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# Original Articles.

## CANADIAN MEDICAL ASSOCIATION—ADDRESS IN MEDICINE.

### THE GROWTH AND ORGANIZATION OF THE MEDICAL PROFESSION IN NOVA SCOTIA.*

BY D. A. CAMPBELL, M.D., HALIFAX.

*Mr. President and Gentlemen.*—The first duty resting upon me is to thank you for the wholly undeserved distinction which you have conferred in choosing me to deliver one of the general addresses at this meeting of this Association.

I wish to apologize for my presumption in undertaking so serious a responsibility, feeling that local reasons, rather than any fitness on my part, must have counselled your request.

The subject upon which I shall endeavor to address you may be entitled "The Growth and Organization of the Medical Profession in Nova Scotia."

It was not without misgivings that I selected such a local topic, but I have been assured that there are ample precedents for such a course.

It may be confidently stated that there is at the present time a growing interest in the history of the medical profession in all its aspects. This may be regarded as part of the modern

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recognition of the important fact that no subject can be thoroughly studied and fully understood unless studied historically. Not only is this fact acted upon by the leaders of modern thought and the great teachers of the age, but it is becoming generally recognized by all thinking men that we must have some knowledge of the past to understand, really, the present and to make progress in the future. Every movement has its past history, its present struggles, its ideals for the future.

The satisfactory condition of the medical profession in this province to-day has not been attained without much effort and a long history.

The present standard of medical education is sufficiently high, and the average attainments of the rank and file of the profession satisfactory, so that everywhere the public can obtain the services of men capable of coping with the ordinary emergencies met with in practice. The members of the profession are respected, and exercise considerable influence in social and public affairs. In their organized capacity they enjoy self-government—a privilege which they have used for the public benefit, but have never abused. There are active and energetic associations for mutual improvement and protection. The grosser forms of quackery are not prevalent, and what may be called "medical heresies" are scarcely represented. It can be affirmed without exaggeration that the position of the profession in Nova Scotia compares favorably with that which obtains in other provinces of Canada or in the states of the American Union. Such a status for the profession has not been achieved except by the continuous struggles of many generations.

It is to the past, then, that we may now turn attention for the better understanding and appreciation of the present. And if, in doing so, I should seem to present much that belongs to general history rather than specially to medical history, my excuse is that it is desirable, if not essential, to note the general condition of the province and its population, at different periods in order to see what field there was for the special work of the profession.

It is now just three centuries since the first European settlement was made in this region of North America, at Port Royal, now Annapolis Royal, in this province, which is, thus the oldest continuous European settlement on this continent north of Florida. The settlement was really made and the colony established by Poutrincourt, under a grant from de Monts, who had arrived there the previous year, 1604, with

a grant, from Henry IV. of France, of all the territory between the 40th and 46th parallels of latitude. The Acadia of the seventeenth century was thus a very wide region, including the present New Brunswick, and, indeed, for a long time, the name Nova Scotia was applied to the same region. Sieur de Monts made many and extensive explorations during the summer, crossed the Bay of Fundy, and established a settlement on the island of St. Croix. The colony of St. Croix suffered great hardships during the winter of 1604-5; and it is from that settlement that we have the earliest account of anything of strictly medical interest in Acadia. That year Samuel de Champlain—a name illustrious in Canadian history—was with de Monts at St. Croix, and he has left a most interesting account of a serious malady which attacked the colonists. Here let me quote part of Champlain's narrative:

"During the winter, many of our company were attacked by a certain malady called the mal de la terre, otherwise scurvy, as I have since heard from learned men. There were produced in the mouths of those who had it great pieces of superfluous and drivelling flesh (causing extensive putrefaction), which got the upper hand to such an extent that scarcely anything but liquid could be taken. The teeth became very loose, and could be pulled out with the fingers without its causing them pain. The superfluous flesh was often cut out, which caused them to eject much blood through the mouth. Afterwards a violent pain seized their arms and legs, which remained swollen and very hard, all spotted as with flea bites; and they could not walk on account of the contraction of the muscles, so that they were almost without strength and suffered intolerable pains. They experienced pain also in the loins, stomach and bowels had a very bad cough and short breath. In a word, they were in such a condition that the majority of them could not rise nor move and could not even be raised up on their feet without falling down in a swoon. So that out of seventy-nine, who composed our party, thirty-five died, and more than twenty were on the point of death. The majority of those who remained well also complained of slight pains and short breath. We were unable to find any remedy for these maladies. A post-mortem examination was made of several to investigate the cause of their malady.

"In the case of many, the interior parts were found mortified, such as the lungs, which were so changed that no natural fluid could be perceived in them. The spleen was serous and

swollen. The liver was woody and spotted, without its natural color. The vena cava, superior and inferior, was filled with thick coagulated and black blood. The gall was tainted Nevertheless, many arteries, in the middle as well as lower bowels, were found in a very good condition. In the case of some, incisions with a razor were made on the thigh where they had purple spots, whence there issued a very black, clotted blood. This is what was observed on the bodies of those infected with this malady. Those who continued sick were healed by spring, which commences in this country in May. That led us to believe that the change of season restored their health, rather than the remedies prescribed.

"During the winter all our liquors froze, except the Spanish wine. Cider was dispensed by the pound. The cause of this last was that there were no cellars under our store-houses, and that the air which entered by the cracks was sharper than that outside. We were obliged to use very bad water, and drink melted snow, as there were no springs nor brooks; for it was not possible to go to the mainland in consequence of the great pieces of ice drifted by the tide, which varies three fathoms between low and high water. Work on the hand mill was very fatiguing, since the most of us, having slept poorly, and suffering from insufficiency of fuel, which we could not obtain on account of the ice, had scarcely any strength, and also because we ate only salt meat and vegetables during the winter, which produced bad blood. The latter circumstance was, in my opinion, a partial cause of these dreadful maladies."

Thus it appears that three centuries ago the French surgeons who accompanied this expedition were impressed with the value of post-mortem examinations for determining the nature of disease, and that they at least suspected the causal connection between salt food and scurvy. And this latter view was confirmed by further observation. After the awful experiences of the first winter at St. Croix, the survivors moved to Port Royal There were still fatal cases of scurvy. By the third winter affairs had greatly improved, owing, no doubt, to the fact that the colonists had taken to hunting and providing themselves with fresh food instead of salt. Champlain reports of this third winter:

"We spent the winter very pleasantly and fared generously, by means of the Ordre de Bon Temps, which I introduced. This all found useful for their health and more advantageous than all the medicines that could have been used. By the rules

of the order a chain was put, with some ceremony, on the neck of one of the company, commissioning him for the day to go a-hunting. The next day it was conferred upon another, and, thus, in succession. All exerted themselves to the utmost to see who would do the best and bring home the finest game."

