantly being slapped down: in the realm of cancer I was no surgical lord of creation. So I turned my back on the frustrating agency. This, you will agree, was a deplorable manifestation of emotional immaturity. I was being one-eyed—using only the eye that saw the failures, keeping the one that should have watched the successes closed. Obsessed with failure, I wasn't giving the attention I should have to greater possibilities of cure. But having had—largely as a result of the visit Dr. Kottmeier of the famous Radiumhemmet of Stockholm made us last year—my journey to Damascus, I now come penitently before you with my new testimony.

The first point I want to make contains no novelty. It's this: Prevent, if you can: otherwise get it early. Unfortunately, practically all cancer of the female pelvic organs is hidden and can neither be seen or felt by the patient herself. She can only rely on her symptoms to take her to her doctor, and sometimes these are confused or delayed. She may be developing an ovarian tumor but think she is putting on fat: she may be bleeding vaginally from a uterine cancer but think she is just having the change of life.

The importance of the earliest possible recognition lies in these facts: If a woman has had symptoms of cancer of the cervix for more than a month, the growth is no longer in the easily curable Group I category. If she has had them for from 1-3 months, the growth is probably in Group II, where the cure rate is 50% of Group I. If she has had them for more than three months, the growth is in Group III or IV—where the cure rate is very low indeed. What we find is this: If we get a Group I case we cure two out of three, if we get a Group II case we cure one out of three, if we get a Group III case we cure one out of seven, and if we get a Group IV case we cure practically none. You can see from this how vitally important it is that we get these cases in the Group I stage where the outlook really is very favorable: in very few parts of the body is cancer so curable.

Perhaps you would be interested in the details of our grouping in cancer of the cervix as mentioned above. We use the new international definitions. Group I is where the growth is confined to the cervix: Group II where it has extended anywhere on to the vaginal walls, and/or where it has extended into the parametrial tissue as far as the pelvic walls but not attaching itself to them: Group III is where the growth has extended to the pelvic walls, or involves bladder or rectum: Group IV is where there is massive pelvic involvement with evidence of secondaries in the glands or elsewhere in the body.

Cancer of the ovary also shows a much more favorable rate if it can be gotten in the earliest stage, before it has become more than lightly adherent to neighboring structures. Unfortunately, we see most cases very much later than this. A woman at or after the menopause who develops a low abdominal swelling will often put it down to fat until she gets pain. Pain means more or less serious invasion. The important point to accept here is that *all* pelvic tumors in women at or after the menopause should be removed at once, no

matter how small they are. *If they are tumors of the ovary, both ovaries and the entire uterus should be removed at the same time and, no matter what the pathological report says, the woman should have subsequent deep therapy x-ray.* While this rule should apply to all women for all ovarian tumors at the time of the menopause or subsequently, it should also apply to all younger women with papilligerous cysts. I have not infrequently seen recurrences in cases where the above rules were not followed. Let me stress again the importance of more or less disregarding the pathological report in certain types of ovarian malignancy. For one thing, the pathologist himself finds it difficult often to be sure that some of these tumors are innocent or malignant. The same tumor may show benign and cancerous areas. Or a tumor in which no evidence whatsoever of malignancy could be found will have its removal followed by recurrence in the other ovary or the uterus. This is not an unusual, it is a fairly common occurrence.

I stated above that "all" tumors of the pelvic organs in women at or after the menopause should be removed. In the past—and still to a considerable extent—women with fibroids are told that these will probably disappear with the menopause. This is bad medicine for two reaons (1) it is largely false—they often get bigger after the menopause, and (2) the diagnosis as between fibroids and ovarian tumors, especially when these are smaller than a grapefruit, is so difficult that even gynecologists of long experience make mistakes. If a case, diagnosed fibroid and left where it is, turns out to be a malignant ovarian tumor, the result for the woman is catastrophic. I have seen this happen on more than one occasion. I believe it is a safe—not to say remunerative—rule *to remove any tumor that appears anywhere in the body as soon as it appears.* Tumors are composed of rebel cells, and when that rebellion goes all out they are cancerous. *Ecrasez l'infame!*

Should a woman from the forties onward come to you for regular checkups? This is strongly advocated by some, but I doubt that what you gain on the swing anymore than compensates for what you lose on the roundabout. It's like this: The woman comes for her checkup and you find nothing—three weeks later she begins to bleed irregularly. "It can't be anything serious," she tells herself, "the doctor just gave me a clean bill of health." So she rides on it until a Group I cancer of the cervix becomes a Group II, and her chances of cure drop 50%. To be truly effective the regular checkup would have to be done every two months, and I doubt if women would agree to so strict a regimen. My own feeling is that we will do better to impress on all women the urgency of coming to us the moment they notice any change of function, or any new pelvic symptom. Of course, a woman has nothing to lose from a yearly checkup, especially if a Papanicolaou test is done each time. The occasional very early, symptomless case will be picked up. But such checkups should not be our main line of attack. If we can get women to come to us at the very earliest disturbance of function, and if we then put them through the real diagnostic works, including Papanicolaou—and if necessary biopsy—we shall do much better for them.

Here is another point I would like to make: Every woman with irregular vaginal bleeding or recent vaginal discharge should be examined not only manually but per speculum: a Papanicolaou test should be done, and if necessary a biopsy under anesthetic. So frequently women come to our Clinic who have been given ergot rather than the two fingers: this is very, very bad

medicine. It puts us in the category of that young lady of Harwich, whose technique one can't but disparage. (If you recall that one!)

Let us now discuss cancer of the pelvic organs as it affects the individual organ.

Cancer of the Vulva: One of the most important facts about cancer of the vulva is that it is so frequently the result of a fairly long-standing luecoplakic vulvitis. Leucoplakia is easy to recognize: it causes an intense local itching, and its whitish appearance is unmistakable. I know of no effective cure short of excision, and have tried both hormones and x-ray. These two forms of medication may cause a temporary amelioration of the symptoms, but never in my experience a disappearance of the lesion and its replacement with normal epithelium. It is therefore now my practice always to excise it whenever I see it. If the condition is of some standing and there are cracks in the surface of the affected skin, these areas should be sent separately to the pathologist to determine malignancy. On several occasions I have seen such innocent fissures turn out to be malignant.

The next point I would make about cancer of the vulva is that local excision is not enough: there should be a complete vulvectomy, and both inguinal gland areas should be dissected out whether glands can be felt or not. If the gland in the crural canal is involved, an incision should be made above Poupart's ligament in the abdominal wall muscles, the peritoneum pushed inward, and the glands along the external iliac removed.

The final point I wish to make concerns the frequency with which cancer of the vulva either involves or is closely associated with the urethra. While this makes the outlook less hopeful, it does not rule out surgery. On several occasions I have removed the outer half of the urethra without interfering with urinary control. It is only when the growth is fixed to the pubis that excision is useless, in which case radium should be used. While this form of cancer is resistant to radiation, radium should be employed when surgery is impossible, and we always give these cases post-operative x-radiation.

Cancer of the Cervix: This is the commonest type of cancer of the female pelvic organs and fortunately the most amenable to radiation. Let me repeat that the important factor in cure is early recognition. Forget about The Cancer Age in dealing with it: any woman who bleeds irregularly from the cradle to the grave can have it—two cases have recently been reported in young infants. *But they don't all bleed.* Every now and then we see a fairly advanced case where the woman denies bleeding, *although she does have a dirty discharge.* This happens where there is the sclerotic type of growth present that is often so hard to diagnose. But if all women with a dirty discharge had their cervix inspected, a Papanicolaou done, and if that is negative a biopsy, the malignancy would come clear. Very often when you have such a patient under the anesthetic for the biopsy, the friability of the erstwhile firm cervix becomes definitely apparent.

