Writing for the Medical Press*

S. S. B. Gilder, M.B.,
Toronto, Ontario.

IT is a safe bet that this year someone will make a contribution to the Anglo-Saxon medical literature in which he will complain of the increase in illiteracy among medical men and offer suggestions for raising the standards of medical English. Concern at the poor standards of literary style, grammar, spelling and calligraphy among scientists is by no means localized, nor is the assumption warranted that the English themselves employ their language any better than do the inhabitants of other countries. Last year the dean of Westminster Hospital Medical School complained bitterly that the work of some of his candidates for entrance "bordered on illiteracy"; he did not even comment on their literary style—presumably they had none.

Since every medical man is called on at some time to write something, even if it is only case notes, and since clear and sensible prose is much more agreeable for everyone than obscure meanderings, it may not be inappropriate to discuss in this article some of the commoner pitfalls encountered in medical writing. It is of course the function of the trained medical editor to see that the common faults in contributions to his journal are corrected. He should, as it were, act as an obstetrician to the author and see him safely delivered of his thesis with a minimum of interference but nevertheless with a certain amount of antenatal care. Ten years of daily contact with authors have convinced me that nearly all need some care. I shall hope to show by taking some examples from current medical journals and reports what happens when the necessary antenatal care is not forthcoming. In searching for awful warnings I was careful to avoid the work of Canadian authors—not because they are any less likely to commit such sins but because of the traditional distaste for fouling one's own nest.

It is of course only fair to fellow-editors to point out that a few apparently share Virchow's view about his famous *Archiv*—"In my journal, anyone can make a fool of himself." This is a view I cannot share; it seems to me to be the editor's job to stop any contributor from unconsciously exposing himself to ridicule.

Obscurity.

The editor should in particular try to persuade his authors to use plain English instead of the pretentious guff which Congressman Maverick called "gobbledygook" and Sir Ernest Gowers calls "pudder." There are several reasons for using plain language. In the first place, use of unnecessary jargon or slovenly construction is discourteous to the reader. He may be forced to read you because of the scientific content of your paper but he will never love you. Secondly, the author should pay himself the compliment of assuming that persons whose native tongue is not English will want to read and translate his work. Nothing shows up woolliness of thought more than an attempt to translate the thought into another language. Thirdly, the colloquial terms used

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to-day may be forgotten and incomprehensible or frankly comic in twenty years time. An Englishman who wishes to send his Canadian friends into gales of laughter has only to say that something is "awfully jolly," a current phrase in the English of the twenties. Beware of the "awfully jollies" in scientific prose.

Now here is a nice example of obscure writing and thinking from a U.S. Journal:

> "In case of a more complete work-up the cause effect relationship between causative factors and their symptoms could be accomplished on a more satisfactory and scientific basis."

This rather dim glimpse of the obvious presumably means that if you studied your cases more thoroughly you would be more likely to find out the cause of the symptoms.

Another pleasant example comes from South Africa. Writing of a well-known Scottish surgeon, a social scientist says:

> "he was preaching the fundamental truth that virtuosity alone was liable to be frittered away unless consummated in the fields of after-care and social service."

Note the rather offbeat Freudian symbolism. First you have virtuosity and then it is consummated in the fields, a sort of rehabilitational honeymoon.

An expert of rheumatism writes:

> "The use of hormones generally should be restricted to a small portion of the overall spectrum of patients with rheumatoid arthritis."

Does this mean that only a few patients with rheumatoid arthritis should be given hormones? We suspect so.

I have collected some odd adjectival phrases from recent literature:

> "martial predication situations, happiness adjustment items, a semi-sitting portable roentgenogram, goals approximating middle class social mobility aspirations, serious hyperadrenal pitfalls."

A sentence I like is: "After removal of the affected epididymis the vesicles and prostate usually settle down and become quiescent," no doubt hitting the perineal floor with a gentle thud as they setttle down.

Elegant Variation.

The desire to be non-repetitious sometimes leads to what is called the elegant variation, which is alas more often inelegant. For example, children become "patients of paediatric age" and old people "patients of geriatric age." It reminds one of the old story of the reporter who had to write a piece about bananas, and after using the word banana three times was driven in desperation to use the synonym "elongated yellow fruit," a name by which he was ever after known in the newspaper office.

Why do straightforward, honest doctors write in this odd way? First of all, because it has become fashionable, and rigid conformity to fashion is the hallmark of our society. Emily Post's book of etiquette does not get any slimmer in this age of freedom; its contents just change. So if you do not want to feel socially and intellectually inferior you must use the good old cliches and jargon, even if you know that they are silly. You have to "initiate" treatment, not begin it; you have to "do a liver profile" because that is

the smart thing to do, but you must not "sit on a perforated gastric" because that is inadvisable.

How are you to avoid obscurity? The answer is to have some reliable friend read your work through and criticize it. If you are unfortunate enough not to have a sense of humour, be sure to marry a woman who has. She may stop your writing such comic sentences as:

"Those (patients) in distress due to the loss of functioning pulmonary parenchyma are first decompressed and expanded by catheter."

Ambiguity.

Sometimes—indeed often—a medical writer produces a sentence with two meanings. Only this year the programme of a provincial medical society's annual meeting contained this gem:

"Please indicate what you would like to do to the ladies at the Registration Desk, who will do their best to meet your wishes."

Here is a more serious but no less ambiguous one:

"One died of a tuberculous meningitis with belief that her onset of symptomatology was due to isoniazid therapy, when actually her findings were due to an advancing unrecognized meningitis." (Whose belief? The patient's?).

Redundancy.

In the days before World War II, a venerable old gentleman called Charlie used to deliver at orators' corner in Hyde Park, London, a speech which never varied in content or phraseology. His regular audience, who knew the speech by heart, would at times chant it a sentence or two ahead of the speaker, and would then yell at him "Shut up, Charlie, we've said that already." What a pity the reader cannot say that to the author Length of a paper is no criterion of its quality, though few authors would admit this. Let us therefore prune out all the dead wood systematically. If this were aways done, we should not have such statements as "The degree of focus on hypochondriacal complaints was of only moderate or minimal degree." Why not, "he was at the most only moderately hyperchondriacal. Again (same article): "The great number of these self-help devices are too numerous to mention." 'Lowering of the level of medication was done." (Why not say "The dose was reduced"). "She was treated medically with various types of therapy." All this is unnecessary ballast that does nothing to further absorption of the pill of knowledge, or even to sweeten it.

Metaphors.

One would have thought that persons had been sufficiently warned against the dangers of the comically confused metaphor, but not a bit of it. Here is a nice mixed image from a contemporary:

"For those gifted with ability to *sift* pertinent data from a mass of confusion and *unfold* it in a systematic and comprehensible fashion."

The person who can do that should also try his hand at "weaving loose ends on a long-term basis" (From an American Professor). A nice combination of the hunting field and the machine shop is seen in the statement about rehabilitation in South Africa:

"The need to conserve manpower in a young community in full cry after industrialization is likely to act as a powerful lever to forge the necessary co-operation between medicine and industry."

Clause Trouble.

Dangling clauses with nothing to modify abound in the literature. I have several favourites:

"As soon as detected the psychiatrist should take over."

"On admission, we were confronted with a well nourished boy."

"Emerging from this animal work, it appears to be safe to cool to 25C. within an hour." (from Guy's Hospital, no less).

Sometimes the words get displaced in the sentence. An English otologist writes:

"Polypi due to allergy usually exist in a nose which is clean but not always." An odder displacement has occurred in the sentence: "These were all active, severely crippled persons with rheumatoid arthritis." The word "active" should of course precede "rheumatoid arthritis."

Mrs. Malaprop.

Mrs. Malaprop is by no means dead. In an article on medical education, a subject which often brings out the worst in writers, the author remarks that "an agent proceeds the team" (instead of precedes). An English writer on abortion says: "This seems to be a very large number (of abortions) and goes to prove that many cases never result in criminal procedures." Criminal procedures should precede criminal proceedings.

Pet Words.

I would like to mention a few pet words which seem to hypnotize medical authors and spread like a rash over a printed page. Once you notice such a word when reading, it keeps catching your eye and distracting you from taking in the sense of what you are reading. *Show* is a common culprit. The patient mentioned below put on quite an act:

"The first patient showed a pregnant abdomen. She showed some asymmetry, and tenderness was shown on palpation in the left iliac fossa. She did not however demonstrate rigidity." *Exhibit* is another word which should be used with care:

"The patient exhibited an enlarged spleen" (in a bottle?) The build-up seems unnecessary in the sentence "examination *revealed* a boy lying on his side." *Following* is another medical editor's bugbear. It replaces "after" quite unnecessarily, and does inadequate duty for a lot of other words as well:

"Following the fascia is a layer of fat" suggests a procession.