With the de Monts colonists were several surgeons, some of whom may have fallen victims to the then mysterious disease, before the Ordre de Bon Temps brought fresh game and health to the adventurous little company.

In 1613 the colony of Port Royal was greatly injured by an expedition from Virginia; war between France and England followed; but upon the restoration of peace, in 1632, France was still permitted to hold Acadia.

The work of colonization was resumed under the auspices of the new company of France; some sixty families of farmers, fishermen and artisans were brought over, settling first at La Have, and subsequently at Port Royal. Most of these came from districts on the west coast of France where it was customary to protect the low-lying lands from the encroachment of the sea by dykes, and they adopted the same method, with notable success, to reclaim the rich and extensive marshes about the Bay of Fundy, and soon made comfortable homes for themselves. The progress of colonization was long retarded by internal dissensions, and by strife between the rival claimants to the territory—France and England.

From the final cession of Acadia to Great Britain and the peace of Utrecht, in 1713, to the year 1749, when Halifax was founded, not the slightest effort was made in the direction of securing British settlers for Nova Scotia. France, by the retention of Cape Breton and the fortification of Louisburg, was enabled effectively to checkmate the plans of England. When war broke out between the two nations in 1744, the governor of Louisburg promptly sent an expedition to regain Nova Scotia. Canso was attacked and destroyed, and it was determined to capture Annapolis—which meant the capture of all Nova Scotia. This attempt failed, but it so exasperated the New England people that they resolved to secure possession of Louisburg. A scheme, planned by a lawyer and executed by a citizen commander, with an army of artisans, fishermen, farmers and lumbermen, snatched, by sheer audacity, from the grasp of France the great stronghold of Louisburg, defended by a garrison of veterans. At the close of the war, however, Louisburg, conquered by arms, was restored by diplomacy. A

storm of indignation swept over New England, which had the effect of quickening a plan long cherished by the British government, of establishing a permanent settlement and strong military station on the Atlantic coast of Nova Scotia, as a counterpoise to Louisburg, and Halifax was founded in the early summer of 1749.

## Halifax.

A fleet of transports, with 2,576 immigrants, of which 1,546 were adult males, sailed for Chebucto Bay, under the command of Hon. Edward Cornwallis. New Englanders also came in considerable numbers, and contributed largely to the success of the undertaking. The plan of the town was quickly made, building lots were assigned to the settlers, and before winter closed in all were under shelter. A little later a German colony was planted at Lunenburg.

In 1758 Louisburg was captured by General Wolfe, and Quebec in 1759. With British rule thus assured immigrants from New England and elsewhere soon began to flow into the country and to occupy the fertile lands and the best fishing stations, so that by 1770 there was an estimated population of 13,000 in the Nova Scotia of that day.

During the progress of the war between England and the revolted colonies of New England, many adherents of the Royal cause were driven from their homes and sought refuge in Nova Scotia. After the evacuation of Boston about two thousand refugees came to Halifax with the British forces. When the war closed large numbers of Loyalists withdrew from the United States, the greater part settling in Ontario and Nova Scotia. They consisted chiefly of the middle and upper classes, and were an intelligent and enterprising body of men, of sterling character. They diffused themselves quite generally among the older colonists, and also laid the foundation of new settlements in widely scattered parts of the province.

Among the 2,500 settlers who came to found Halifax in 1749 there were twenty-eight medical men. Eleven of the number were accompanied by their families, which indicates that they, at least, came with the intention of staying in the country. All, probably, were army surgeons, thrown out of employment at the termination of the war with France, who were thus willing to accept a free trip to America and a grant of two hundred acres of land. How bitter must have been their disappointment when they beheld for the first time an

unbroken expanse of forest, and realized that this was the home upon which they had based great hopes. Some found employment in connection with the hospital which had been established, but this did not last long, as the home authorities complained to Cornwallis that he supported too many surgeons and apothecaries. Only three out of the twenty-eight appear to have had the courage to face such a future. These remained with the other colonists, shared their hardships, and achieved some measure of success. The names of the three were Robert Grant, John Steele, and Alexander Abercrombie. These were the pioneers in medicine in Halifax. Grant became a member of His Majesty's Council; Steele, a member of the House of Assembly; and Abercrombie, when he died twenty-eight years later, was deeply lamented, both for his medical skill and his benevolent disposition. The fate of the other twenty-five is unknown.

Only one physician accompanied the 1,500 German colonists who settled at Lunenburg, and it is uncertain whether he remained in the country. The New England and North of Ireland settlers, who came to the province prior to the Revolutionary War, were usually able to obtain medical aid. The missionaries, who regularly visited the sparsely settled and remote districts, had some medical knowledge. At some points the garrison surgeons looked after the sick. A few physicians came from New England and engaged in practice in the more thriving districts. Of these latter the professional knowledge and skill may not have been great, but they were usually resolute, enterprising men, and useful members of the community in which they lived.

A large number of medical men accompanied the Loyalists. They were well qualified. The majority had served as surgeons during the war, and their influence in improving the status of the medical profession was marked, owing to their number, skill, and strong personality. In respect to the effect of the Revolutionary War on the fortunes of physicians and surgeons, Sabine remarks:

"The physicians who adhered to the Crown were numerous, and the proportion of Whigs in the profession of medicine was probably less than in either that of law or theology. But unlike persons of the latter callings, most of the physicians remained in the country and quietly pursued their business. There seems to have been an understanding that though pulpits should be closed, and litigation be suspended, the sick should not be

deprived of their regular and freely chosen attendants. I have been surprised to find from verbal communications, and from various other sources, that while the 'Tory doctors' were as zealous and as fearless in the expression of their sentiments as Tory ministers and Tory lawyers, their persons and their property were generally respected, in towns and villages where little or no regard was paid to the bodies and estates of gentlemen of the robe and surplice. Some, however, were less fortunate, and the dealings of the Sons of Liberty were occasionally harsh and exceedingly vexatious. A few of the Loyalist physicians were banished; others, and these chiefly who became surgeons in the army or provincial corps, settled in Nova Scotia or New Brunswick, where they resumed practice."