The treatment of cancer of the cervix is radium and x-ray. Total or subtotal hysterectomy is no treatment for this condition. Not only is there a 100 per cent recurrence rate, but the operations actually interfere seriously with the effectiveness of the treatment by radiation. Radium is employed not only against the cervix, but inside the uterine cavity, and we have found that the intrauterine radium is very important in effecting a cure and preventing radiation damage: we cannot use it this way if the uterus has been re-

moved. I stress this point because every year we have to treat cases of cancer of the cervix where a hysterectomy has been mistakenly done. No woman who bleeds irregularly should have a hysterectomy until her cervix has been thoroughly examined.

What do I mean by a thorough examination of the cervix? The following at least: (1) Examination with the finger to detect any irregularity or change in consistency of the part, (2) Inspection through a speculum. (It continues to amaze me that hysterectomies are done without the benefit even of these two simple diagnostic procedures). (3) Probing of any suspicious areas with a wooden applicator—if the applicator will go into the tissue it is malignant as surely as Adam loved spare ribs. (4) Curetting with a fine curette the cervical canal in all cases where the vaginal portion of the cervix appears normal. (5) Taking a Papanicolaou. (5) If still in doubt a biopsy and curettage of the cervical canal under anesthetic. If the above strategy is carried out the correct diagnosis should appear in practically every case.

A moment ago I stated that hysterectomy played no part in the treatment of this disease. We make one exception. There is the occasional case that resists radiation and the woman is left with a stinking vaginal ulcer. In such a case I do a Wertheim hysterectomy—an undertaking which differs very formidably from the ordinary total operation, entailing an extensive dissection of the pelvic anatomy.

Let me repeat again that we save two out of every three women who come to us in the earliest group of the disease, and only one out of every three in the next most favorable group . . . .Early diagnosis . . . . .*early diagnosis* . . . . . EARLY DIAGNOSIS!

Cancer of the Body of the Uterus: We have changed our treatment of cancer of the corpus lately. Previously, it was our policy to do a vaginal hysterectomy immediately on all women who bled after the menopause, but we found that this procedure was not productive of the best results in those cases that actually turned out to be cancerous. We now curette all post-menopausal bleeders. If the curettings are frankly malignant we put radium into the uterine cavity and do the hysterectomy 4-6 weeks later. If we are doubtful of the curettings we send them to the laboratory, wait until we get the report and if malignant insert radium and do the hysterectomy later. In advanced cases it may be necessary to repeat the radium, and in still more advanced cases—the inoperable ones—to rely on radiation (radium and x-rays) alone. Hysterectomy in these cases means total—nobody should do subtotal hysterectomies in women who bleed after the menopause—in fact, nobody should do subtotal hysterectomies.

I hold that all women who bleed after the menopause should have their uteri removed, whether the curettings reveal malignancy or not. For one thing, the curette may miss a malignant area, especially an early one. For another, the other conditions that can cause this type of bleeding—certainly fibroids and endometrial polypi—require such treatment for cure. And thirdly, vaginal hysterectomy offers a safe procedure for women of this age.

All cases of cancer of the body should, in addition to the intrauterine pre-operative radium, have radium inserted into the vagina at the end of the hysterectomy or a day or so later, to prevent local recurrence in the vaginal vault.

Chorioepithelioma of the Uterus: I have just four things to relate about this comparatively rare condition:

1. It grows so rapidly that you have no time to lose.
2. If you have to curette a woman for bleeding after a miscarriage, a full-term labor or the passage of the hydatidiform mole, be sure to send the curettings to a laboratory for examination.
3. If chorioepithelioma is reported, remove the whole uterus, both tubes and ovaries, and insert radium into the vagina.
4. If it is a true chorioepithelioma the woman will die: if it is the form known as chorioepithelioma destruens she will probably not.

Cancer of the Ovary: While the outlook for cure is relatively bright in most of the previously described conditions if they are brought to treatment early, we cannot be so sanguine about cancer of the ovary. Unfortunately, an ovarian tumor has to be of some size as a rule before the woman is conscious of anything wrong, and when it begins to cause pain it has already begun to invade the neighborhood. A large proportion of ovarian tumors occurring in women after the change of life are malignant. A fair proportion of ovarian tumors that occur in younger women are malignant. It therefore behooves us to root out all ovarian tumors no matter at what age they occur, but particularly if they occur after forty. And when I say root them out I mean, lock, stock and barrel—the other ovary and the entire uterus whether these show signs of malignancy or not.

No case is entirely hopeless—not even the hopeless case. A woman came to us two years ago who had had a malignant tumor of the ovary removed some months before. She was so full of juice she required to be tapped once a week. We gave her the radiation works, tapping her as required. She lived for about a year and a half, for at least half that time in comparative comfort, and did not need to be tapped again until the very end.

We operate on all cases, however hopeless appearing, and we give all, no matter how desperate, the benefit of x-radiation. In the hopeless appearing cases we first give x-rays to the abdomen. This loosens up the adhesions that are always present and enables us to get better planes of cleavage when we operate. Admitted, when we get the tumor out we have left malignant and invasive cells behind, but with that tumor out they are much more accessible to radiation.

If one ovary shows a malignant growth, spare neither the uterus nor the other ovary. While there is the odd exception to this in younger women, there is none in women over thirty-six.

In every case from which a malignant ovarian tumor (together with uterus and other ovary) has been removed, the pelvis should be treated with x-rays and radium should be inserted into the vagina.

I believe it important to regard no case as hopeless until the last possible stone of treatment has been turned. This is true even when there is a recurrence. Generally speaking, if a growth recurs after an apparent cure, the outlook is hopeless. This does not always hold. Three years ago I treated a case of cancer of the cervix. A year and a half ago she came back with a small, hard nodule near the urethra that proved to be recurrence. It was removed and radium inserted in the nodule bed. She is still around. Some months ago I removed a large ovarian cancer that was adherent to the sigmoid omentum

so close to the pelvic wall that a thin shell of growth was left behind in that location. She received x-ray treatment afterwards. When I examined her three months later I could feel no pelvic induration and she was free of symptoms. I have no illusions that she is cured, but I do know that she has had the death sentence postponed and is more or less enjoying life in the meantime. All of which is gain. Some ovarian cancers are very sensitive to radiation: in any case every woman with ovarian cancer should have the benefit of it.

Finally, let me say that my message regarding cancer of the female pelvic organs is one of—shall we say—restrained optimism. We have a lot more to offer the woman with this type of cancer these days, and our results are steadily improving. Several factors have influenced us for good here: (1) Dr. Kottmeier's visit last year and his suggestions as to improvements in technique which have already greatly reduced the amount of radiation damage we were getting, (2) Our own deepening interest in the disease, (3) Our Gynecological Cancer Clinic—a working combination of the gynecological and radiological services of the Victoria General Hospital—which meets every Tuesday and Friday at noon, and at which every case of cancer is discussed fully not only at the first admission but at every subsequent checkup (and we check for five years).

We would be only too glad to put the services of our Cancer Clinic at your disposal either for diagnosis or treatment. We would welcome a visit from you to it at any time. For we know that only through our combined efforts—yours and ours—can we gain the fullest victory over this most formidable of the captains of death.