"Following operation, the patient was followed by surgeons of this clinic for two years." (don't look round, but . . . . .).

Just as "following" takes the place of "after", "prior to" almost always replaces "before" nowadays. Why a phrase almost never used in speech should be so persistently written down is as big a mystery as the use of "markedly", a word medical editors strike out on sight. Everything in medicine is "marked-

ly" enlarged or "markedly" engorged or "markedly" blue. One can imagine the young physician saying to his girl friend, "If you will marry me, I'll make you markedly happy." Maybe they do talk that way.

Develop is another boss word. People do not get thinner, they "develop emaciation." Like *occur*, this verb should always be scrutinized with care before it is written down, to see whether a better substitute is available.

Cases, conditions and patients.

In medical writing, cases, conditions and patients are often confused. The sentence "types of patients seen were anxiety states, phobias, alcoholics, and obsessive compulsive states" is fundamentally incorrect. A phobia is not a patient, it is a condition. The sentence "Two acute appendices were admitted to hospital" suggests that these organs had already been removed elsewhere. "Cases" cannot die, nor do they leave hospital, although they are made to both these things in the medical literature every day.

Tables.

Contrary to what is sometimes believed, tables are not included in an article to embellish it, but to assist the reader in understanding it and assessing it. They must therefore be as simple as possible, and must really show something. Hot air, even if arranged neatly in columns, remains hot air. It is also as well if the figures in the columns add up correctly. This is not always the case. The writer of this article has had depressing experiences in the past, with last-minute frantic searches through the text for three missing patients or two surplus white mice.

References.

In a recent check of references submitted with manuscripts, an error was detected in over ten per cent of items listed. Either the author's name was wrong, or the name of the journal, or the year or the page number. For such inaccuracies there is no excuse. It is not essential to give references, and it is downright sinful to give incorrect ones and have your readers (or the editor's staff) wasting time and energy looking up imaginary papers. Where an original paper has not been seen, and the statement is based on a quotation, it is only fair to say so ("quoted by X in Y"). Hearsay can lead to awkward situations and is best avoided. "What the soldier said isn't evidence," as the judge said to Sam Weller.

The classical story of the dishonest reference was told by Clifford Dobell in *Parasitology* in 1938. It is the story of the mythical O. Upplavici. For years this name figured in the literature as the Serbian author of an article on dysentery. Dobell finally wrote his obituary note after discovering that in Serbian the words "O Upplavici" meant "About diarrhoea."

Conclusion.

Writing is a fascinating craft, to be practised always with the greatest humility and care. Whenever the writer begins to think that he is mastering his language, he may be sure that all kinds of pits are yawning at his feet. With this proviso, he may conveniently use as his guide the four points enumer-

ated by Sir Arthur Quiller-Couch many years ago. Sir Arthur said of good writing that it should be appropriate, clear, accurate and persuasive. The last of these is the most difficult to achieve. It can only be obtained by constantly remembering that in scientific writing the only person who counts is the reader. A Joyce or a Kafka can ignore his readers; Dr. Smith will do so at his peril.

SOCIETY MEETINGS

Western Nova Scotia Medical Society

Twenty-nine doctors from Western Nova Scotia gathered in the Grand Hotel Friday evening, April 20th, for a dinner meeting sponsored by the Dalhousie Post-Graduate Committee and presided over by Doctor Robert Belliveau of Meteghan.

Doctor W. T. Mustard, Associate Professor of Surgery at the University of Toronto was to speak to us on "The Present Status of Heart Surgery" but was grounded by fog at Saint John.

We were extremely fortunate in having with us Doctor Bernard Shaw, Medical Director of Maritime Medical Care, Halifax, N. S., who ably filled the breech and whose talk provoked an interesting and profitable discussion of medical problems.

Strong objections were voiced at the recent unfavourable publicity given over the small charge made for injections of Polio Vaccine at the Clinics.

The recent increase in The Medical Society of Nova Scotia fees was discussed at length and opinions expressed both for and against.

The Grand Hotel provided an excellent fish dinner nicely served in the private dining room.

The Saturday morning Clinic on Orthopaedics also had to be cancelled due to Doctor Mustard's enforced stay in Saint John but he has indicated a willingness to return next year.

Doctor Dagleish of Roseway Hospital, Shelburne, gave a very interesting talk on medical practice in England under the National Health Scheme.

D. F. MACDONALD, M.D.,
Secretary-Treasurer.

Some Observations on Divisional Secretaries

Max O. Klotz, M.D.
President, Ontario Division, Canadian Medical Association

RECENTLY a situation developed within our Province which caused our Executive Committee to pause and reflect on the role played by the members of our secretariat in the Medical scene. It struck me then that we were extraordinarily complacent and possibly casual about these officials who function with such efficiency, devotion and lack of turmoil that one is inclined to take their existence for granted, overlooking the incalculable contributions which they can and do make to the progress and development of organized medicine.

The responsibilities assigned an executive or general secretary of a large medical organization are so broad, diverse and in some instances nebulous that it is difficult to draw a clear picture of the activities which he endeavours to crowd into a twenty-four hour day and seven day week. The nature of his duties and his contacts are such that quickly he becomes a super specialist, an expert in medical economics, medical politics, ethics and methods of practice (desirable and otherwise). Quickly he becomes more interested in the welfare of the profession as a whole than any other single member of the group. Qui kly he learns to palpate with great delicacy the pulse of Government thinking and Government interest as well as that of other groups who concern themselves with medical affairs.

The office of the secretary is the hub on which the organization must rotate if progress is to be made. Today in the hurried hubbub of practice no one can devote the time to this onerous office which it deserves and still do justice to his patients. Of recent years we have found that the pressure and complexity of our activities have necessitated the creation of endless committees and subcommittees. If the efforts of these hard working committee members are to be utilized to the fullest it is imperative that they have available the services of someone who can gather together and sift the raw materials with which the committee must work, someone to co-ordinate effort and prevent reduplication, someone to interpret policy and clarify terms of reference and directives. Only a secretary who has access to the information sources, who sits in on all committee meetings, including those of the board and executive can discharge these responsibilities with efficiency.

By virtue of his interest and knowledge of every phase of organized medicine a secretary becomes almost an oracle. It is to him that members of the profession turn both as individuals and groups for guidance and advice and it is through him that their problems are brought to the board. Likewise the public quickly learns of his existence and follow the example set by their family physician in seeking his help when certain of their problems touch the profession. Thus it is that he becomes a public relations officer promoting good will not only

between his medical confreres but also between the profession and the public at large. This matter of public relations is, of course, an enormous task and one which the profession has too long neglected. The urgency of accepting this burden is emphasized by the renewed interest with which Governments at all levels are now scrutinizing the profession.

The executive secretary is a dedicated individual; dedicated to promote the welfare of his medical confreres by all means within the confines of the Hippocratic tradition. As such he becomes the "Idea Man", the individual competent to express self-criticism of the profession and who from his vantage point can best see those areas in which deficiencies exist, can best foresee the pitfalls in our path and direct our steps to smoother highways. As the "Idea Man" it is often he who creates the nucleus from which a major project may develop.

From the foregoing one might wrongly deduce that a medical society would be in danger of deteriorating into a one man organization. Nothing could be further from the truth as the secretary must always function through his board or executive. However, by virtue of the fact that he is daily devoting his total energies to the matters of organized medicine he is in a position to bring to his board a clear, concise picture of the problems and is at the same time competent to suggest alternative solutions and the merits or otherwise of each. Final policy must, of course, always remain the responsibility of the board.

One criticism which I have been able to direct at those secretaries with whom I have had contact emanates from the fact that as a result of their efforts they evolve if possible too many projects and problems, in brief their role as slave drivers is from time to time somewhat trying, especially so when the crises and problems which are brought to our attention appear at those times you had planned to go fishing.

From what has already been said it is obviously my opinion that nothing will strengthen and integrate an active and progressive medical society as much as the establishment of an efficient secretariat revolving about the full time executive or general secretary and I am convinced that any society which creates such a unit will never have cause to regret their decision.

FULL-TIME SECRETARY

Applications are invited for the post of full-time Secretary of The Medical Society of Nova Scotia. Salary range $10,000 to $12,000 per year. Applications should be forwarded to the Chairman of Selection Committee, care of The Medical Society of Nova Scotia.