I feel, sir, that this address bids fair to become too long, and there is still much ground to be covered. It seems desirable, therefore, that I should present the chief remaining facts of this subject in a summary form, and for this purpose it appears best to select certain important points, and to group the facts around those dates.

## 1749-1790.

The first date I have chosen is 1790, as we have an estimate of the population for that year. Prior to that date the population fluctuated very considerably; afterwards it steadily increased. The estimated population of Nova Scotia, in 1790, was about 35,000. The number of practitioners in the province at that time, as far as I have been able to ascertain, after considerable research, was thirty-five, a very large number when we consider the slender resources of the inhabitants and the limited extent of the settled area. The presence of so many practitioners at that early period is explained by the circumstances that fully one-third of the number held permanent appointments in connection with the military establishments at Halifax, Windsor, Annapolis, Shelburne, and Sydney—appointments which they had received as a partial compensation of the losses they had sustained by the Revolution. Their official duties were light, and gave them ample time for general practice. After the founding of Halifax about nine-tenths of the physicians who came to Nova Scotia came from New England, and of the thirty-five practitioners in 1790 fully three-fourths were Loyalists. The latter did much to create that ingrained respect and loyalty towards the profession which is a characteristic of Nova Scotians, and this was accomplished by the

individuality and force of character of those men as well as by their professional skill. The inscription on the tombstone of Dr. John Haliburton, in the old St. Paul's Cemetery, might not unfittingly be applied to each one of them:

> "If unshaken loyalty to his King, steady attachment to his friends, active benevolence to the destitute, and humble confidence in God can perpetuate his memory, he will not be forgotten."

## 1790-1828.

After 1790 no distinctive event stands out from which we can look back upon the growth of the profession, until the year 1828, when an Act to regulate the practice of medicine was passed by the legislature. During this period of thirty-eight years the population had risen from 35,000 to 150,000—an increase largely due to an extensive immigration from the Highlands of Scotland. The older settlements had made substantial progress, and afforded an improved field for practice. The number of medical men had increased from 35 to 65; but the ratio to population had fallen from one in about 1,000 to one in about 2,300.

Two of those in practice in 1790 still survived—Jonathan Woodbury, of Annapolis, who came to the province as early as 1763, and Joseph Norman Bond, of Yarmouth, a veteran of the Revolutionary War, who enjoys the distinction of being the first medical man to perform vaccination in Nova Scotia. This was in 1802.

The additions to the ranks of the profession, during this period, were principally British graduates, who brought with them the traditions and customs of the profession in Great Britain. Many of them were retired army and navy surgeons, who had seen considerable service, and were accustomed to order, discipline, and regulations. Their personal influence proved a potent factor in improving the status of the profession; their intimacy both with their comrades in active service and with the practitioners of the province became a means of diffusing throughout the country a knowledge of the advances and improvements in our art, at a time when communication was slow and uncertain and professional periodicals were still in the stage of infancy.

During this period a few medical men also came from the United States. About 1800, we note the appearance of native Nova Scotians, who had studied either in Great Britain or in

the neighboring republic. Towards the close of this period there was a decided increase in the number of these. The first Nova Scotians were: Samuel Head, of Halifax, son of Dr. Michael Head, who came from Ireland to the province shortly after 1750; David B. Lynd, of Truro, a graduate of the University of Pennsylvania; Robert Bayard, of Cornwallis, a graduate of Edinburgh, better known in New Brunswick than in his native province; and W. B. Almon, of Halifax, also an M.D. of Edinburgh, and son of Dr. W. J. Almon, who first came to Halifax during the Revolutionary War. All of these were in practice in 1810.

The preamble to the Medical Act and a subsequent amendment point to the presence of a number of unqualified practitioners, especially in districts where medical aid could not be easily obtained. Many of these were men who had gained some knowledge, either through apprenticeship or a partial course at some college. Generally speaking, they were a deserving class, and should not be regarded in the same light as quacks and pretenders.

The early practitioners had to encounter many hardships and difficulties, except in the more populous districts. Many of the roads were mere bridle paths through the forest. Streams had to be forded. Water carriage, when available, was regarded as a boon. In the winter snowshoes were often necessary to complete a journey. Accommodation was very poor; domestic comforts were few; medical periodicals did not exist, and libraries were limited to a few volumes. The serious emergencies of a mixed practice had to be surmounted single-handed. Yet, in spite of all these disadvantages educated men toiled through long years, serving well their generation, and adding their quota to the slow but steady advancement of their profession.

Another point worthy of note is that, owing to the scarcity of educated laymen, and the absence of lawyers outside of Halifax, the doctors also rendered service to the public in the capacity of magistrates, judges of the Inferior Court, of Common Pleas, prothonotaries, sheriffs, judges of probate, and they were frequently elected to the House of Assembly. This added to their labor and perhaps their income, and widened the sphere of their influence. It may be affirmed with justice that no other class gave more useful service to the public than the physicians; nor do the best men of the past suffer by comparison with the leaders of to-day; and they have left us patterns of humanity and energy well worthy of imitation.

## 1828-1854.

The next important step in the progress of the profession was the formation of the Medical Society of Nova Scotia in 1854. This association grew out of, or rather was an expansion of, the Medical Society of Halifax, which had been formed in 1844.

Between 1828 and 1854 the population had nearly doubled, chiefly through natural increase, and the number of practitioners had risen from 65 to 120. An analysis of the list of practitioners in 1854 indicates that more than one-half of them had been born in the province. Of the total number 50 per cent. had been educated in the United States, 35 per cent. in Great Britain, and 17 per cent. were provincial licentiates. During this period the medical supply reached its lowest ebb, because but few practitioners came from abroad, and the cost of a complete medical education in a foreign country was greater than many Nova Scotians could afford. Quackery became prevalent and offensive. The petitions of medical men to the legislature had been disregarded, and the conviction became general that the only way to secure a remedy was by united action; hence the formation of the Medical Society of Nova Scotia.

## 1854-1872.

The next period, extending from 1854 to 1872, when a new Medical Act of great importance was secured, is characterized by a less rapid expansion of the population, owing to the fact that the era of emigration from the province had begun. But for the people who remained there was a better medical supply.