Early Ambulation In Obstetrics

A. Gaum, M. D., Sydney, N. S.

CONTROVERSY over early ambulation has gone on for years. As early as 1812 Charles White of Manchester, England, was in favor of letting patients up before the third day, while in 1820 Robert Gooch, Professor of Obstetrics in St. Bartholomew's Hospital, London, was in favor of keeping his patients in bed for three weeks. The Sioux Indian squaws have been known to go into the woods in the cold months of winter, and while there, give birth to the papoose which they brought back together with the load of wood to keep the home fires burning. The Apache Indians believed it essential that as soon as the placenta was expelled, the parturient be kept upright and walking for half hour in order that all the clotted blood would expel from the womb. In the Antilles, food was offered as soon as delivery was completed and after a few hours, the usual labor of the household resumed by the patient.

Stimulus to early ambulation in obstetrics resulted from the "Blitz" of 1940-41 in London when fear of casualties prompted obstetricians to allow hospital patients to get up 24 hours after delivery and to go home on the third day. At the Women's Clinic in Helsingfors a study of over 4,000 women who were allowed out of bed very soon after delivery was made, and it was found that the incidence of thrombosis was definitely less and that the bladder and bowel functions, as well as their general well-being, were better than women kept in bed for ten days.

In Sydney, Nova Scotia, prior to 1930, 90 per cent of obstetrics was done at home and although we have no figures to substantiate our conjectures, we feel that the numerous complications, such as phlebitis, embolism, sub-involution of the uterus, atony of the bladder, were very few compared with hospital admissions and this we presume, was due to the fact that the patients were up and around much earlier at home, and, even when confined to bed, were more active there.

What may have stimulated a migration of obstetrical patients to our hospitals in Sydney is hard to say. It may have been due to the higher economic standards of living during the war years, prepaid hospital plans, or because of shortage of doctors they were forced, of necessity, to be confined in a hospital. Regardless of the cause of this complete swing-over to hospital obstetrics, we were not equipped for this mass admission. There was only one small obstetric hospital which had a maximum of eleven beds and roughly about fifteen more beds divided amongst the two general hospitals. In order to accommodate the continual flow of patients, it was necessary to ambulate the patients very early and likewise to discharge them very early.

Because there was no gradual transition from the old standard teachings of absolute confinement in bed for seven to ten days to the early ambulation within 24 hours, one had to be very cautious for fear of:

1. Medico-legal consequences.
2. Fear that episiotomy wounds would break down.
3. Excessive post-partum bleeding.

4. Too much strain on the pelvic floor with subsequent development of prolapses and retroversions.
5. Fear that patient would not approve of early rising.

It was in the fall of 1945 that we began some form of modified ambulation, getting the patient up and about the third post-partum day, and when we found that the patients were most receptive to this type of treatment, and also having been influenced by reports on the subject that were being published at the time, we gradually cut down on the post-partum days so that by 1946 the patients were getting up 24 hours after delivery and the following advantages were to be noted:

1. Asthenia was minimized.
2. The patient's morale was very high.
3. Post-operative care was simplified because there were very few pulmonary complications such as resulting from phlebothrombosis or thrombophlebitis.
4. Hollow viscus atony was reduced with consequent avoidance from the use of catheters and enemas.
5. Episiotomy wounds had the same incidence of good healing as those who were confined to longer periods of rest.

The following is a table of the 2,236 cases studied:

	No.	Per Cent
LOCHIA:		
Normal	—	80.
Moderate	—	5.
Excessive	—	15.
Perineal Healing:		
Good	2,222	99.5
Poor	14	.5
Involution of Uterus:		
Good	2,236	100.0
Poor	0	0
Catheterization	59	2.5
Thrombosis	3	0.135
Embolism	1	0.045
Other Complications:		
Mastitis	1	0.045
Endometritis	0	0
Post-partum haemorrhage	2	.090
Pyelitis	0	0

Abdominal wound healing was good in all Caesareans. All patients had normal bowel function following enema.

Our present study represents 2,236 confinements up to date of this article. In the earlier years the method ambulation was to allow the patient to move freely in bed immediately following delivery, or if an anaesthetic were given, immediately following recovery from this. Every eight hours in the first 24

hours, she was allowed to sit up on the side of the bed for a few minutes. She was encouraged to cough vigorously in order to clear the respiratory system of any mucous and also ordered deep breathing exercises to stimulate circulation in the lower extremities. On the second day the patient was allowed to stand upright on the floor for a period of 15 to 20 minutes on four different occasions during the day. On the third day ambulation about the room for short periods was permitted. Thereafter, bathroom privileges and intermittent periods of ambulation and rest were allowed. The other extreme, as in the more recent years, patients are getting up within 24 hours, and ambulating and resting intermittently. Now only three days post-partum we have a great deal of difficulty in persuading the patient to be hospitalized for at least a minimum of six days.

The contra-indications to early ambulation were indeed very few, e.g. those with long labors and toxemias were confined to bed: major surgical deliveries, and thirdly those with temperature over 99 degrees. These were all kept in bed.

Results: In all instances patients expressed the opinion that a general feeling of well-being occurred from the ambulation and this is particularly true in the case of the multi-gravida who were able to compare their present cases with their long-confined previous cases.

Lochia: The greatest drainage occurred in the first three days, and the patients were warned about this. It was quite obvious that this would be so because in the ambulant position the uterus would have a greater tendency towards anteversion and better drainage in contrast to the retroversion that would ensue from lying in supine position with subsequent poor drainage.

Bladder and Bowel:

In very few incidences was catheterization necessary. It was also noted that the use of enemas and laxatives were less and fewer patients complained of haemorrhoids.

Episiotomy: There was a notable lack of complaints about episiotomy pain after second day of ambulation and as regards dehiscence of the wound this was no more frequent than in non-ambulant cases.

Patients ran less temperature because there was less catheterization, except possibly in primipara cases where the head had been down on the perineum longer and possibly because of oedema of the urethra. Likewise toilet habits have improved because it was never meant for patients to use a bedpan, etc. As a matter of fact, according to Rusk et al, it has been shown that there is more energy and oxygen consumed and expended in using a bedpan than in actually being allowed to use a commode or going to the lavatory.

All in all, early ambulation was initiated with an understandable amount of anxiety upon the part of the staff and with an equal understandable reluctance on the part of the patients in their first contact with such a program. This reluctance was however much more pronounced and more difficult to overcome with private patients than in ward services. But as more and more patients experienced general improvement as a result of early ambulation, reluctance changed to enthusiasm and they actually insisted on being handled in this way.

It is difficult to say whether early ambulation will have any untoward results as regards relaxations, etc., but it is not within the scope at this short time to make a statement. We feel that at least a period of 15 years should elaspe before any definite statement can be made.

Summary and Conculsions:

Our data would indicate that it is quite safe for early ambulation in the puerperium. It is our opinion that early rising results in more rapid and comfortable convalescence with less weakness and less post-partum depression, the bowel and bladder function approximate the normal more readily, it has reduced the nursing care which is a great advantage in these days of nurse shortage. It is most important to the patient economically. It is our hope that the future years will show that this has been a definite milestone in the advancement of obstetrical practice.

1. Cornell, E. L. & Mullen, J. J.—Early Rising after Delivery, Modern Medicine, 55, 768-777, 1948.
2. Editorial, Knee Chest Position—Early Rising in Puerperium—Malpositions of Uterus, Queries and Minor Notes, J.A.M.A. 135, 68-69, Sept. 1947.
3. Guerriero, W. F.—Early Controlled Ambulation in the Puerperium, Am. Journ. Obstet. & Gynaec. 51, 210-212, Feb. 1946.
4. Hall, J. E.—Early Ambulation in Obstetrics, Brooklyn Hosp. J. 41-44, 1947.
5. Joyce, H. T.—Early Ambulation in Gynaecology and Obstretrics, Medical Times, 77 Mar. 1946.
6. Pavey, C. W.—The Use of a Pessary as an Adjunct to Early Rising in the Puerperium Ohio State M.J., 42, 1047-1049, Oct. 1946.
7. Rosenblum G. et al—Early Rising in the Puerperium, J.A.M.A., 129, 849-853, Nov. 1945,
8. Smiley, W. L.—Early post-partum Ambulation, J. Missouri, 44, 756-758, Oct. 1947.