BURSARY FOR TRAINING IN CLINICAL PATHOLOGY

A Bursary covering training in Clinical Pathology leading up to certification in this subject will be available commencing in July, 1956. For further information interested parties are asked to write the Director of Radiological and Laboratory Services, Department of Public Health, Provincial Building, Hollis Street, Halifax, N. S.

AWARD IN HOSPITAL ADMINISTRATION CREATED BY JOHNSON & JOHNSON LIMITED

President Sidney E. Smith of the University of Toronto has announced the setting up of an annual award of $1,000. for the outstanding student in the University's Graduate Course in Hospital Administration. This award is to be known as the Robert Wood Johnson Award and has been made available through the generosity of the officers and board of Johnson & Johnson Limited, well-known manufacturers of surgical dressings and supplies.

The award will be given at the end of the second or residency year and will be conferred upon that member of the class who gives the most promise of making a real contribution towards the advancement of hospitals and hospital administration. Consideration is to be given to personal attributes—particularly to motivating principles, to capacity for leadership, to executive ability, to industry, and to the ability to give and gain co-operation. Academic standing is to be a consideration although not the sole one. This award will be made by the Director of the School of Hygiene upon the recommendation of the Department of Hospital Administration.

Commenting upon this announcement, Dr. Harvey Agnew, head of the Department, said: "We are delighted with this gift made possible by the generosity of Johnson & Johnson. We are proud of the fine young people who are taking this Course and this award will be an added incentive to further effort and a fitting reward for work well done."

ELEVENTH ANNUAL SCHERING AWARD COMPETITION OPENS

Devoted to research and the communication of knowledge in the medical profession, the Schering Award has begun its eleventh annual program for medical students in the United States and Canada.

Students are invited to participate by selecting one of three suggested subjects and submitting papers to the Schering Award Committee, Bloomfield, N. J. Both a $500 first prize and $250 second prize are offered for each of the three subjects. Decisions are made by a group of judges who are authorities in their respective fields. In addition, every participant in the contest receives a professionally useful gift.

The three subjects for 1956, announced by C. J. Szmal, M.D., chairman of the Schering Award Committee, are:

1. The Clinical Use of Adrenocortical Steroids in Collagen Diseases
2. Metabolic Aspects of the Aging Process
3. New Applications of Antihistamines in Medicine and Surgery

Literature and entry forms are being distributed in the medical schools. Students who are interested in participating, either individually or in teams, should submit their entry forms before July 1, 1956 and manuscripts must be postmarked not later than Sept. 30, 1956.

In a letter to the deans of medical schools, Francis C. Brown, president of Schering Corporation, said the Schering Award Committee was pleased that during the past several years Schering Award-winning papers have been met with increasing interest by professional journals and that many have already been published. The outstanding work of participating students has been such that they will undoubtedly contribute significantly to the professional literature during their careers in medicine, Mr. Brown added.

FEDERAL RESEARCH GRANT FOR MARITIME PROVINCES

Ottawa, April—A federal research grant for a diagnostic study of neurotropic virus diseases in the four Atlantic Provinces is one of three new health grants for the Maritimes, Hon. Paul Martin, federal health minister, disclosed on April 19th.

Mr. Martin said the study planned under the grant represents a clinical and laboratory investigation of neurotropic diseases prevalent in the Atlantic Provinces. Since vaccination against polio has been introduced, a number of clinical symptoms resembling nonparalytic polio have been found which were caused by agents other than the three known types of poliomyelitis virus. The purpose of this study would be to identify and classify these agents and to establish their relationship to nonparalytic polio and other diseases of the nervous system.

The research project, for which a federal grant of $10,275 has been made, will be carried out jointly between Dalhousie University's department of medicine and bacteriology and the Nova Scotia Department of Public Health. It is to be directed jointly by Dr. C. E. van Rooyen, an outstanding research worker and authority in the virus field who recently joined Dalhousie's faculty of medicine, and Dr. R. C. Dickson of the university department of medicine.

In New Brunswick a grant of $2,000 goes towards the purchase of prosthetic appliances and medical aids for use in the province's expanding rehabilitation program.

In Prince Edward Island a grant of $500 has been awarded to Robert D. Donnelly of the provincial Department of Health for a fourweek field training course at the Robert A. Taft Sanitary Engineering Centre, Cincinnati, Ohio. Mr. Donnelly is director of the Sanitary Engineering Division of the provincial health department.

The Importance of Good Obstetrics*

B. Tenney, M.D.,**
Boston, Mass.

DOCTOR Atlee has invited me to present this subject. We have not forgotten the talk he gave in Boston some years ago.

This is a wide field of course, but it certainly is a very important approach to this subject. It is very hard to define what good good obstetrics is. Basically, good obstetrics is the process in which one can deliver a baby in perfect health and leave the mother in as good or better condition than she was when she conceived that pregnancy. The criteria for this are difficult. To start in with, the dramatic and publicized estimate of good obstetrics relates to maternal mortality. We do not have any really good figures in the United States that we can compare because different States use different criteria. We do have a very accurate estimate in the State of Massachusetts and I would like to give you a few figures for the past year. In this State a maternal mortality consists of a death during pregnancy and up to ninety days following delivery. In the year 1954 out of approximately one hundred thousand births there were fifty-two deaths in the State of Massachusetts. These deaths were all very carefully reviewed by a Committee appointed by the State to do so. The doctors were interviewed, the hospital records were examined and all possible information was gathered. About two-thirds of these deaths were preventable. One-third consisted of certain complications that were unavoidable, such as patients with brain tumor or various things—accidental deaths of that type that no one could have predicted and that could not have been prevented. Two-thirds of the deaths definitely could have been prevented. On going through these statistics we divided them about equally. Of the two-thirds that could have been prevented, one-half were due to doctor's negligence and the other half to patient's negligence. You must face both those facts. The patient can be just as careless, can be just as much responsible for her own death, as can poor pre-natal or poor obstetrical care. Of course, the only way we can get at this angle of the problem is by public education and by circulating and talking to people in general.

In regard to the preventable deaths that were due to improper medical care, they were largely of two types—either the pre-natal care had been poor—by that, I mean the patient had not been properly seen or examined—or else the doctor had not taken steps until complications were too far advanced for treatment.

The other type of case was delayed replacement of haemorrhage during labour and childbirth. Unfortunately, this delay was not limited to small hospitals that had difficulty in obtaining blood but had taken place in good institutions, where blood was relatively available. The doctor in charge had not recognized blood loss soon enough to save the patient. So, in a State, well equipped with hospitals and doctors, we have a rather sad story and I am afraid that you would find the same story elsewhere. I merely bring this up to show that a great deal still can be done with the medical profession.

**Director of Obstetrics and Gynaecology, Boston City Hospital.
*Paper presented at Post-Graduate Course, Halifax, N. S., September 26, 1955.

As you all are aware maternal mortality has dropped terrifically in recent years. The various causes of maternal mortality have changed but there is still much to be done in that way. Now I bring this up, first, not as a means of method of trying to indicate what good obstetrics is, because good obstetrics lies far beyond the problem of maternal mortality. With proper care, most patients can be carried through pregnancy, no matter what their complicating disease or condition may be. At the present time, we do not fear to take the patients through pregnancy with heart disease, diabetes or other severe complications such as tuberculosis. It is simply in the proper care of these people that the answer lies. There is only one real situation that we are not able to provide the answer in this field and that is the problem of severe renal disease. Patients with severe renal disease are actually incompatible with pregnancy and we are unable to treat them in the proper manner. The health of the baby and the mother is the real problem. Too much of serious illness in children and in future life is due to poor obstetrics.

Recent studies in mental institutions, particularly in institutions of cerebral palsy and various forms of mental deficiency, have shown a marked relation to poor obstetrical care. Studies have shown in checking back on obstetrical records that children with cerebral palsy frequently have had periods of anoxemia or trauma during obstetrical delivery Mental deficiency is another state for which the obstetrician must accept a certain amount of responsibility. There again in retrospect we realize that many cases of mental deficiency relate back to prematurity and again to certain anoxemic episodes during labour and delivery.

In regard to the mother herself, there are certain results of poor obstetrics which may cripple her for life. Certainly such things as cystocele and rectocele, certain anaemias and other problems are related directly to their obstetrical care. If you consider the future surgery which may result in these patients, one has to take the whole picture as a part of obstetrics itself. There is a definite relation between cancer and postpartem care of the cervix. It certainly has been shown that cancer of the cervix is definitely related to chronic infection and erosion of the cervix, following delivery. An anaemic state may become chronic, if not properly treated. A patient who has severe shock and trauma in obstetrics will frequently be crippled for the rest of her life, from various causes.