The new medical society soon made its influence felt. For some years its efforts were concentrated upon safe-guarding the interests of the profession and the promotion of measures to improve the public health. In 1856 the old Medical Act was amended, and new provisions were added to repress unqualified practice. A tariff of fees was framed; a code of ethics adopted; better remuneration for public services was secured: health legislation was improved, and an act for the collection of vital statistics was obtained.

The union of the provinces in 1867 widened the outlook of the profession; and the new order of things was promptly signalized by the formation, that year, of this Canadian Medical Association. And here permit me to refer to the fact that the honor of first presiding over the deliberations of this important

organization was accorded to a Nova Scotian, a gentleman of high standing in his profession, but one whose widely-recognized pre-eminence as a political leader and constructive statesman has caused his professional career to be almost forgotten—I refer, of course, to the Hon. Sir Charles Tupper. And I cannot omit mention of the second president of this association, also a Nova Scotian, and the ablest practitioner in the province, chosen for that place of honor because of his sterling character, public spirit and successful professional career, one who fortunately is still with us, an inspiring influence for all that is noble and good—I refer, of course, to the Hon. Dr. Parker.

In the same year, 1867, the Medical Society of Nova Scotia was reorganized. Up to that time the society had held all its meetings in Halifax. It was then decided to hold the annual meeting at different points in the province, with the view of securing the more hearty co-operation of members in the various parts of the country.

In 1867, also, a medical school was founded in Halifax in connection with Dalhousie College. At first nothing more than a short preparatory course, during the summer months, was aimed at. The venture met with success, and in 1870 it was decided to establish a full course of study and to confer degrees. This project encountered considerable opposition at first, and was not approved by the Medical Society. The supporters of the medical school took advantage of a strong and growing sentiment in the profession in favor of a more prolonged period of study than was required in the schools of the United States, from which the great majority of students obtained a qualification; and they took steps to secure the adoption of a new Medical Act, succeeding in 1872. The existence of a medical school within the province lessened materially the force of the objection raised in the legislature that the cost of a more prolonged period of study would restrict competition, and seriously affect the medical supply of the more sparsely settled districts. The propriety of founding a school at that time has been fully proved by the important part which it has played in promoting and maintaining a greatly improved system of medical education.

## 1872-1905.

Before considering the Medical Act of 1872, mention may be made of some minor events which have resulted in good. The Nova Scotia branch of the British Medical Association, formed in 1887, which meets at Halifax during the winter

months, and the Maritime Medical Association, formed in 1891, which holds its annual meeting alternately in the three capitals of the Maritime Provinces, have greatly promoted harmony and good feeling, as well as mutual improvement. The *Maritime Medical News*, founded in 1888, has been of material benefit to the various associations by preserving in an accessible form a record of their proceedings, and of their more valuable contributions.

The medical legislation in 1872 is of so much importance that I trust you will pardon me for giving an account of various steps leading to it. By medical legislation I mean, of course, enactments designed to regulate the study and practice of medicine, it being generally conceded that the state has full power in this respect. The basis of medical legislation is the necessity of affording protection to the people against ignorant persons and pretenders. The intention of such legislation is to secure a standard of professional education to be exacted of every one who is desirous of engaging in the practice of medicine, and such standard is obtained in various ways needless to specify.

The first step was taken while the military element in the profession predominated, and was perhaps suggested by the Medical Acts of Upper and Lower Canada. The Medical Act of 1828 is very brief, and is entitled "An Act to Exclude Ignorant and Unskilful Persons from the Practice of Physic and Surgery." Its substance is as follows: No person shall demand or recover any fee or award for medical or surgical aid unless he has a diploma from some college legally authorized to grant the same, or of having been examined in respect to his professional capacity by judges to be appointed by the Governor-in-Council. The Act being simple in character and adapted to the wants of that period, had some influence in restraining irregular practice, and it afforded partially instructed and deserving men already in practice a chance to obtain a legal qualification.

Next came the Act of 1856, promoted by the Medical Society of Nova Scotia. It provided for the registration of qualifications in the office of the Provincial Secretary. In addition to being unable to recover fees for services, unregistered persons were prohibited from holding provincial medical appointments, and were also liable to a fine of £5 for practising. Persons with defective qualifications could still become duly qualified by passing an examination before a board of examiners. This Act, like the previous one, was moderate in its provisions, and free

from objectionable features. It remedied some defects which practical experience had shown to exist in the former measure.

The Act of 1872 conferred the privilege of self-government, as its provisions secure to representatives of the profession full control of all matters relating to medical education, registration and discipline. The Act has since been frequently amended, but its essential features remain unchanged, and as they are similar to those of other provinces, further explanation is not necessary. But the composition of the governing body and its policy in respect to some questions demand brief consideration.

The profession as a whole is not incorporated in Nova Scotia, as it is in Ontario. The Act makes provision for a body corporate, called the "Provincial Medical Board," consisting of thirteen qualified medical practitioners, of not less than seven years' standing—seven to be appointed by the Governor-in-Council for life, and six to be elected triennially by the Medical Society of Nova Scotia. No other provision is made for collegiate representation, and there is no annual tax as in other provinces, the revenue being obtained wholly from examination and registration fees.

Until quite recently the requirements for registration differed in one important respect from those in other provinces, inasmuch as submission to a professional examination was not required from holders of diplomas from reputable schools, obtained after a sufficient course of study. Instead of examination the board insisted upon a rigid compliance with all its regulations relating to the preliminary examinations, period of study, and course of study—tests which effectually excluded applicants from schools of doubtful repute. This policy enabled the board, while maintaining the status of the profession, to keep an "open door" for licentiates from other provinces—a courtesy which so far has met with no reciprocal recognition. At the same time honest men from schools of good repute were spared "vexatious penalties of mind and body."

The principle of state examination was adopted a few years ago, not through conviction of its merits or necessity as a test of professional fitness, but from a desire to co-operate with other provinces in a general scheme of reciprocity. For the past three years an examination in the practical subjects has been demanded from all applicants for license, and the day is probably not far distant when the policy of the board, in this respect, will be adopted by other provinces, as it is now very generally recognized that medical boards and councils have not the requisite

equipment, and can scarcely provide competent and independent examiners, to conduct examinations in the scientific subjects on the lines of the more recent methods of instruction.

The Act of 1872 proved an important factor in causing a diversion of students from American to Canadian schools.