Physician's Art Salon

WITH a total entry list not far short of 600 exhibits, the Physicians' Art Salon marked another successful appearance in Montreal June 18-22 and has produced a large selection of material to be incorporated in the Physicians' Art Salon calendar for 1952, which will be sent to every Canadian physician by the sponsors, Frank W. Horner, Limited.

The salon, staged annually in conjunction with the Canadian Medical Association convention, this year included a wider range of exhibits from members of the profession than ever before. The seventh consecutive annual salon occupied a large area of wall space in Montreal's Mount Royal Hotel and was seen by many hundreds of delegates and friends, all of whom showed considerable interest in the large collection of artistic offerings at hand.

Most frequent comment was that this year's salon had "gone modern." To a degree this was true, since the salon did include a fairly large proportion of impressionist studies. Notable among them was "Marrakech," an entry of Mr. Claude Jutras of Montreal, which was awarded first prize in the fine art section. The judges remarked in awarding the prize that Mr. Jutras' entry showed "a significant sense of the abstract". Mr. Jutras, a University of Montreal medical student and son of Dr. Albert Jutras, set something of a salon record by also receiving recognition for his photographic work. His study, "Joan", which the judges said "exuded impersonality and timelessness", was given an award of merit.

Dr. L. J. Notkin, another Montrealer, was conceded first prize in the monochrome photography section for his snow scene "Taps." Commenting, the judges said the work showed "quality and strong composition in a low key."

First prize winner in the color transparency section was Dr. A. J. Grace of London, Ont., for his entry "Untimely Winter." In commenting the judges gave the opinion that the work showed "a sensitive artist behind the camera, with fine composition and fine cohesive charm."

Judges for this year's salon were all outstanding authorities in their fields. Members of the panel were the widely-recognised Canadian artists Dr. Arthur Lismer and Mr. Sheriff Scott and the well-known photographer and critic Mr. Raymond Caron.

Particular attention was drawn this year to the special section of the salon set aside for the work of first prize winners in previous salons. Their work was grouped in the "Palette Club" section and their entries were hung hors concours.

One other innovation this year was the award of a "popularity prize" for fine art and another for black and white photography, based on the results of a poll among visitors to the salon. Winners were Dr. J. B. Maxwell, of Toronto, for his painting "Birch Lake" and Dr. Norbert Vézina, of Outremont, for his photograph "L'enfant au manteau noir."

The presentation of awards to most of the 22 winners took place June 21 in the Chalet atop Mount Royal at the C.M.A. garden party.

Planning for next year's salon, at Banff, Alta., has already begun with the Art Salon committee forseeing few changes in structure and handling. The profession will be advised of any new developments for 1952 by Frank W. Horner Ltd.

Following is the full list of prizewinners:

1st Prize—M. Claude Jutras, 3682 rue Ste.-Famille, Montreal, Que. — "Marrakech" (Impressionistic Study)

2nd Prize—Dr. W. D. S. Cross, Westminster Hospital, London, Ont. — "Reflections" (Landscape)

3rd Prize—Mr. Talbot Déry, 92, rue de Callières, Quebec, Que. — "Nature Morte" (Still Life)

Awards —Dr. M. C. Mooney, 377 Main Street, Farnham, Que. — "Undaunted" (Portrait)

Dr. L. J. Notkin, 4752 Upper Roslyn Avenue, Montreal, Que. — "Gourds" (Still Life)

Dr. W. J. Hart, 19 Oakview Avenue, East Kildonan, Man. — "Floral" (Still Life)

Dr. R. F. Ross, 44 Dominion Street, Truro, N. S. — "Off Cape Sable" (Landscape)

Dr. John Parnell, 1735 W. Broadway, Vancouver, B.C. — "Howe Sound, B.C." (Landscape)

Dr. Paul Larvière, 3417 rue St.-Denis, Montreal, Que. — "Variations" (Abstract)

MONOCHROME PHOTOGRAPHY

1st Prize—Dr. L. J. Notkin, 4752 Upper Roslyn Avenue, Montreal, Que. — "Taps" (Landscape—Snow Scene)

2nd Prize—Dr. Max O. Klotz, 181 Carleton Road, Rockcliffe, Ottawa, Ont. — "Our life is closed—Our Life Begins" (Portrait)

Awards —M. Claude Jutras, 3682 rue Ste-Famille, Montreal, Que. — "Joan" (Portrait)

Dr. A. B. Walter ..... "Freedom"
377 Lawrence Street ..... (Nature Study)
Saint John, N. B.

Dr. B. S. W. Brown ..... "I'm Mr. Doyle"
23 Drummond Street ..... (Character Study)
Granby, Que.

COLOUR TRANSPARENCIES

1st Prize—Dr. A. J. Grace ..... "Untimely Winter"
530 Wellington Syreet ..... (Landscape)
London, Ont.

2nd Prize—Dr. F. E. Wait ..... "Bow Valley"
401 Canada Building ..... (Landscape)
Saskatoon, Sask.

3rd Prize—Dr. S. J. Navin ..... "Long Lac, Ontario"
Caramat, Ont. ..... (Landscape)

Awards —Dr. L. E. Jaquith ..... "Birds of Paradise"
2 College St. ..... (Fantasy)
Toronto, Ont.

Dr. A. F. Perl ..... "Prairie Road"
137 Wellington Street ..... (Landscape)
Sarnia, Ont.

Dr. Helen McKinley ..... "Enchanted Evening"
1087 Gerrard Street East ..... (Seascape)
Toronto, Ont.

Dr. W. W. Hughes ..... "Nature's Music"
Embro, Ont. ..... (Seascape)

Dr. R. M. Taylor ..... "Dunster Cottage"
9 Beach Avenue ..... (Landscape)
Deep River, Ont.

Society Meetings

THE NOVA SCOTIA SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

A COMBINED meeting of the Nova Scotia and New Brunswick Ophthalmological and Otolarynoglogical Societies was held at Moncton, N. B., May 9th, 1951. The meeting was held in the auditorium of the Nurses' Home of the Hotel Dieu Hospital, Moncton, N. B.

Dr. Arthur Ross of Moncton opened the meeting by welcoming all and hoped that this would be the inauguration of closer relationships between the two Provincial Societies.

The Moncton Doctors presented the following clinical cases—Bilateral Buphthalmos—Monocular Buphthalmos—Deep Recurrent Keratitis in a child—Bilateral Optic Atrophy with Pituitary Tumor.

There was considerable discussion of the various cases and it was noted that in this particular district, Buphthalmos seemed to be relatively more prevalent than in the Halifax area.

Dr. R. T. Hayes of Saint John presented a paper with slides on diseases of the Fundi particularly Retinal Degenerations in the older age group.

There was discussion of the paper by Doctors Schwartz, Stoddard, MacRae, Glenister of Halifax and Doctor Silver of Saint John.

The use of Potassium Iodid was advocated in many of these senile types of Retinal Degeneration, for it seemed to slow the degenerative process.

At a group meeting of the Nova Scotia Members on a motion by Doctor Glenister, seconded by Doctor Stodard, Doctor A. G. Shane of Halifax was elected to membership.

There followed a general discussion concerning the holding of combined meetings, and various problems common to both societies. A suggestion was made that at the Annual Meeting of the Nova Scotia Society the question of combined meetings or some similar arrangement be considered.

Doctor Fuller of Yarmouth, N. S., Vice-President of the Nova Scotia Society, presided at the afternoon session.