Infection is one of the most crippling types of the complications of pregnancy in that sterility may result. Severe and dangerous surgery may be performed and often chronic invalidism results from this complication. Chronic pelvic inflammatory disease may be the result of infection during pregnancy and is one of the most crippling afflictions women have, particularly in the cases of early and infected abortion. All these things enter into the picture of the proper care of the pregnant woman.

In the days since Doctor Atlee and I started to practise obstetrics, there have been many changes which have occurred in our general policy of treatment. Twenty-five years ago, it was considered a last resort to do a Caesarian section. The reason for that was that then there was a mortality from Caesarian section of approximately four per cent. To-day the mortality from Caesarian section is less than one-quarter or a third of one per cent. As a result of that, the incidence of Caesarian section has increased markedly in practically all obstet-

rical clinics. The reason for this is very simple. Traumatic obstetrics and difficult forceps deliveries are extremely dangerous for the mother and for the baby. Some years ago, a paper was published from the Boston Lying-In Hospital in which the maternal mortality in mid forceps was twice that of the maternal mortality and Caesarian section. The foetal mortality in mid forceps was ten times that of patients that had Caesarian section. As a result, we have come to believe that proper delivery consists of two types. Either delivery by the normal method, or low forceps, which of course is the most desirable, or by Caesarian section. The traumatic forceps which we employed in the old days is so dangerous that it has largely been eliminated from our procedure. Twenty-five years ago, the sign of a good obstetrician was the ability to do a high forceps. To-day high forceps are considered practically inexcusable under any conditions as we have learned that trauma, as such, is one of the things which we have to avoid at all costs. Another reason why a Caesarian section is safer than it used to be, in addition to the presence of blood and antibiotics, which we now have available, is that we have also learned that the time to do a Caesarian section is not as a last resort, but when the patient is still in good condition and a good surgical risk. That means that we have to make up our minds and make our decision earlier and with more justification than when we left Caesarian simply as a last resort when everything else had failed.

You gentlemen hear a lot about pre-natal care. It may seem a very dull and dreary subject to you. I know it did to me when I first came across such teaching. However, pre-natal care is the basis and the foundation of good obstetrics. The object of pre-natal care is to have a mother in perfect physical health at the time of labour and delivery. Also, if the patient becomes pregnant, who is in poor physical condition for one reason or another, the pre-natal period must be spent in bringing her up to her top physical health before labour commences. If you have a patient who enters labour in perfect health, you have won nine-tenths of your battle as far as the safety of the mother and child is concerned. In the clinic at Boston City Hospital, where I do my work, we draw from the lowest economic and social group of a large city. They are people who have trouble getting enough to eat. Their nutrition is terrible. Their environment is poor and they have no rest or peace in their lives. From this group of people, we see time after time the difference between those whom we can have for six months before labour and those who come in without pre-natal care at the time of labour. It is the latter group that present us with our obstetrical problems and our obstetrical pathology, particularly in relation to toxemia, pre-eclampsia, anaemic states, haemorrhagic states and such things. The great majority of those problems come from this group of people, whose health is way below par.

Now, pre-natal care is relatively simple. There are only a few outstanding things that are actually necessary for a healthy patient. The first one that is important is the restriction of sodium. As everyone knows the pregnant woman has a marked tendency toward sodium and fluid retention If you give a pregnant woman either sodium or fluid, but particularly sodium, their excretion is markedly delayed and they have a tendency to store the substances in the tissues. One finds sodium and fluid retention in sixty per cent of pregnant

women. This is not clinically evident in many cases, except in weight gain. Women can store ten or fifteen pounds of fluid without any sign of clinical oedema or any external sign of the fluid retention. We have learned that if one can regulate the weight of the pre-natal patient, if one can keep them within specific bounds and limits, that we can prevent this fluid and sodium retention and we can practically eliminate pre-eclamptic toxaemia from our clinic. This has been quite evident because it has only been during the last few years that a great deal of pressure has been put on this particular point. Previous to two years our hospital was known for having the most active and interesting pre-eclamptic clinic in the city. But due to the proper use of nutritionists, the proper use of instruction and care of our patients, we have practically eliminated our pre-eclamptic clinic. Our so-called hypertensive clinic is simply essential hypertention and patients with renal disease. This is such a simple thing and so easy to achieve that you can eliminate one of the great problems of obstetrics and one of the great causes of maternal disease and actually maternal death.

The second most important point in the pre-natal care is the question of anaemia. She has more red cells than the non-pregnant patient, but also she has more plasma. The plasma volume is increased to a greater extent than are the red cells. This must not be taken as a fact and disregarded, because there are certain limits. A pregnant woman, at term, that has ten or more grams of haemoglobin is considered within normal limits. If it is below ten, or certainly nine, you are dealing with some type of abnormal anaemia in the patient. This usually is of the iron deficiency type, which is very easily controlled with proper iron replacement. A small number of cases develop a nutritional anaemia, which is slightly more difficult in treatment but does respond very well, principally to some of the factors of the B vitamin complex.

Another problem is hypoproteinemia. We do not see that very much in the northern part of the States and I do not imagine you do very much up here. But down in the South it is one of their big problems. It is one of their commonest causes or one of the commonest physiological factors in the type of pre-eclampsia that they have in the deep South. This is simply due to the fact that the diet of the people in those regions is very low in protein They develop hypoproteinemia, increased water and sodium retention, clinical oedema. In those cases the curing of the hypoproteinemia itself will frequently relieve the condition.

In addition to these facts there are certain others. Just common sense—such as proper rest, proper exercises and particularly the proper psychological approach to the problem of pregnancy. All these things, added up together, with occasionally certain specific problems in certain specific patients, will bring your patient up to labour in a state of good health. Take, for instance, cardiac disease. It was not too long ago that cardiac disease was considered incompatible with pregnancy. However, at the present time I think we can say that in the majority of clinics we feel no hesitation in taking a cardiac patient through pregnancy There again, it is the realization of the physiology involved in this condition and in the proper treatment during pregnancy. The same applies to tuberculosis. Not many years ago, tuberculosis was frequently considered an indication for termination of pregnancy. That

certainly is not true to-day. We have many patients with active tuberculosis that go safely through pregnancy and are delivered of a healthy, normal, living child. We feel that in almost any condition, with proper care, a patient can be carried through pregnancy.

Now the other important part of your pre-natal care is the estimation of the patient, as to her function in child-bearing. This is not as easy as it may seem at first hand. As you know there are three factors that we have to consider, and there is only one factor we can know in advance. The three factors are: the size of the baby, the force of the uterus, and the size of the pelvis. The size of the pelvis is the only thing we can get any accurate information on before labour begins. The force of uterine contractions or the efficiency of uterine contractions is something that has to be found by time and trial. The size of the baby is still a vague and indefinite thing, clinically speaking, so that there again that has to be somewhat dependent upon trial and test of the labour itself.

I do not believe that in more than one patient in a thousand, can you say in advance of labour, that this patient cannot possibly have a baby from below. Of the other nine hundred and ninety-nine there probably might be fifty who are questionable. But there is only one patient that you can be sure of and therefore the actual trial and test of labour is the important thing in making this estimation. Now, actually, the conduct of labour is probably more important in your result than the actual technique of the delivery. I think that Doctor Atlee would agree with me if I said that the thing that worries us least in obstetrics is actual delivery of the average child. The things that worry us the most are the conduct of the labour itself and the conduct of the third stage. The delivery of the baby is the dramatic thing, it is the thing that appeals and is exciting. But it is the final termination of a properly conducted labour which makes for a good delivery.

There are several things in regard to conduct of labour that are extremely important and the first one that I want to mention is the question of analgesia and anaesthesia. I am very much impressed with the work that is being done here, by Doctor Atlee and his colleagues, on so-called natural child-birth, because I think it is terrifically important. Certainly some adjustment of that technique is going to be the final solution of the management during labour. You can definitely damage a baby, temporarily, and sometimes severely, by improper use of analgesia during labour. You can turn a normal labour into an abnormal labour by the accepted use of analgesics. Now Boston, where I come from, is sometimes considered the home of anaesthesia, although this was violently disputed by some other places, but it certainly has been a town where anaesthesia has been predominately in people's minds. I think most of my colleagues will admit, that we went way overboard in the wrong way regarding analgesia. It became the practice in certain hospitals that when a patient would enter she would receive an injection as soon as she was in labour, and she would know or remember nothing else until some hours after the baby was born. That became quite a fashionable custom at one time and patients actually used to demand that type of obstetrical care. We learned from our own experience that that was a very dangerous form of obstetrics to practise and I think that most of us have gotten pretty far away from that sort of treat-

ment now. Just how far we can go or anyone can go in the conduct of labour with minimum analgesics, I think is being, as I said, very well demonstrated here in this hospital.