The ever-increasing proportion of Canadian graduates added yearly to the Medical Register is a marked feature of this period, and is worthy of special notice. An analysis of the Medical Register of 1875—thirty years ago—shows that of the whole number of practitioners, 78 per cent. were American graduates, 14 per cent. were British graduates, 2 per cent. were Canadian graduates, and 6 per cent. were Nova Scotia licentiates. A similar analysis of the Register of 1904-5 gives widely different results. Of the whole number, 53 per cent. were Canadian, 44 per cent. were American, and 3 per cent. were British graduates. The change in favor of Canadian schools is still more strikingly illustrated by an analysis of the additions to the Register from 1895 to 1904. Of the number added, 85.5 per cent. were Canadian, 14.2 per cent. were American, and 0.3 per cent. were British graduates. During the year 1904-5 the additions to the Register were exclusively Canadian graduates.

The predominance of the American graduates, numerically, has come to an end, but their influence, always exerted for good, will be felt for years to come; and it is pleasing to observe that the many evils which resulted from a lowering of the standard of medical education in the United States did not sensibly affect the status of the profession in Nova Scotia. This has been due in some measure to our geographical isolation, but chiefly to the circumstance that, from the earliest period down to the present time, the students from this province who went to the United States to obtain a qualification, have almost invariably selected the best schools in Boston, New York and Philadelphia.

The burden of maintaining and improving the status of our guild in this province and throughout our great Dominion is now fairly placed on the shoulders of Canadian graduates.

I fear, Mr. President and gentlemen, that I have rather overtaxed your patience, but trust that I have made it clear that our profession in this part of Canada has had a long and ever-widening history, and hope I have shown, by the citation of definite facts, that the profession in this province has, to say the very least, fully kept pace with the general progress of the country.

# "TWO CASES OF NEPHRO-LITHOTOMY."*

BY HADLEY WILLIAMS, M.D., LONDON, ONT.

The object of this paper is a plea for early operation for stone in the kidney.

The weekly journals contain scarcely anything on this subject, yet it is of considerable interest to the profession when we consider that one out of every three cases will die and that an operation, if undertaken early, promises much success. The condition is not so frequent in Western Ontario, but neither is it so rare as we are led to believe. I have two patients operated upon within the year; another who passed a stone of undoubted renal origin; and two other cases, so far refusing operation, who are undoubtedly suffering from renal calculi. Both of my cases were, at one time or another, diagnosed as lumbago, neuralgia, and hysteria (but one would rather believe this to be due to carelessness in the examination of the urine than ignorance on the part of the physician)—yet it must be remembered that there are cases, post-mortem, where a kidney has been found almost totally destroyed by huge, branching calculi, whose presence was unsuspected during life.

Case 1.—I. S., male, age 42 years, farmer. Referred by Dr. Smith, of Aylmer. Complained of a constant, dull aching pain in the right loin with gastric disturbance. increased by exercise or riding in a carriage, becoming on occasions acute and agonizing; a month was the longest interval of peace. This had lasted five years and the patient attributed the trouble to an injury, over the region of the right lobe of the liver, received at that time.

The urine was examined during and after attacks, and always gave, with few modifications, the following analysis: Reaction acid; sp. gr., 1.030; large number of red blood cells; pus; oxalates and urates in abundance. There was frequency of micturation, worse after exercise or jolting, and the average dai'y amount was 36 ounces. Dr. Smith suspected stone, with which I concurred. During the operation there was great difficulty in bringing the kidney to the edges of the wound for examination. Counter pressure by an assistant was of no value as the organ lay deeply behind the ribs. Only by packing the lower angle of the wound with pads could the kidney by brought down until it rested on the edges of the divided lumbar fascia. It was then thoroughly palpated and a hard substance easily felt. With the aid of a needle thrust into the pelvis from behind, a stone was located lying above

*Read at Annual Meeting of Ontario Medical Asso., Toronto, June, 1905.

the entrance of the ureter, but not obstructing it. An incision, parellel with the ureter, was made in the pelvis and the stone removed with forceps. The little finger was then inserted, the pelvis and calices explored, the wound closed with a continuous Lembert silk suture, two strips of gauze and a tube placed in position, and the whole returned. No vessels were tied and no hemorrhage took place. The tube was removed in three days, the gauze on the fourth, urine ceased to come through the wound on the ninth, and complete healing was affected on the twelfth. The average daily amount of urine the week prior to operation was 32 ounces. The first week after, 40; second week, 30; third week, 45. Patient left the hospital in five weeks and made an uninterrupted recovery. A few fleeting pains have been felt from time to time since, but are of no importance and he has increased twenty pounds in weight.

The stone is composed of oxalate of lime, weighed 10½ grains when removed, and 8½ grains when dry, and is about the size of a finger nail.

Case 2.—Mrs. T., female, age 36 years, St. Thomas. Referred by Dr. H. Arnott, of London. Complained of an aching pain in the right side extending across the abdomen, becoming acute and even agonizing with gastric irritation, especially after much walking or riding in a buggy—even after a short railway journey had to rest in bed for some days. Frequency of micturition was marked during the daytime. Gave a history extending over seven years; treated at first for lumbago; six years ago for tubercular trouble in apex of right lung; two and a half years ago a surgeon, diagnosed tubercular kidney; urine examined daily, for ten days, gave an average analysis. Reaction, acid; sp gr. 1.022; pus; marked quantity of red blood cells. Examination for bacillus of tubercle negative. As the kidney was freely mobile, enlarged and quite easily felt, we decided to operate. The diagnosis of stone by Dr. H. and Dr. D. Arnott was received with some reserve on my part as no crystals were found in the urine, and the case seemed as much tubercular as one of calculous. As guinea pig injection would have taken some time we proceeded with the operation. The kidney was easily found. Its surface showed signs of renal inflammation, was much larger than normal and cystic in the centre. It was brought well up into the wound until it rested on the edges of the lumbar fascia. Palpation gave some evidence of a stone which a needle verified. It was removed through a vertical incision made at the back of the pelvis; with the incision about one ounce of turbid fluid escaped which had formed a cyst of one of the calices above the stone. After the little finger had explored the interior of the kidney in every direction, a plain cat-gut continuous Lembert suture was applied. The drainage and subsequent treatment were similar to the previous case. No

hemorrhage whatever took place. The average daily amount of urine before operation was 17 ounces; the first week after 37 ounces; second, 30; the third, 38. The stone weighed 35 grains, was pear shaped, flattened and very rough, an inch in length and three-quarters of an inch in width, I am not quite sure of its composition. No urine whatever came through the loin, and the wound gradually closed after the fourth day. (Here, then, are two successful cases taken early, before the advance of serious kidney disease.)