Doctor J. G. Cormier of Sydney presented a paper giving some of the high-lights of the course given at Toronto in the section of Ophthalmology.

The use of Beta Irradiation by means of the Burnham Radon Applicator and Iliff type, also Strontium Radium and Radium D Applicator.

These were useful in treating Vernal Conjunctivitis also other chronic types of Bulbar and Palpebral Conjunctivitis, Corneal vascularization and small corneal scars.

Uveitis is still an unsolved problem, having many possible causes: allergy or any secondary infection, such as from: T. B., Herpes, Parotitis, Sarcoiditis, acute Diffuse Serous Charditis, Toxoplasmosis.

At the present time Cortisone is the most advantageous treatment, also Streptomycin and Promizone.

Glaucoma—the importance of early diagnosis, the various provocative tests and their realiability. The emphasis of field study and the indication for early surgical treatment with progressive field changes before the field cuts are too near the fixation point.

The paper was discussed by Drs. Holland, MacRae and Glenister of Halifax, and Dr. Fuller of Yarmouth, and Dr. Silver of Saint John.

Doctor W. A. Pullen gave a paper on Bifocal Corrections, he discussed the problems of Jump—Displacement and Chromatic Aberration, and the use of Trifocals.

This paper was discussed by Doctor Glenister, Doctor Schwartz and Doctor Stoddard of Halifax, and Doctor Fuller of Yarmouth.

This concluded the scientific meeting and through the courtesy of the Sisters of the Hotel Dieu tea and refreshments were served by the nursing staff of the Hospital.

E. I. GLENISTER, M. D.
Secretary-Treasurer

Post-Graduate Week in Obstetrics, Gynaecology and Paediatrics

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

1. It will be limited to 6 applicants and the first six who apply will be accepted. Applicants from all the Maritime Provinces and Newfoundland will be welcome. Only those intending to take the entire course will be accepted and applicants should state whether or not they will be able to do this.
2. The dates will be November 26th to December 1st, inclusive.
3. Applications should be made to the Post-Graduate Office or Dr. Carl Tupper, Victoria General Hospital, as soon as possible.
4. Men taking the course will be given a bed in a dormitory at the Grace Hospital for the entire week, so that they can see all public cases delivered at the hospital that week. They will pay the Grace $5.00 for this purpose at the beginning of the course.
5. They will be able to get their meals in the cafeteria of the Victoria General Hospital at the usual meal rate charged there.
6. They should be in the front hall of the Grace Maternity Hospital at 8.45 a.m. on Monday, September 24th, where they will be met and have further details explained.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
9-9.50 Management of labor	Congenital Heart Disease	Ca. Cervix Diagnostic Pts.	Wet Smears Vaginal Discharge	The Nephritides	9-10.30 Symposium on Ante Partum & Post Partum Bleeding
10-10.50 Care of baby in first hour of life	Acute Rheumatic Fever	X-ray Pelvimetry	Ward Walk	Meningitis Convulsions	10.30-11.30 Feminine Hygiene
11-11.50 Induction of labor & Indic. for C.S.	Fluid Balance	Manikin Demonst. with Forceps	Endocrine Therapy	Round Table Ward Cases	
12-1 Abortions	Round Table Respiratory Infections Infants	Panel on Toxaemias of Pregnancy	Panel on anything new in Literature	Behavior Problem	12-1 Rh Factor
		NOON RECESS			
2-5 Gynaecological Patient Clinic at V.G.H.	2-5 Pre Natal Clinic Out Patients	2-3 X-ray films	2-3 Problems of New Born Prematurity	2-5 Pre Natal Clinic at at D.P.H.C.	
		3-4 Skin Diseases	3-4 Asphyxia		
		4-5 Surgical Problems			

Personal Interest Notes

The Canadian Medical Association in annual meeting at Montreal on July 18th passed a resolution of its general practice section which asked that large city general hospitals be requested to set up departments of general practice. This would enable family doctors to maintain their professional standards and would enable them to draw on modern medical knowledge and scientific aids. General practitioners work closely with specialists in smaller hospitals but much of the work they could do in larger hospitals now is being done by specialists.

Rating of Canadian hospitals, carried out until now by the American College of Surgeons, will be taken over by a body set up by the Canadian Medical Association in co-operation with other groups. In the past, the Canadian Medical Association has approved hospitals for interneship and for the training of technologists, but there was no complete standardization and approval body. The new body will not conflict with the rating system established by some provinces, on which provincial hospital grants are based.

"We hope to provide Canadian hospitals and their staffs with a standard for efficient and effective care of patients," said Doctor Norman H. Gosse, Halifax, Association President. "Through regular inspections and ratings, the hospitals and those working in them will be able to improve the quality of medical and hospital care."

The decision was made necessary by the withdrawal of the American College of Surgeons from the rating field in both Canada and the United States. A joint Commission of Medical and Hospital Groups in the United States will take over their work and although Canada may have representation on that commission, the Canadian Medical Association will still take the lead in forming a Canadian rating body.

Provincial medical associations have been asked to join with the Canadian Medical Association in appealing to provincial and federal governments for an increase in the present $3,000-a-bed hospital construction grants.

The increase is sought to make possible a proposed addition of 1,000 beds to Canadian hospitals for the treatment of arthritis.

Doctor R. S. Grant, youngest son of Dean and Mrs. H. G. Grant of Halifax, has left for Montreal where he will undertake post-graduate study in paediatrics at the Children's Memorial Hospital under the direction of Doctor Goldbloom, Professor of Medicine at McGill University. Mrs. Grant and their son, Garry, will join him in the early fall.

Doctor J. J. Stanton and Dr. N. F. Macneill, members of the staff of the Nova Scotia Sanatorium at Kentville for the last year, who have also been taking post-graduate work in tuberculosis treatment, left during June to take up new positions in the Provincial Public Health Department field.

Doctor Stanton has been appointed divisional medical health officer with headquarters at Pictou and Doctor Macneill has been appointed to the same position at Sydney, Doctor H. V. MacKay, Pictou, a graduate this year from Dalhousie Medical School, has accepted a position on the staff of the Sanatorium.

Doctor and Mrs. J. A. Noble, who spent the past three months in Scotland and England, where the former has been engaged in special study at the University of Edinburgh, returned home to Halifax the middle of June.

Prime Minister St. Laurent has praised the efforts of the Canadian Medical Association to organize a medical health plan on a national basis and said all levels of government would be "most anxious" to help the medical profession to carry it out.

He said in the Commons that the possibility of setting up a special Parliamentary Committee to study the question was something that would have to be considered at a later date.

Mr. St. Laurent said the government had not yet considered the matter. But "several members of the government—and I am one—have noted with interest and have welcomed this interest on the part of the medical associations" in starting such a plan.

The Medical Associations were subject to provincial legislation and enjoyed a large measure of autonomy. If they could supply adequate medical care for all Canadians it would "be all to the good."

At the first meeting of the Canadian Psychiatric Association held on June 21st at Montreal, Doctor R. O. Jones of Halifax was elected President. Other officers elected were: Doctor C. Stodgill of Ottawa, Vice-President; Doctor R. Hamilton of Montreal, Treasurer; Doctor J. P. S. Cathcart of Ottawa, Secretary and Doctor C. S. Marshall of Halifax, Nova Scotia Director.

Doctor J. C. Wickwire, Liverpool, is continuing his studies in cardiology with the Harvard Post-Graduate School of Medicine, where he will spend the month of July, under Doctor Samuel Levine and Associates, at the Peter Bent Brigham Hospital, Boston.