In regard to anaesthesia itself, that has rapidly climbed up among the important factors in maternal mortality. Due to the dropping out of certain other factors, anaesthesia is now up around the third or fourth most common cause of maternal mortality. There are two main types of obstetrical anaesthesia, spinal or general anaesthesia. There are two schools of thought on that. If you talk to any neurologist, who has spent his life in the field, he will tell you that no one should ever have spinal anaesthesia, because he is the one that sees the dreaded results that do sometimes occur, sometimes weeks and sometimes months after the actual anaesthesia and frequently these disasters, which occur later, are never known or seen by the original doctor who handled the original anaesthesia. Fortunately this danger in spinal anaesthesia is rare. Serious complications probably do not occur more than once in fifteen or twenty thousand cases. When they do occur they can be very severe and very dreadful. The main danger, in general anaesthesia for the obstetrical patient, is aspiration of vomitus and aspiration pneumonia, if not immediate death. There were two patients, among the fifty-two I mentioned in the State of Massachusetts, who died from that cause alone. So if you are going to use extensive anaesthesia of either of these two types, you must realize the potential danger involved and you must take every precaution that every safeguard is used. Again, I understand, much anaesthesia here is the pudendal block which certainly is the safest form of anaesthesia for labour and delivery.

Another important factor is the conduct of labour, and this is something that you ladies and gentlemen should learn as soon as you possibly can, is to tell the difference between a normal labour and an abnormal labour. That is a question of experience—usually long judgment—but it is probably the most important knack or talent that you can develop. The patient that is having abnormal labour, no matter what the cause is a potentially dangerous case and is in potential trouble if she is not properly handled. On the other hand, the patient who is having normal efficient labour can be allowed to progress at her own time and speed, without interference and she will have a successful termination. Again, the difference or the estimate of this difference, is extremely important. Obstetrics is a peculiar field from a temperamental point of view and I think obstetricians are rather strange people, as a rule. They tend to be, shall we say, somewhat lethargic in that they seem to move slowly and seem to have inexhaustible patience, which in the hands of a general surgeon is possibly a somewhat rare quality. But added to this patience, added to this so-called lethargy, there must be the hidden factor of the ability to move suddenly and fast when occasion arises and more than that—the ability to recognize the occasion when it does arise.

Now, as you know, the majority, possibly ninety per cent of women, if they are in proper condition at the time of labour, and if they went through labour unattended, would probably have a living child and be in reasonably good health themselves. The odds are very much in your favour in this type of case. On the other hand, in the other ten per cent is where you are going to run into serious trouble. Out of the other ten per cent, probably eight or

of those ten, the problems or difficulties are minor and can be adjusted or handled without difficulty. The remaining small percentage requires rather dramatic action in order to save the mother and child. We put a great deal of faith, and I think everybody does, in the so-called test of labour. I think it should be better called the test of an obstetrician. That is, again, the ability to recognize, after a patient has been in labour for a reasonable period of time, whether she is a normal case or an abnormal case. Certainly to-day we rarely do an elective section without a test of labour. We watch for a certain amount of progress or certain length of labour itself and then we try to make up our minds as to whether the patient should be successfully delivered from below or whether we should section her. Now, you never know, at times, whether you are right. For instance, if you make up your mind that this patient's labour shows definite signs of disproportion, or if you feel something contra-indicates a delivery from below and you decide to do a section and you get a healthy baby and mother, you may or may not have done the right thing. On the other hand, if you make a mistake the other way and you finally end up with an extremely traumatic and difficult forceps, which is likely to injure the infant and possibly injure the mother, you know that you have made the wrong decision. But it is in that period, that test of labour period, that trial labour period, where you are going to make your decisions and where your decisions are going to decide as to your success or failure in handling this patient.

Now one of the things we are afraid of is prolonged labour. We feel that there is a definite limit to labour that any woman should be allowed. Hours are vague things, but we say generally around twelve to fifteen hours for a multipara and possibly eighteen to twenty-one hours for a primipara. The patient should be delivered within this period of time. Now, by that, I do not mean to say that all patients are delivered within this period of time, but if they are not delivered within this period of time we know why they are not. In other words, we know whether we are dealing with a posterior head or some other common cause for delayed labour. We have ascertained whether we are dealing with disproportion or one factor or another and we feel that no patient should be allowed to go over this length of time unless we know exactly why they are doing so. Therefore we are extremely careful with all our patients that the onset of labour is carefully timed and that the duration of the progress is equally well watched.

When we come to the third stage of labour, which is probably the most dangerous period in a woman's entire child-bearing career, there again we reach certain decisions and policies which are extremely important. Number one. A PATIENT LOSES A GREAT DEAL MORE BLOOD IN OBSTETRICS THAN THE CLINICIAN REALIZES, and that applies to all of us. All studies and tests that have been made of fluid volume loss or any methods that have been used to judge blood loss, have shown that it is usually about twice as much as the estimate by the clinician in charge. This blood loss in the third stage of labour can be due to many factors of course, but the blood loss itself can precipitate other complications such as cardiac complications, sepsis, and other factors which may ultimately seem to be the chief trouble, but they were primarily promoted by the original blood loss. In the handling of the

third stage of labour, it is extremely important that blood loss be kept at an absolute minimum. All hospitals should have a rule that no obstetrician shall break his "scrub up" technique until the uterus is acting properly and all blood loss has ceased. Sometimes that means staying with the patient and aseptic technique for half an hour or an hour after delivery. Only in that way can we be sure that bleeding is recognized and cared for. Too often in the reports of maternal mortality you see on the record—"Physician delivered the patient, went home to supper, went to another hospital to see another patient, called back by the nurse. When doctor returned the patient was in shock and the shock was irreversible." We see that too often in maternal mortality, and that is just the simple fact that blood loss was not properly estimated and not properly recorded. Of course, blood loss can come from various areas, which must be distinguished The most common, of course, is the uterus itself, the atonic uterus, which is a problem of its own. But blood loss can come from lacerations of the cervix, from lacerations of the vagina and even considerable blood loss can come from an episiotomy, which frequently is entirely disregarded. All these factors must be carefully watched and carefully handled in the indicated way

With proper care of the third stage, the patient is returned to bed, in proper and good condition. Of course the present policy is early ambulation and early discharge from the hospital. It was not too many years ago, at least in our town, the patients were kept in bed eighteen days after delivery. It took them anywhere from three days to three or four weeks to recover at home from the weakness and debility that they had developed from lying three weeks in bed in the hospital. But nowadays we let our patients up the next day. We feel we have definitely diminished the incidence of phlebitis. We feel that we have better involution and drainage of the uterus. We have found that the thing we were afraid of, that there would be an increase of certain tensions and stresses on the organs, causing cystocele and rectocele and uterine prolapse, have not been true. If anything, the patients have done better from that aspect under early ambulation than they have with long stay in bed.

Now, generally speaking, we find in clinics that have a combined service of obstetrics and gynaecology, that we are running out of certain types of gynaecology that we used to see in great quantities in the not too long ago. The cystocele, the rectocele and the prolapse are still, of course, the common situation in any gynaecological clinic, but the numbers and proportions have markedly fallen from even fifteen and twenty years ago. We feel that that is due, probably, to better obstetrics and is also probably due to certain specific things in obstetrics. Probably the most important thing in preventing that type of injury in future life is the simple procedure of episiotomy. The episiotomy is designed to take the stress and strain off the supporting structures of the perineal body during birth itself and if properly done and if properly repaired it does save the tearing and internal damage which used to be so prevalent before that became a standard procedure. By dividing, in the normal planes and anatomically, the structures involved, a baby can be born through the birth canal with no actual damage to the internal tissues. The episiotomy can be repaired anatomically and surgically and the patient should be, from that point of view, as well off as she was previous to bearing a child. To carry the

the analogy further, the same thing applies to the cervix. With proper care of the cervix in the post-partum period, proper treatment of erosions, infections and conization of certain bad cervices we can keep the cervix in a relatively good condition and I am sure it would have a great deal to do with the lowering of the incidence of carcinoma of the cervix in later years.