The symptoms which lead one to suspect stone are, broadly speaking, two in number: "the character of the pain and the character of the urine." It is obvious that where a renal tumor is present from a hydro- or pyo-nephrosis, or some other condition due to stone, one's attention will be drawn to the kidney immediately. The conditions which simulate renal calculus are many, but, even after investigation, tubercular disease easily takes the first rank and is frequently difficult to differentiate. The urine in both these cases showed an acid reaction, pus, blood, oxalates and urates in the first, no crystals whatever in the last. Quite prominent also were frequency of micturition, more marked during the day, with pain in the loin affected by exercise, and causing considerable irritation of the stomach. A thorough history of a case is of the utmost importance and a systematic examination of the urine, not only during the attacks but for sometime after, for the bleeding may be very minute or even absent altogether. In my two cases the X-ray utterly failed to give a shadow, though the utmost care was taken to obtain one. Uric acid is said to be the only calculi which will, on all occasions, give this test. My own experience is too limited to either assert or deny this statement.

I have also a uric acid calculus passed by a gentleman, age 76 years, who for some time gave a history of stone in the kidney. It is rough, half an inch in length, quarter of an inch in thickness and oval in shape, which was passed under great suffering. Cases where a stone of such a size successfully navigates the ureter are unfortunately rare. The stone that only weighs 8½ grains is the smallest removed from the kidney that I can find in the literature of nephro-lithotomy, except one mentioned by Ia. Cobson in his table of twenty-one cases. After the operation the urine increased in both cases for the first week, lessened the second and increased again afterwards. This immediate increase seems to point to a good workable condition of the opposite kidney, which is of the utmost importance to the life of the patient. The kidney can be better examined if brought well out of the wound and made to rest on the edges of the lumbar fascia, where the surgeon can see every part, and palpate under the best conditions for stones are frequently missed by an incomplete exploration. The opening into the pelvis from behind is associated with no

bleeding, comparable to cutting through the kidney substance, and heals just as readily and perhaps with less danger. Great care is necessary to make the incision "clean cut," and large enough to allow removal of the stone without tearing, so that the edges can be more accurately approximated by the continuous Lembert suture. The hemorrhage from incision of the kidney proper, in some published cases, has been severe enough not only to delay the operation considerably, but even to threaten the life of the patient; though one is aware that there are cases of large, branching calculi, which cannot be removed in any other way. Examination of the pelvis of the kidney by the finger seems a most satisfactory method and its accomplishment quite easy; though, wi h the needle and the finger combined, a stone is still liable to be missed altogether. The formation of a permanent urinary fistula, so much to be deplored, depends in the main, to whether the ureter is obstructed or free, yet attention to details, such as accurate ligature of the kidney, and early removal of the tube, are of considerable importance. Nephro-lithotomy, if undertaken early, gives excellent results with a minimum of danger to the patient. Neither of these two cases had a bad symptom, which of course, was due more to the favorable condition of the kidney than any particular care on my part. And yet, this operation should not be lightly undertaken and without exhausting every means at the surgeon's command. Dickinson, twenty years ago, gave a mortality of 69 per cent. Recently, Ia. Cobson, in his operative surgery, 14 per cent., the kidney being in various stages of destruction, and of all cases a mistake of over 30 per cent. in diagnosis. There must be more exhaustive examinations of the urine, and the possibility of tubercular disease of the urinary tracts. Agonizing, pain, with blood in the urine to-day, are not sufficient for a nephro-lithotomy to-morrow. To my knowledge, and against my advice, a patient has suffered a large incision in the loin, the lifting of a normal kidney from its bed, and an exploration, for a pain that was evidently hysterical and for blood in the urine, whose only source was the accidental contamination of a menstrual flow. But, when the diagnosis is made, and the patient understands the risks of delay, as well as the favorable chances of recovery (when taken quite early) nephro-lithotomy offers, not alone the only method of relief, but the certainty of much success.

# REMARKS ON THE CUTANEOUS AFFECTIONS OBSERVED IN HYSTERICAL PATIENTS.*

By Graham Chambers, B.A., M.B., Toronto.

Hysteria is a neurosis, characterized by mental stigmata, usually of a moral and emotional character, as well as by an almost infinite number of symptoms, the result of nervous disturbances of function of the various organs and systems of the body. These disturbances may be of motor, vasomotor, sensory, trophic, or secretory origin, so that in the symptomatology of hysteria of any organ, one may find symptoms referable to disturbed functions of every nerve tissue taking part in the life process of that organ, and further, the more dependant the nerve tissue upon the psychic centres for its functionating power, the more likely its functions to be disturbed in hysteria.

The skin, on account of its exposed position, offers an excellent opportunity for observing the functionating conditions of the various nerve tissues. In addition, it gives an hysterical individual an opportunity for simulating disease by the production of feigned eruptions, and thus put in play the peculiar dissembling character and morbid craving for sympathy which is always present to a greater or smaller degree in all hysterical persons.

These feigned eruptions, when produced with no ulterior motive, should be looked upon as the outcome of defects of character, and, in a way, should be considered as a manifestation of hysteria.

The cutaneous affections seen in hysteria, and due to the mental condition and functional disturbances of this disease, I have, therefore, classified as follows :

1. *Feigned Eruptians.*
2. *Sensory Neuroses* :
   - (*a*) Hyperesthesia.
   - (*b*) Dermatalgia.
   - (*c*) Pruritus.
   - (*d*) Paresthesia.
   - (*e*) Anesthesia.
3. *Vasomotor Neuroses* :
   - (*a*) Anemias.
   - (*b*) Asphyxia (Raynaud's Disease).
   - (*c*) Gangrene
   - (*d*) Erythemas.
   - (*e*) Urticaria (including urticaria factitia).
   - (*f*) Edemas.
   - (*g*) Purpuras.
4. *Secretory Neuroses* :
   - (*a*) Hyperhydrosis.
   - (*b*) Anhydrosis.
   - (*c*) Hematohydrosis.
   - (*d*) Uridrosis.
5. *Trophoneuroses* :
   - (*a*) Alopecia.
   - (*b*) Atrophy and dystrophy of nails.
6. *Motor Neuroses* :
   - (*a*) Cutis anserina, etc.