Doctor C. S. Morton of Halifax was one of seven graduates of the class of 1901 from the University of Toronto's Medical School to receive Doctor of Medicine degrees on June 16th. The seven graduates of fifty years ago were honoured along with graduates of the class of 1951 at a special dinner held at Hart House the night before.

Doctor and Mrs. J. C. Worrell of Halifax and little daughter, Christine, left by car on June 11th to motor to Oakville, Ontario where they will take up permanent residence. Their month old daughter, Carolyn Jane, and nurse, will make the trip by plane in a month's time.

Doctor J. J. Quinlan, assistant medical superintendent of the Nova Scotia Sanatorium at Kentville, has been made Governor for Eastern Canada of the American College of Chest Physicians, of which college he is a "Fellow." Doctor Quinlan with his wife, Doctor Helen Holden Quinlan, also of the Sanatorium staff, attended the annual meeting of the American College of Chest Physicians, held early in June at Atlantic City, N. J.

Doctor J. E. Hiltz, medical superintendent of the Nova Scotia Sanatorium at Kentville, and Mrs. Hiltz, left early in July by plane from Halifax

for St. John's, Newfoundland, and proceeded on the S. S. Christmas Seal for Labrador where Doctor Hiltz will make a tuberculosis survey of the Eskimo population.

The trip along the coast was made on the Christmas Seal which is the mobile X-ray unit operated by the Newfoundland Government.

The survey in Labrador is under the Department of Indian Medical Services and is one section of a general survey being made of all Eskimos in Canada which is being undertaken this Summer. Doctor Hiltz will be away five weeks, and during his absence Doctor J. J. Quinlan, the assistant superintendent, will be in charge of the Sanatorium.

Doctor J. C. Theriault of Halifax, Dal. 1949, who recently completed post-graduate studies in psychiatry, has accepted the post of assistant to the Director of Mental Health for Prince Edward Island, and has taken up residence in Charlottetown. Doctor Theriault attended the Canadian Psychiatric Association meetings held in conjunction with the Canadian Medical Association meetings at the Mount Royal in Montreal in June.

Doctor and Mrs. W. K. House and family of Halifax left during June on a motor trip to the United States and Toronto, Ontario.

Doctor J. S. Manchester of Halifax left early in July for New York where he will further his studies in radiology at the Bellevue Hospital.

Doctor R. M. Ritchie, who graduated from Dalhousie Medical College, September 1st, 1943, and has been taking post-graduate studies in Montreal, has arrived in Halifax to take up permanent residence.

The Bulletin extends congratulations to Doctor aad Mrs. R. C. Young of Halifax on the birth of a daughter, Joan Beverly, on June 25th; to Doctor and Mrs. H. K. Hall (nee Barbara Wagstaff) of Halifax, on the birth of a daughter on July 9th; and to Doctor and Mrs. H. R. Roby (nee Irene Lowe) of Windsor on the birth of a son, John Harold, on June 30th.

Doctor Norman H. Gosse of Halifax, past national president of the Canadian Medical Association, was operated on at the Montreal General Hospital on June 23rd, and is progressing favourably.

Doctor K. A. MacKenzie of Halifax who was a patient at the Victoria General Hospital for two and a half months, has returned home, and is much improved in health.

The following announcements have been made—Doctor J. F. Boudreau has opened an office for the general practice of medicine at 410 Robie Street, Halifax; Doctor F. J. Barton has opened an office for the purpose of engaging in the general practice of medicine and the speciality of general surgery in association with the Dartmouth Medical Centre; Doctor J. F. MacLellan has opened an office for the practice of medicine in Whycocomagh, and Doctor H. C. Still has moved his office from 261 Quinpool Rad to 168 Quinpool Road, Halifax.

The following were successful candidates in the Medical Council of Canada examinations held at Halifax last spring: Clark Hazen Adair, Moncton, N. B.; Robert Thompson Annand, Bridgetown; George Warburton Bate, Saint John, N. B.; Albert Calvin Billard, Glace Bay; Harold John Blackwood, St. John's, Nfld.; John Francis Boudreau, Halifax; William Goulding Cameron, Dryden, Ontario; Alexander Craig Campbell, New Glasgow; Horace Bernard Colford, Halifax; John David Earle Cowan, St. John's, Nfld.; Joan Margaret Crosby, Halifax; Frederick Gerard Dolan, Sydney; Arthur William Elliot, Halifax; William Alan Ernst, Halifax; George Everett Fletcher, Marysville, N.B.; Donald Edgar Forbes,Elmsdale; Carl Cleveland Giffin, Halifax; John Oakley Godden, Sudbury, Ont'; Franklyn Herbert Hicks, Bridgetown; John Elton Higgins, Newport, Hants County; Burton Daves Howatt, Bedeque, P. E. I.; Donald Bruce Keddy, Mahone Bay; Gordon Ernest Lawson, Bathurst, N. B.; James Arthur Lewin, Halifax; Douglas Elroy Lewis, Digby; Douglas Andria Cassuolo MacDonald, Charlottetown, P. E. I.; John Cameron MacDonald, Freeport, Digby Coun-ty; John Wilfred MacIntosh, Halifax; Harold Vernon MacKay, Pictou; Alvin Edward Clark MacRae, Milford Station; Donald Andrew Charles Malcolm, Saint John, N. B.; Emerson Amos Moffitt, McAdam, N. B.; Francis Joseph O'Keefe, Gowan Brae, P. E. I.; James Alroy Phills, Sydney; Harry Peter Poulos, Halifax; James Kent Blair Purves, Halifax; John Howden Quigley, Halifax; Neil Douglas Reid, Ottawa, Onl.; Donald, Ingram Rice, Halifax; James Frederick Ross, Halifax; Joseph Alphonsus Ryan, Bathurst, N. B.; Caroline Phelps Scott, Halifax; Albert Edward Shapter, St. John's, Nfld.; William Ross Stewart, Charlotetown, P. E. I.; Albert William Taylor, St. John's, Nfld.; James Bernard Tompkins, Dominion; Noel Brown Trask, Dartmouth; Herbert Harold Tucker, Halifax; Charles Donald Vair, Halifax; James Charles Vibert, Truro; Donald Cyril Wilansky, Detroit; Douglas Leo Wilansky, Halifax; James Arthur Wilson, New Dominion, P. E. I.

Doctor and Mrs. M. M. Davis of Halifax had a ten day trip to the Seignory Club, Quebec, in June, where Doctor Davis presented a paper before the annual meeting of the Canadian Society of Obstetricians and Gynaecologists.

Doctor and Mrs. R. F. Plumer of Halifax were on a motor trip through the United States and Montreal during June.

Doctor Kenneth A. MacKenzie of Halifax, former President of the Canadian Medical Association, was elected a senior member of that Association at the annual meeting held in June.

The medical profession must be kept free so it can voluntarily adapt itself to the new order, Doctor N. H. Gosse of Halifax, retiring president of the Canadian Medical Association, stated at the annual meeting at Montreal in June.

Doctor Gosse said in his valedictory address that ended two days of a general Council session, that the medical profession is threatened by vast social changes, which are being forced on it from the outside. Changes imposed on medicine in other countries had too often done harm.

Doctor Gosse proposed three ways of combating attempts to fetter medicine:

1. Unity within the medical profession.

2. Broadening of education of the doctor to include more intensive study of literature, philosophy and other subjects known as the humanities.

3. Voluntary adaption by the medical profession to the inevitable social changes sweeping the world.

He said that in other countries "that speak our tongue, there have been rattling of sabres and wars of nerves, from which our own country had not been altogether excluded, for there had been threat of destruction to the system to which we also have been accustomed.

"However, because of wise leadership in our country, it has found us making an honest attempt by medically-sponsored medical care, plans and otherwise to meet the demands of our time. This attempt has brought about a respect for us in the minds of the better-thinking men."