Now, as I said earlier in my talk, you cannot estimate your success, or you cannot estimate good obstetrics from the fact that your mother and baby left the hospital alive. You have got to make your final estimation on the health and growth of that child and on the future health of the mother herself. There is a certain small town in which a great many babies, with obstetrical paralyisis came to Boston for surgery and treatment. One man at the Children's Hospital was talking to a friend of his, in another line of work—he was a gynaecologist—and this gynaecologist said: "Well! Now! That is very strange. From that town we have a terrific amount of mal-positions, lacerations and trouble, following child-birth, in the mother." Yet, statistically, that town and that hospital are just as good as any in the State. Certain inquiries were made and it became quite evident that that was a true story and that very poor obstetrics were being done at that institution. Now, there is only one person who knows whether he has done a good job with the patient and that is the obstetrician himself. You know what you can do and you have got to try to do the best you can. We have tried to give you, to-day, a touch of an ideal to shoot for and if everybody tries, they will not always succeed, but at least their conscience will be clear and we will have better obstetrics.

The Annual Meeting, Halifax Medical Society
May 9, 1956

Come out from under the tables boys — that crash was only the "little women" coming in with a blast that shattered to atoms a hundred year old tradition of the Halifax Medical Society!

Stag indeed! The dust those feminine H-bombs kicked up sizzled with fun and happiness; that gladioactive ash is all over town, and believe me this "fall out" is a knock out!

One of the most delightful medical gatherings in the memory even of old timers marked this unique 112th meeting of the Halifax Medical Society. Unique because it was brightened and made beautiful by the presence of our wives, those delightful and talented shrews whose lights we have been hiding under a bushel of children and neglect all these years! Bless their hearts, may they never again leave us to the dull monotony of mere business!

Beginning with the President's reception the meeting flowed along on a high level of fun and lightheartedness, and the largest gathering in the history of the Society, some two hundred members, wives and guests sat down to an excellent dinner which was planned, supervised, tested, prenataled, and delivered under the critical eye of that incomparable master, Bill Colwell.

The guest speaker, Dr. W. R. T. Flemmington, President of Mount Allison University, gave a delightful address, full of anecdote and wit, with just glimpse enough of the beauty of poetry and old books to make us yearn for a bit of leisure and the courage to throw this months journals into the fire! His subtle plea for the support of universities by graduates and friends proved him to have the instincts of a good doctor, who, though he dines at his friend's table, cannot refrain from observing the state of his host's health!

The entertainment that followed was delightful. We were all thrilled with the previously hidden talents of our colleagues and their wives. Mrs. Cameron as pianist and accompanist gave real pleasure to all of us and Doug. Roy in his dual roll did a grand job. Mrs. Ian MacGregor showed what a mother can really do with swords and Ian has wisely been fishing ever since, unless he came back early to get Nick and Cy out of the way! But that Tabby Bethune! That snake in the gra--- that snake charmer! What a bevy of snakey hipped charmers he blew up for himself! And with just an ordinary flute too! A weird and plaintive musical sound has been heard about the south entrance of the V.G. since that night. Could it be----?

Then came that Jolson, that Plunket, that dermatological Dennis Day, that magnificent Howell who with his chorus of lovelies brought a howl of delight from the whole gathering! And what steppers! Those delectable "Dockettes"! There are no nicer kneeses on any T-Veeses! The Society wishes to remind the husbands that these gals are to be kept in perfect shape, training that is, and sent for a try out at the Roxy this Fall! Who says a doctors life is not a happy one?

If Rabbie Macnabbie had teamed up with Rabbie Dickson in the dance that night it would have been a bad day for the Irish. Strong men have been been killt by a flick of the kilt before now and the undulating tartan is forever the undoing of all lesser breeds. Swing low sweet sasenach!

Ah — but that beautiful quartet of sweet and feminine voices "Les Sylphides Slobboviane" rang tears from the hardest eyes! Their harmony was of that lilting and ethereal quality that only the truly inspired or touched (in the head) can hear with complete appreciation. And the lyrics — ah — there was a flavor, an aroma, a little stench reminiscent of Mrs. Snodgrass there! You'll never get used to it — you'll just go on loving it!

The Halifax Medical Society extends our congratulations, and indeed, our sincere thanks to the immediate past president, C. L. Gosse, whose energy and genial personality made possible not only the splendid innovation of this mixed dinner meeting, but also a very successful year in the life of our Society. Our thanks are equally due to his talented and charming wife, Betty, for a grand production job so very well done, and to his active and faithful committees for their unexcelled effort.

And what of the wife wranglers? Those two creeping Crippens from Coburg Road? I'll bet, as long as they live, they'll never attend a medical dinner meeting again — without their wives!

J. W. R.

Symposium In Dermatology

THE Post-Graduate Committee of the Faculty of Medicine, Dalhousie University, presented a two day Symposium in Dermatology at the Victoria General Hospital on April 9th and 10th, 1956.

This was the first post-graduate course entirely devoted to Dermatology.

The course was under the general direction and chairmanship of Doctor Denis R. S. Howell, Assistant Professor of Medicine (Dermatology) Dalhousie University and we were most fortunate to have as our guest teacher Doctor Lemuel P. Ereaux, Dermatologist in charge, Royal Victoria Hospital, Montreal, and Associate Professor of Medicine (Dermatology) at McGill University.

The programme included lectures on a variety of common dermatological conditions by Doctor Ereaux, Doctor Howell and Doctor Goldberg. Doctor R. C. Dickson gave a talk illustrated by some interesting patients on "Skin Manifestations of Internal Disorders." Doctor J. G. Kaplan discussed the "Physiological Aspects of the Skin" and Doctor W. A. Taylor the "Diagnosis of Dermatoses by Means of Biopsies." Doctor Gordon Wiswell and Doctor Ereaux discussed "Dermatoses of Infancy" and with Doctor J. F. L. Woodbury, Doctor J. Fraser Nicholson and Doctor G. J. H. Colwell, "The Management of Psoriasis and its Complications."

Doctor Howell showed a film he had made on "Surgical Planing for the Removal of Scars."

Dermatological clinics at which a wide variety of skin conditions were seen and discussed were held by Doctor Ereaux on both days, and the symposium wound up with a stimulating and critical session on "Errors in Diagnosis and Treatment."

Throughout the course, most of which was essentially practical in content, there was ample opportunity for those attending to discuss problems of diagnosis and treatment of the skin conditions under review, and Doctor Ereaux gave most generously of his knowledge and practical "know how."

The following physicians attended:

Dr. Marjorie L. Smith, Spryfield; Surg. Lt.-Cmdr. V. P. K. Connolly, H.M.C.S. Cornwallis; Dr. R. C. Zinck, Lunenburg; Dr. R. C. Young, Kentville; Dr. G. M. MacDonald, Yarmouth; Dr. Philippe H. LeBlanc, Little Brook; Dr. H. I. MacGregor, Halifax; Dr. C. Blake Smith, Kennetcook; Dr. H. C. Still, Halifax; Dr. H. A. Creighton, Lunenburg; Dr. A. Elmik, Canso; Dr. W. M. MacRae, Halifax; Dr. D. R. MacInnis, Shubenacadie; Dr. G. D. Gass, Sackville, N. B.; Dr. W. Guzdziol, Port Hawkesbury; Dr. M. E. Burnstein, Halifax; Dr. H. D. Lavers, Truro; Dr. W. F. Verge, Dartmouth; Dr. Douglas I. Rice, Halifax; Dr. J. A. MacCormick, Antigonish; Dr. A. E. C. MacRae, Dartmouth and Dr. J. E. MacDonell, Antigonish.

H. C. S.

THE ANNUAL MEETING

The 103rd Annual Meeting of The Medical Society of Nova Scotia will be held in Halifax at the Nova Scotian Hotel.

The Executive Meetings will be held on Tuesday, September 4th, and the General Meetings will be held on Wednesday, Thursday and Friday, September 5th, 6th and 7th, 1956.

The Chairman of the Housing Committee is Doctor A. W. Titus, 32 Connaught Avenue, Halifax, who will look after all requests for hotel accommodation for the meeting.

Please use Application Form for hotel accommodation on other side of this page.

HOUSING APPLICATION FORM

103rd Annual Meeting — Halifax, N. S., September 4 - 7, 1956

The Medical Society of Nova Scotia

Dr. A. W. Titus,
Chairman, Committee on Housing,
32 Connaught Avenue,
Halifax, N. S.

I am planning to attend the Annual Meeting of The Medical Society of Nova Scotia at Halifax, N. S., September 4 to 7, 1956.

Will you please reserve the following:

..... Double room with bath or shower (double bed).

..... Double room with bath or shower (twin beds).

..... Room for.....persons (bath or shower).