*Read at Annual Meeting of Ontario Medical Asso., Toronto. June, 1905.

## FEIGNED ERUPTIONS.

As the consideration of the relationships which these affections of the skin bear to hysteria would lead me beyond the limits of this paper I shall limit my remarks to feigned eruptions and some of the forms of neuroses of the vasomotor system. These are eruptions of artificial origin purposely produced with the object of exciting sympathy or of avoiding work. Most of the cases which have been recorded in which the craving for sympathy was the sole object of the patient, have been in hysterical subjects. All forms of lesions that are possible to produce by the application of pigments or irritants to the skin have been observed. These are usually pigmented or erythematous patches, vesicles, blebs or ulcers.

The vesicular, bullous and ulcerative eruptions are usually situated on the trunk and extremities. They can generally be detected by the distribution and characters of the lesions not conforming to any known disease of the skin. The lesions are distributed in some cases symmetrically, in others asymmetrically. When symmetry is attempted it is frequently too accurate. This should make one suspect an artificial eruption. Then again, with regard to the characters of the lesions, one should keep in mind the appearances of lesions formed by common vesicants and caustics, such as cantharides and carbolic acid, as these are commonly used by malingerers. In some instances, particularly if a liquid has been applied to the skin, the lesions have peculiar irregular outlines as if the irritant had run on parts beyond the surface to which it was applied.

This character was well marked in a case of feigned eruption, produced by applying carbolic acid to the skin, that I saw about five years ago. The patient was a young woman, under the care of Dr. J. B. Webster, of Toronto. The eruption was situated on the trunk and extremities. Some of the lesions were large blebs, others almost confluent slightly elevated vesicles, while others again were covered with closely adherent scales, appearances known to everyone who is familiar with the local action of carbolic on the skin. These characters, together with the peculiar outlines referred to above, and the fact that the patient was extremely hysterical, led us to make a diagnosis of feigned eruption.

When pigments are used for stimulating a disease of the skin. the lesions are usually situated on the face, no doubt with the idea of attracting greater attention to the condition. This was the case in a very interesting patient whom I saw in consultation in the fall of 1903. The following are brief notes of the case:

The patient was a young girl who, while attending college in 1900, met with a slight accident, the result of a chair being withdrawn from under her. The disablement was out of all proportion

to the nature of the accident. Immediately after the injury she complained of severe pain in the back and was confined to her bed for three months. During this time, dark patches, like bruises, appeared at intervals on her thighs and trunk. At the end of three months she was able to return to Toronto, but had some difficulty in walking. Shortly after, dark pigmented patches appeared below the eyes, somewhat similar in appearance to those observed after a severe shock. The condition excited great sympathy in her parents and friends. She was sent to several summer resorts to recuperate, and after about three months the discoloration disappeared.

In the following year there was a slight recurrence, but it only lasted for a week or two. In 1903 the pigmentation under her eyes again returned, and the attending physician at that time requested me to see the patient.

On examination the patient presented a very striking appearance. There was marked pigmentation of a blackish hue on both upper and lower eye-lids. On the lower, the pigmentation, which was most intense near the eye lashes, extending well out to the central parts of the cheeks, where it gradually merged into the normal color of the skin. On the sides of the nose, adjacent to the inner canthi of the eyes, the mouths of the follicles, which are frequently somewhat patulous in these positions, appeared as if plugged with a black pigment. This led me to suspect malingering, a suspicion which was confirmed when I removed some of the discoloration by rubbing the pigmented patches with a moist towel.

Naturally I thought of determining the motive in the case, and as a further examination showed the presence of anesthetic areas, vaso-motor disturbances, and other symptoms of hysteria, I came to the conclusion that a desire for gaining sympathy was the object sought by the patient.

Through the kindness of Dr. Walter McKeown, I am able to report another instance of malingering in which pigment was applied to the skin to simulate disease. The following are brief notes of the case:

Two years since, a young woman of decidedly neurotic temperament, then living in an American city, who had been left alone during the absence of the family at church, was found on their return in a state of collapse. Upon reviving sufficiently to talk she stated that a man had entered the house and attempted to assault her. She afterwards positively identified one suspected of the crime and he is at present in prison for the alleged offence. After this she was the object of much sympathy and subject to "spells." These attacks at length came on so frequently that she was sent to Toronto in the hope that the change, remote from the scene of the unfortunate experience would help toward her recovery. In the family with whom she lived here, she was the object of constant solicitude, which she repaid by convincing them

frequently by her actions that she was about to die. One night during a particularly alarming attack, Dr. McKeown was called to see her, her friends being unable to reach her regular attendant. The patient presented a ghastly appearance—intensely pale, her eyes wide open and fixed, and beneath them deep black circles, rendered more marked by the intense pallor of the surrounding skin. She was apparently unconscious, although the conjunctiva was sensitive and the pulse regular and normal in frequency. This complex of symptoms suggested hysteria, and as soon as it was found that the pigment could be removed from the eyelids, there was no doubt in the doctor's mind about the diagnosis.

## VASOMOTOR NEUROSES OF THE SKIN.

A purely vasomotor neurosis of the skin is an affection due to functional disturbances alone of the nerve vessel mechanism. This may exist in a pure form, as in morbid blushing, and the fleeting erythemas due to excitement or exertion, but it is quite probable that in many of the eruptions placed in this category, trophic as well as vasomotor disturbances are present.

Vascular disturbances are very common in diseases of the skin, both of organic and of functional origin. This, together with the fact that they may be due to an almost unlimited number of causes, makes the determination of the role of hysteria as a causitive factor, a very difficult matter.

Before we can hold hysteria accountable for an affection of the skin, the condition found must be one capable of being produced by functional disturbances, and all other possible causes must be excluded. In addition, there should be present other signs of hysteria, such as the peculiar mental stigmata, anesthetic areas, hystero-genic zones, etc.