Doctor N. K. MacLennan, of Dalhousie University, has been awarded a Life Insurance Medical Fellowship of $3,500, it was announced in Toronto in June by the Canadian Life Insurance Officers' Association. This is the first time such a fellowship has been awarded in the Maritime Provinces.

Doctor MacLennan plans a study on "natural childbirth and its effect on the mother and the baby."

These fellowships, which are awarded annually by the standing committee on public health of the Canadian Life Insurance Officers' Association, are designed to assist the medical schools of Canadian Universities in retaining the services of outstanding research workers.

Doctor Norman H. Gosse of Halifax, President of the Canadian Medical Association announced, formation of Trans-Canada Medical Services, a doctor-sponsored, country-wide organization for pre-paid medical care, at the annual meeting in Montreal in June.

Representatives of seven Canadian Medical Care plans sponsored by medical groups ironed out difficulties to formation of the national service at a meeting, prior to opening on June 18th of the 82nd annual meeting of the Canadian Medical Association.

Doctor Gosse said a private bill in Parliament will be necessary for formal incorporation but the organization will not wait that long to begin operations. Doctor H. P. McNulty of Winnipeg is chairman of the new organization which will not supplant regional medical care plans but will extend their services in several ways.

An important role of the organization will be to extend pre-paid medical care coverage to all Canadians, Doctor Gosse stated.

"The Canadian Medical Association believes medical care insurance should be available to all Canadians with the state paying the premium, in whole or in part, of those who are unable to pay for themselves.

"If it is necessary to work with the federal government in attaining these objectives, Trans-Canada would act as the representative of the plans.

"We believe that in this way we can provide better and more economical care for all Canadians than could be done through a government-run plan," he said.

A change in public attitude toward mental sickness was urged by Doctor R. O. Jones of Halifax, in an address to the Halifax Progressive Club on June

5th. Doctor Jones said that mental illness is something that should be treated as soon as possible, and people should not attach a stigma to those who have spent time in mental institutions.

He also deplored the limited psychiatric research carried on in Canada. He said that only $30,000 was allotted for research up until two years ago. He did say, however, that more extensive measures are being carried out now.

Doctor Jones said that psychiatry, the study of human behaviour, was of great importance to people in all fields. Doctors, nurses, social workers, school teachers, lawyers and others were finding it as an invaluable aid in their work, he stated.

Doctor C. J. MacKinnon, of the staff of Camp Hill Hospital, Halifax, has been appointed chairman of the Disaster Services Committee of the Nova Scotia Division of the Canadian Red Cross Society.

All 20,000 physicians in Britain's socialized health services told the government on July 19th they would resign September 25th unless their demands for increased rates were submitted to arbitration.

The ultimatum was delivered to Health Minister Hilary A. Marquand after British Medical Association committees from all counties conferred for seven hours in London.

The medical men, who signed up under Britain's national health service, include all except 1,000 of the county's general practitioners. The income of each is estimated between $3,000 and $6,000 a year. The average British worker is credited with an income of $873 a year.

Negotiations for a pay increase have been under way for months between the Ministry of Health and the physicians' group but the doctors insist they have been getting nowhere.

The marriage took place in Halifax on June 11th of Gloria Lorraine, granddaughter of Mrs. John Thomas Lawrence, North Sydney, and Doctor John Howden Quigley, son of Mr. and Mrs. J. Gordon Quigley of Halifax. Doctor Quigley graduated from Dalhousie Medical College in May of this year, and is now taking post-graduate studies at Sunnybrook Hospital, and the Toronto General Hospital, Toronto.

The marriage took place at Kentville on July 4th of Lindsay Clark, daughter of Mr. and Mrs. W. C. Gemmell, Kentville, and Doctor James Allan Myrden, son of Mr. and Mrs. James Myrden, Halifax. Doctor Myrden graduated from Dalhousie Medical School in May of last year, and is now taking post-graduate studies at the Victoria General Hospital, Halifax.

The marriage took place at Port Williams on June 2nd of Doris Melissa Lantz, daughter of Mr. and Mrs. Lantz of Port William, and Doctor Garnet James Henry Colwell, son of Lieutenant-Colonel and Mrs. G. J. Colwell of Halifax. Doctor Colwell graduated from Dalhousie Medical School in 1950, and is now taking post-graduate studies at the Royal Victoria Hospital, Montreal.

On May 19th at North Sydney the marriage was solemnized of Helen Gertrude, daughter of Mr. and Mrs. S. F. MacDonald of North Sydney and

Doctor Emerson Amos Moffit, son of Mr. and Mrs. Amos Moffit, McAdam, N. B. Doctor Moffit graduated from Dalhousie Medical School in May of this year and is now practising at North Sydney.

The marriage took place at Milford, Nova Scotia on June 6th of Jean Margaret, daughter of Rev. J. A. and Mrs. Nicholson, of Milford to Doctor Alvin Edward Clark MacRae, son of Mr. and Mrs. Earle MacRae of Brookfield, P. E. I. Doctor MacRae graduated from Dalhousie Medical School in May of this year and is at present practising in Halifax.

The marriage took place at River Hebert in June of Leta Naomi, daughter of Doctor and Mrs. D. M. Cochrane of River Hebert, and Doctor Gerald Rosborough Clayden, son of Mr. and Mrs. F. R. Clayden of Vancouver, B. C. Doctor Clayden graduated from Dalhousie Medical School in 1949, and is practising at River Hebert.

Obituaries

DR. LOUIS MORTON SILVER

Doctor Louis M. Silver died at Halifax on June 6th in his 88th year. He was born at Halifax, one of a large family. The Silvers were merchants in Halifax and had a place of business on the present site of the main office of the Bank of Montreal. Young Louis went to King's College at Windsor, where he graduated in Arts, and then to the University of Edinburgh for Medicine. From boyhood he had an intense love of the country and its wild life. In those days in Edinburgh classes went on the year round with vacations far too brief for a trip to Nova Scotia. One Spring the urge for home and fishing became overwhelming and the medical student took French leave, securing for a guinea the services of a fellow student to answer his name at roll call. We may be sure that he returned to his studies refreshed and with a new interest.

The Eighties was an era of famous teaching in the Medical School of Edinburgh. Anatomy and Physiology were given exceptional emphasis and above all the observation of clinical signs. Histological pathology had now an established place but Morbid Anatomy was the chief source of interest in the post mortem room. At the Edinburgh Infirmary the majority of deaths were investigated and the clinician who was incorrect in his diagnosis in more than 10% of cases was considered inefficient. Preceding Louis Silver as a student at Edinburgh was Arthur Conan Doyle, but the tradition which inspired the sleuth of Baker Street was still present and the stress on observation and deductive reasoning so marked in the teaching of Bell had seized and held the imagination of that generation of students and professors alike.

Following graduation in 1889, Doctor Silver went to Wakefield, England, as assistant to a physician with a large panel practice. At that time there was literally an epidemic of lead poisoning there chiefly among domestics in the families of the well-to-do. It did not take the young physician long to discover the cause. Water had been "laid on" for some time in the homes of the affluent, and the source of the trouble was the lead piping. But why were the servants affected and not their employers? Quite simple! The servants drank the water in the morning that had rested over night in the pipes. If the family drank water at all it was later in the day and comparatively free from lead in solution. After two years of successful work the call of home again became overpowering and Doctor Silver returned to his native city of Halifax.