In view of a large expected attendance no single rooms will be available at the Nova Scotian Hotel unless cancellations permit. If coming alone please check here.....(v) if you are willing to share a room. If you have a preference for some party to share with please insert name here.....

Name of persons who will occupy above reservations:

NAMES (Dr. and Mrs.).....

ADDRESS .....

Expected date of arrival in Halifax.....

There are in addition very lovely motels situated on Bedford Highway. If you prefer this type of accommodation please check here.....(v) and we will endeavor to arrange reservations for you.

30th Annual Dalhousie Refresher Course

October 15th - 19th, 1956

Organization and initial programming for the 30th Annual Dalhousie Refresher Course has been going on for some time and the Committee is pleased to advise that another week of widely diversified interests for the general practitioner is scheduled for October 15th - 19th, 1956.

Known to many of you as a man of distinguished teaching ability, as well as for his clinical knowledge, Dr. Duncan Graham, is to be our John Stewart Memorial Lecturer. Dr. Graham, who is Professor Emeritus of Medicine at the University and Advisor, Medical Education and Research, D.V.A. Ottawa, will speak on Medical Education.

During the first part of the week Dr. William Scott, Professor of Urology, Johns Hopkins University of Medicine, and Dr. Lennox G. Bell, Dean of Medicine, Professor and Chairman, Department of Internal Medicine, University of Manitoba and Physician in Chief, Winnipeg General Hospital, will be our guest speakers.

During the latter part of the week, in addition to a clinical presentation by Dr. Duncan Graham, the program will comprise contributions by two more guest lecturers, Dr. John R. Naden, Chief Medical Officer, of the Workmen's Compensation Board of British Columbia, and Dr. H. E. Taylor, Professor of Pathology, University of British Columbia and a graduate of Dalhousie University in 1936.

The Members of our Faculty of Medicine are being asked to prepare presentations upon subjects which we feel are pertinent to the conditions found in general practice in the Atlantic Provinces, and we know these will be of general excellence and wide interest.

Extracts from the New Constitution, The Medical Society of Nova Scotia

The following are extracts from the recently adopted Constitution, which I am bringing to your attention for consideration before the Annual Meeting.

1. Branch members are eligible for membership in Nova Scotia Division.
2. Branches nominate members for Executive Committee as follows:

50 members	— 1 Executive member
50 - 100 members	— 2 Executive members
Over 100	— 3 Executive members

3. The Branch Secretary to submit a list of the members in good standing to the Secretary of the Nova Scotia Division on or before December 1st of each year.
4. The Branch Secretary — on or before May 31st each year to submit the name or names of the nominee(s) to the Executive Committee together with the names of alternates. All members of the Executive are to be members of The Canadian Medical Association.
5. Each Branch appoints one member to the Nominating Committee with the name of an alternate — the names are to be submitted in writing before the Annual Meeting.
6. The Nominating Committee is to be elected at the first session of the Annual Meeting.
7. The time and place of the Annual Meeting decided by the Executive Committee.
8. The Quorum for a general meeting is 20.
9. The Quorum for an Executive meeting is 7.
10. The Editorial Board (including Editor) to be appointed by the Executive Committee.
11. The Editor is to attend meetings of the Executive Committee.
12. The Chairmen of Committees to be appointed by the Executive. The Chairman chooses the members of his Committee and must submit the names in writing within one month of the Annual Meeting.
13. The Executive has power to appoint a member to fill a vacancy from a Branch.
14. The Executive appoints representatives of the Division to various bodies.
15. The Chairman of the Executive shall call a special meeting on the request of 5 members in writing.
16. The Executive Committee is responsible for appointment of appointive officials — designate responsibilities and fix salaries.
17. The Executive appoints a Budget Committee at its first meeting, with the Honorary Treasurer as Chairman.
18. The Executive Committee at its first meeting appoints a Finance Committee of which the Treasurer is ex officio a member.
19. Amendments to the Constitution are made in the following ways:
    (1) Notice of motion by one or more members to be placed in the hands of the Secretary three months before the date of the Annual Meeting.

(2) Amendments may be proposed by an Annual Meeting, by the Executive Committee or the Committee on By-Laws without notice of motion but the proposed amendments shall be published in the Bulletin at least two months before the Annual Meeting.

(3) Subject to condition in Sections (1 and 12) By-Laws are amended by a majority vote of a duly advertised General Meeting of the Division.

While the foregoing represents a summary of salient features of the Constitution, I would advise that each member should read the complete section in the Constitution dealing with any specific item, as sometimes, mistakes are made by reading out of context.

This is submitted for information only.

Yours truly,
M. R. Macdonald, M.D.
Secretary.

Obituary Notice

DR. EDWIN BISHOP ROACH

Dr. Roach died on April 5th, 1956 in Toronto. He was born at Nappan. After attending Amherst Academy and Mount Allison University, he entered Dalhousie Medical School and was graduated in 1901. He practised in Halifax for a few years and moved to Calgary in 1911 where he practised as a pediatrician. During World War he served with the R.C.A.M.C. In 1947 he moved to Burnaby and served as Health Officer there until 1951.

He is survived by his widow, the daughter of the late Judge Russell, one daughter and two sons. A sister Miss Emily Roach resides in Halifax.

Abstracts

Drug Therapy in Hypertension with Haemorrhagic Hypertensive Retinitis*

THE purpose of this paper is to add the author's experience with the newer hypotensive drugs in the treatment of patients with severe hypertension and haemorrhagic eye-grounds to the ever-growing list of reports on this subject. This treatment is too new to justify any final conclusions, but, in this short experience, it does appear to offer more than any previous medical therapy in this devasting disease. The authors have selected patients with Grades 3 and 4 hypertension as classified by Keith, Wagener and Barker for reporting the results of drug therapy.

To exclude patients in the terminal stage of this disease who are placed on therapy as a last desperate attempt to postpone catastrophe, they have not included patients in this series treated for less than four months.

Before therapy was begun all the patients were carefully studied to rule out curable causes of hypertension such as pheochromocytoma, coarctation of the aorta, Cushing's disease, renal disease and certain brain tumors.

Patients selected for treatment with the potent drugs were first placed on *Rauwolfa serpentina* (Raudixin), 50 to 100 mg. three times daily, or reserpine (Serpasil), 0.1 to 0.25 gm. three times daily, for three to six weeks at home. After this period of "priming", the patients were hospitalized, and usually one of the autonomic-blocking agents was added. Previously, hexamethonium was used orally or by injection, but since the advent of pentolinium (Ansolysen) hexamethonium has been all but abandoned because of the alleged more prolonged and predictable effect of pentolinium.

By "priming" the patients with *R. serpentina* before starting the ganglionic blocking agents, the authors have been able to use smaller doses of the blocking agents with fewer sideactions and smoother blood-pressure curves

When the authors first began the ganglion-blocking agents, *R. serpentina* was not available, and Apresoline was given in conjunction with hexamethonium, beginning with 25 mg. two to four times daily and gradually increasing the dose until satisfactory lowering of the blood pressure was obtained. Recent experience with Apresoline, however, indicates that in large dosage (400 mg. or more daily) it has certain toxic effects such as bone-marrow depression, produces a rheumatoid type of arthritis and a syndrome resembling acute systemic lupus erythematosus. The authors believe that the threat of these toxic effects, although infrequent and usually relieved by discontinuance of the drug, tends to outweigh the beneficial effects, especially when the blood pressure can be controlled with less toxic drugs. This treatment is directed toward control of the hypertension rather than its cure and therefore must be continued for the life of the patient. This mediates against the use of a potentially toxic drug when it is not absolutely necessary.

Seventy-eight patients with haemorrhagic hypertensive retinitis (Grades 3 and 4 hypertension) were treated with combinations of the newer hypotensive agents. Fifty-five (70.5 per cent) of the seventy-two patients who were followed survived from four to thirty-one months. Seventeen had evidence of severe renal involvement before treatment was started. Although it is too early

to evaluate survival rates in this group, the results are encouraging.

The drugs, themselves, are not without danger unless the dose is carefully controlled. One can best accomplish this by beginning treatment in the hospital and teaching patients to record their blood pressures at home.

Burnett, C. F., Evans, J. A., New England Journal of Medicine. Volume 253, October, 1955.

The Clinical Epidemiology of Poliomyelitis*

In this discussion of the clinical epidemiology of poliomyelitis, attention is focused on the family epidemiology of the disease. Various studies indicating a higher infection-rate among family associates than among outside contacts suggest that factors other than close contact must be implicated, since the whole family seems to be infected as a unit.