The early nineties were good times for a young man to begin practice in the Capital City, especially if he came from Edinburgh. Graduates of that school had a deservedly high reputation. After the great upheaval in medical circles in 1885, the Halifax Medical College and the Victoria General Hospital had taken on a new lease of life. Doctor M. A. Curry, remembered by many, was the young, enthusiastic teacher of Obstetrics, and the younger men who took a hand at anything offered in the way of teaching were Guy Carleton Jones, A. I. Mader, and the newest recruit of all, Louis M. Silver.

It was not long before he had an adequate practice almost wholly in medicine. It was not large or excessively busy, but it was of first class quality and it suited his tastes perfectly. Having some independent means he was able

to do a great deal of charitable work chiefly in the wards of the Victoria General Hospital, and teaching in the Medical College. In those days if his professional interest had one rival it was hunting and fishing. Hunting was chiefly for wild fowl, and fishing was for the prince of game fish, the salmon. Early in the century he built a summer home at Melrose on the St. Mary's River and as the years went by a longer and longer portion of each summer was spent in these delightful surroundings.

I first knew Doctor Silver as a teacher in 1925. At that time he lectured in medicine on diseases of the nervous system, and gave regular ward walks and clinics at the Victoria General Hospital. His lectures were classics of brevity and clarity. He was completely at home with his subject and led us through the intricate anatomical pathways of his field with singular ease. Having been Professor of Physiology at an earlier date his practical command of that subject was amazing and the two combined to give a course of lectures never to be forgotten by any medical student.

I notice that I have just introduced a personal note, and indeed it is difficult to refrain from it as two years later I had the inestimable privilege of being his house surgeon for six months at the Victoria General Hospital. If I admired him as a student this feeling was enhanced beyond measure when he became my Chief. To me he was unremittingly kind, and memories of this and the delightful hospitality of his home can never be effaced. I do not believe he treated me in any way differently to his other internes, and I feel that I share the great boon of his acquaintance with many others in the preceding years.

The first thing that struck amazement into the student on the first day of his ward walks with Doctor Silver was his monoaural stethescope. This was all metal and in two pieces which he carried in his coat pocket and screwed together for use. On one occasion when he forgot it I offered him mine which he refused saying the sounds he would hear would be like thunder. I know that with it he could hear râles and the most elusive mitral murmur never escaped him.

His marvellous clinical sense and his accuracy as a diagnostician were a constant source of amazement to his students and the wonder and gentle envy of his confreres. His first procedure was a long, steady gaze at the patient's face, and what he saw there was often the key he sought. No patient was X-rayed before he had made a diagnosis. X-ray was only for purposes of confirmation. I remember a patient with a classical history and symptoms of carcinoma of the stomach. Within five minutes of seeing him Doctor Silver stated with the greatest assurance that it was not cancer, and it turned out he was right. In fact I never saw him wrong, but the more I saw the less confident I felt that it would never be possible to find another like him. Call it experience, intuition or what you like, in him was a faculty which it was dangerous for lesser men to emulate.

His practise of therapeutics was sound. He used drugs sparingly and often in small doses repeated at short intervals, rather than in massive single doses. This was particularly true of laxatives. He used to say, "Give little doses to worry the bowels; don't put them into a state of spasm by too much." If he had a therapeutic middle name it was Belladonna, and used judiciously in a large variety of cases it had remarkable results in his hands.

So far as I can learn he did the first lumbar puncture in Nova Scotia. It

was in a case of cerebro-spinal meningitis in a lad who was taken ill in Halifax while on the way with his parents to the West Indies. Against the advice of his colleagues Doctor Silver did the puncture and found the spinal fluid under tremendous pressure. The illness lasted for months but the boy eventually recovered.

In 1929, promptly as he reached 65, Doctor Silver retired from his position as Head of the Department of Medicine at Dalhousie University and of the Medical Service at the Victoria General Hospital. Thereafter he practised, as he said, "among a few old friends." His winters were spent quietly in Halifax, his summers on his beloved St. Mary's. About three years ago he had a slight cerebral haemorrhage after which he gradually failed in vigor.

In the eighty-three years of medical teaching in Halifax no man worked so long, so faithfully, or so well in the field of medicine as Doctor Louis Morton Silver. His name has been a byword for sixty years and as long as one of his students lives so long will the memory of one of the great physicians of Canada remain fresh and green. Those he taught will pass his teaching on though none will ever rival him. For me he will always represent the finest in skill and in character that the profession in Nova Scotia has known.

To Mrs. Silver, his son Doctor Gordon of Sherbrooke, and to his two brothers, Mr. H. St. C. Silver of Halifax and Colonel John P. Silver of London. England, the Bulletin extends sincere sympathy.

H. L. Scammell.

The death occurred on June 30th at Halifax of Doctor John Charles Morrison. Doctor Morrison was born at Englishtown, N. S. on August 15th, 1874, son of the late Mr. and Mrs. Neil Morrison. He was educated in the old Halifax Academy, and received his medical degree from Dalhousie in 1903. He did post-graduate work at London and Edinburgh, the Mayo Clinic and the New York Polyclinic. Beginning as a general practitioner Doctor Morrison served as resident surgeon of the Dominion Coal Company, and was a staff member of St. Joseph's Hospital, Glace Bay, surgical staff member of the New Waterford General Hospital, and examiner in surgery of fourth and fifth year medical students at Dalhousie University. He retired in 1943 when he came to live in Halifax.

Doctor Morrison was a Fellow of the American College of Surgeons, a council member of the Canadian Medical Association, vice-president of The Medical Society of Nova Scotia, President of the Cape Breton Medical Society, a member of the Provincial Medical Board, the Halifax Medical Society, Nova Scotia Historical Society, Institute of International Affairs, Canadian Club, North British Society and the Masonic Order.

Besides his widow, the former Maisie Duff of Carbonear, Newfoundland, he is survived by three sons, Fred Charles, New Glasgow; Doctor NeilAlastair, Musquodoboit Harbour, William Duff, Antigonish; one brother, Allan Y. Halifax; one sister, Annie (Mrs. Jack Sanderson), Toronto, and a nephew, Doctor C. N. Morrison of Halifax. Two brothers, Doctor M. D. Morrison and M. B. Morrison, predeceased him. Funeral services were held at St. Andrews Hospital on July 4th, with interment at Camp Hill cemetry.

The death occurred at Vancouver on July 8th of Doctor Guy Stewart Goodwin of Moose Jaw, Saskatchewan, a past president of the Canadian

Medical Association. Doctor Goodwin was born at Halifax in 1891, and graduated from Dalhousie Medical School in 1912. He practised in Moose Jaw from 1921 to 1949, when he retired to Vancouver. Doctor Goodwin served in the Royal Army Medical Corps from 1914 to 1919. Between the First and Second World Wars he was officer commanding the 10th Field Ambulance in Moose Jaw. He was founder of the Associated Medical Clinic of that city.

The death occurred in May of Doctor Theodore Rupert Ford, a native of Milton, N. S. Doctor Ford graduated from Dalhousie Medical School in 1903, and went to Liverpool in 1909 where he practised until a few years ago when, owing to ill health, he was obliged to retire. He is survived by his widow, the former Margaret Levy of Digby, and one son, Eugene. His younger son, Sidney Leslie Ford, was commander of the famous "Wolf" Squadron of the R.C.A.F. and was killed overseas.

The Bulletin extends sympathy to Doctor H. B. Ross of Halifax on the death of his mother, Mrs. H. A. Ross which occurred at Wolfville on June 11th; to Doctor F. A. Minshull of Grand Falls, Newfoundland, on the death of his father, Mr. A. H. Munshull of Halifax, which occurred on June 15th, and to Doctor J. F. L. Woodbury of Halifax, at present in Toronto, on the death of his mother, Mrs. F. V. Woodbury, which occurred at Halifax on July 7th..