Recent tissue-culture methods have made possible the extended study of the behaviour of infection in families. The correlation of the presence or absence of virus excretion with immune status and the determination of complement-fixing antibodies among exposed members help to define precisely the spread of infections through families. Since the complement-fixing antibody is a temporary one, its presence in high titers designates recent infection. This serological test is of diagnostic aid also.

The course of typical clinical and subclinical infections is discussed. Virus is present in the blood for a few days after infections. This period may be barren of symptoms or may be accompanied by minor illness. As antibodies appear, virus disappears from the blood. However, it persists in the throat for one or two weeks and in the faeces for twelve to seventeen weeks more. Neutralizing and complement-fixing antibodies follow infection — the neutralizing antibody persisting for life and the complement-fixing antibody for nine months to several years or more.

It has become apparent in recent years that while morbidity is high and constant among exposed susceptibles, the clinical attack-rate has continually increased in young adults while it has been decreasing in children. As in other virus infections such as hepatitis and measles, exposed susceptible adults are more apt to develop severe infections with a high mortality, while young children tend to experience mild or inapparent infection.

The importance of understanding the patient's illness in relation to his family and home environment is stressed.

Horstmann, D. M., Annals of Internal Medicine. 43: 526 - 533, September, 1955.

Early Diagnosis and Treatment of Congenital Cretinism

Since early treatment of congenital cretinism improves the mental prognosis, it is important to make the diagnosis as soon as possible after birth. Familiarity with the syndrome, described by the author, should enable the clinician to recognize congenital cretinism in the decisive initial period. In a very few cases, the attending physicians has been able to diagnose congenital cretinism at birth or a bit later. Other authorities claim that the first sign of the condition are usually apparent by the age of two months, although the diagnosis is seldom made that early. Often, the parents fail to consult the

physician sooner; often, too, the latter does not recognize this rare disease in its early stages.

In a previous paper, this author called attention to the frequent coincidence of congenital cretinism with excessively prolonged icterus neonatorum (a duration of more than thirty days is extremely rare). Of nine infants with congenital cretinism admitted before the age of three months to the Children's Hospital of Gothenburg, Sweden, six had shown prolonged icterus (lasting at least six weeks). Any infant who shows such prolonged icterus neonatorum during the first five months of life should be carefully studied, and the physician should bear in mind the possibility of congenital cretinism.

From a statistical examination of reported data on therapeutic results, the author concludes that while the somatic prognosis is not worsened by delayed diagnosis and therapy, the mental prognosis is more favourable when treatment is started before the age of five months. Hence the practical importance of awareness of the prolonged icterus neonatorum-congenital cretinism syndrome.

Akerren, Y., Archives of Diseases of Children. 30: 254 - 256, June, 1955.

Management of the Pregnant Diabetic*

Obstetricians are taking a much greater interest in the subject of problems relating to pregnancy in diabetes. Probably because in this relatively small group of patients problems are encountered relating to foetal size, placental function, intrauterine foetal death, hydramnios, toxemia, congenital foetal abnormalities, and neonatal mortality. The solution of any or all of these problems in the diabetic will help physicians understand more about foetal physiology and pathology in general.

The control of maternal diabetes by means of insulin and dietary measures has enormously reduced the maternal risks during pregnancy. The maternal mortality is now as little as one per cent or less, compared with forty-five per cent quoted by Whitridge Williams forty-five years ago. The hazards of repeated pregnancies in the diabetic in terms of morbidity are, on the whole, under-emphasized. Good control of diabetes throughout pregnancy can reduce the foetal mortality, but cannot abolish it.

A very careful assessment is necessary at the beginning of pregnancy, and if good results are to be obtained the closest co-operation between a physician experienced in the management of diabetes as well as a good obstetric team is an essential. The requirements of insulin usually rise during pregnancy and fall during labor and the early puerperium. The latter is of special practical importance, because a continuation of the pregnancy level of insulin dosage after delivery may soon lead to dangerous hypoglycemia unless the true condition is recognized and glucose, not insulin, given.

The overall foetal mortality remains high — the author's is twenty-seven per cent in the present series of 298 pregnancies.

Until antenatal treatment can effectively lower the incidence of intrauterine death and foetal size, Caesarean section must inevitably remain the most suitable method of termination. In the presence of hydramnios, toxaemia, a very large baby, or a very unfavourable cervix, Caesarian section is best, especially if termination is necessary before thirty-six weeks. In multiparae

with satisfactory previous obstetric history and in some primiparae, where the baby is not unduly large, where hydramnios is minimal and the cervix favourable, induction should be employed, especially if it has been thought safe to allow the pregnancy to proceed to the thirty-eighth week. It has always been the author's experience that neonatal death was lower in cases delivered vaginally. His neonatal death rate is 18.5 per cent in 199 Caesaran sections. Against induction are the hazards of a long labour, and the difficulties in the vaginal delivery of a very large baby. Very careful judgment is necessary in selecting cases suitable for induction.

The results of a clinical trial using oral hormones (stilbesterol and ethisterone) are given, suggesting that they have no effect upon foetal survival.

Premature termination of pregnancy before the end of the 37*th week is recommended*, and the relative places of Caesarean section and induction of labour are discussed.

Peel, J. H., British Medical Journal. No. 4944: 870 - 873, October 8, 1955.
*From Medical Abstracts, January, 1956.

A Reevaluation of Sulfonamide Therapy

The development of the more soluble sulfonamides and the sulfonamide mixtures has virtually eliminated the most frequent of the serious toxic effects of the sulfonamides — the formation of crystals in the renal tubules producing haemorrhage and obstruction.

The frequency of the other undesirable side effects is probably in the same range as that seen in association with antibiotic therapy.

The sulfonamides are less potent antibacterial agents than the antibiotics, but also produce less drastic changes in the normal flora of the body that result in subsequent superinfections.

Sulfonamides are as effective as the antibiotics in meningococcal infections, bacillary dysentery, chancroid and trachoma. They are usually effective in most respiratory tract infections and in uncomplicated urinary tract infections.

The sulfonamides are of value in combination with the antibiotics in treating actinomycosis, pneumococcal meningitis, H. influenzae infections and Friedlander's infections.

The use of the sulfonamides in minor infections due to sensitive organisms may delay the development of antibiotic-resistant strains of bacteria and reserve the more potent agents for serious infections.

The average daily cost to the patient for sulfonamide therapy is approximately fifty cents, as compared to $2 for the tetracycline antibiotics.

Yoe, E. M., Annals of Internal Msdicine. Volume 43, August, 1944.

Whereto Tuberculosis*

During the seven years from 1947 to 1953 the most rapid decline in tuberculosis mortality the world has even seen has taken place.

In fifteen countries and the Commonwealth of Puerto Rico for which both mortality and morbidity reports are available, the fall in the death rate has changed from 53 per cent in France to 83 per cent in Iceland.

Morbidity reports show a lesser rate of reduction, the case being now 20 per cent lower in five of the fifteen countries and one commonwealth referred to above; but, there is record of an actual increase during the period under consideration having occurred in Eire; perhaps, also, in Australia.

The acceleration lately in the fall of the tuberculosis death-rate is due primarily to improvement in the treatment of the disease because of the availability of antimicrobial drugs, such as streptomycin, para-aminosalicylic acid and isoniazid, along with more successful surgery.

The ultimate measure of progress against tuberculosis should be the absence of infection. Tuberculin tests in various parts of the world show that boys and girls at age fifteen still react positively from 12 per cent in Lebanon or 18 per cent in rural Eire to 85 per cent in Polish cities. In 1954, among some 150,000 recruits in the United States Navy and Marine Corps, 95 per cent reacted negatively to the tuberculin test.

Finally, because of the sharpness in the decline of tuberculosis mortality, it would be unwarranted to conclude that tuberculosis is no more a major health problem. Taking only the United States, the British Isles, France, and Germany in 1953 alone, 340,416 new cases of tuberculosis were reported. If in addition to these cases, account be taken of old and previously known cases (conservatively estimated at three times the new cases), it can readily be seen that in just these four countries there were, that year, more than one million known cases of active tuberculosis

Drolet, G. J., and Lowell, A.M., American Review of Tuberculosis and Pulmonary Diseases. 72: 419-452, October, 1955.

*From Medical Abstracts, December, 1955.

NEXT?

COFFEE BAR FOR EXPECTANT DADS

Plans for the Garden Park General Hospital in Garden Grove, California, now under construction, call for a coffee bar next to the maternity delivery room, according to a recent United Press despatch.

"It will help expectant fathers to withstand their great ordeal with more composure," a hospital spokesman said.