*Anemias.*—The anemias of the skin due to functional disturbances may be general or local. Both forms may be caused by emotions such as shock, fear and anger—the nervous disturbances at the menstrual period are also exciting causes. The lesions of the localized form are usually situated on the fingers, the condition being commonly known as "dead finger." The affected parts become white and numb, and after remaining in this condition for a few minutes return to their normal color. The phenomenon is usually observed in patients suffering from hysteria and allied neuroses. Pathologically the affection is a spasm of the arterioles and capillaries under the influence of the vasomotor system. It is similar in character to the "syncope" stage of Raynaud's disease but clinically it is generally a distinct affection. In some instances of localized anemia the lesions are not limited to the fingers but are situated on the face, back of hands and other parts of the body. I have seen several cases of this variety, though I believe that it is

somewhat uncommon. The following are notes of a case of this form of localized anemia in a patient who was also afflicted with leucoderma: M. S., age 26, housewife. Patient was seen by me, with Dr. Colling, Toronto, on June 2nd, 1903. She belongs to a neuropathic family. She states that both affections appeared when fifteen years of age. For four or five years afterwards the leucodermic patches extended, but the characters of the anemia remained approximately the same. At the present time the leucodermic patches are situated on the neck, trunk and extremities. The face, hands and feet are not attacked. Some of the colorless areas are very large. All are surrounded by pigmented borders. The lesions of the anemia are transient white patches generally situated on the face and hands. They are usually seen at the menstrual period, though strong emotions will cause them to appear at any time. Sensation is impaired and occasionally anesthesia is present in the affected areas. During the time the lesions are on the hands both the arms and hands feel numb. The previous history of the patient and the present condition of her nervous system indicate that the patient is hysterical.

*Hyperemia: Congestions.*—The hyperemias of the skin, due to functional disturbances of hysteria, may be active or passive. The latter is occasionally seen in hysterical paralysis. Active hyperemia usually takes either the form of morbid blushing or of a fugaceous erythema, which, according to the present system of classification and of nomenclature, would be designated erythema fugax. It is the latter affection on which I wish to report some observations. This form of erythema is characterized by transient erythematous patches and occasionally by reddish papules appearing after emotional disturbances and also, though rarely, after exertion. The lesions are usually situated on the sides of the face and neck, though they may extend to the shoulders and arms, and in rare instances to every part of the body. In the milder forms of the disease, subjective symptoms. other than a slight sensation of heat, are absent, and the lesions are limited to the face and neck. The patients are usually hysterics, or sufferers from neurasthenia, traumatic neuroses, exophthalmic goitre, or other disease in which the vasomotor system is extremely susceptible to irritation. In the severer types of this affection, which are also seen in the same class of patients, the eruption is much more extensive. Like the milder forms, it usually appears on the face and neck, but frequently extends to the shoulders, arms and other parts of the body. Itching is usually present and it is on account of this complaint that the patient sensibly seeks advice. The eruption may be of daily occurrence, in some cases slight exertion, such as moderate exercise, being sufficient to produce it. In the last four years, during which time I have been on the outlook for instances of this eruption, I have met five cases of this severe type of

fugaceous erythema. One was in a girl with marked hysterical symptoms, two were sufferers from exophthalmic goitre, one from traumatic neuroses, while in the fifth I was unable to determine any etiological factor.

*Urticaria.*—Urticaria is a disorder of the vasomotor apparatus, characterized by evanescent wheals or edematous swellings. In determining the etiology of a case of urticaria, one should seek two etiological factors, one being the exciting cause, the other the predisposition of the patient to the disease. This predisposition appears to be a peculiar irritability of the nervous system, and especially of the vasomotor apparatus. That this susceptibility to urticaria exists is evidenced by the fact that it has shown itself through several generations. The condition is, I believe, of a similar nature to that irritability of the nerve vessel mechanism so frequently seen in hysteria and many other diseases, among which I may mention neurasthenia, traumatic neuroses, chronic alcoholism, poisoning by tobacco, and meningitis. When this condition is present in a marked degree, a slight irritation, as for example, that caused by drawing a pointed instrument over the skin, will produce a wheal or an erythematous lesion, which will not disappear for some time. It is, therefore, quite possible that in many cases of urticaria, particularly in the chronic and relapsing types, these constitutional diseases may take a more important part in the evolution of the eruption than the exciting causes, such as auto-intoxication, ingestion of certain forms of foods, mental emotion, shock, external irritation, etc. In considering, therefore, the relations of hysteria to urticaria, I feel that the hysterical state, either active or latent, is frequently, if not always, a pre-disposing factor, the exciting causes being one of those above mentioned or auto-suggestion. In support of this view I shall report two cases of urticaria in which the nervous disturbances of hysteria appear to be an important etiological factor:

*A Case of Urticaria of the Face caused by Exposure to Cold.*—The patient, who was a young woman attending college in Toronto, consulted me in the fall of 1903 on account of an eruption which appeared on her face whenever she was exposed to cold air or washed her face in very cold water. She stated that she had suffered from the same complaint during the two previous winters. The eruption, which was limited to her face and forehead, consisted of wheals almost confluent. On inquiring as to her general health, the patient stated that she was given to emotional attacks which, as a rule, she was able to control. The deep reflexes were increased. The sensations of the skin were apparently normal. Mechanical irritation of the skin produced erythematous lesions, which persisted for some time. There were no symptoms of neurasthenia. This case should be looked upon as a case of

urticaria factitia, the exciting cause being exposure to cold. Similar cases have been recorded due to the irritation of heat.

*A Case of Chronic Urticaria in an Hysterical Patient.*—The patient, a girl about twenty years old, consulted me in November last on account of "hives," from which she had suffered for three months. Family history showed no tendency to neuroses. However, both the previous history of the patient and the present condition of her nervous system indicated that she was hysterical. The lesions of the eruption were similar both in appearance and in course to those of the common form of acute urticaria, but as new lesions appeared daily the course of the eruption had been chronic. The patient did not think that the appearance of the lesions bore any relation to the eating of food, but believed that emotional disturbances always aggravated the condition. The treatment adopted in this case consisted at first in the administration of lime salt and intestinal antiseptics. This did not appear to give any relief. I then, with the idea of exercising a suggestive influence, applied high-frequency currents, using the auto-condensation couch. After the first treatment there was a marked improvement in the condition, and in a week the patient was cured. I suspect that suggestion had something to do with the resolution. I may say that I have heard of cases of urticaria cured by hypnotism.

*Edemas.*—The lesions of the eruption are edematous swellings, pathologically similar in nature to the wheals of urticaria. The clinical features of hysterical edema are somewhat variable. The color of the lesions may be white, pink, red or blue. In some instances the course of the individual swellings is of long duration as in the case of the blue edema described by Charcot. In other cases, each lesion has a transient history, but by the appearance of new lesions at intervals the eruption may pursue a chronic course. The latter type of the affection is usually described as anti-neurotic edema, or Quincke's Disease. Recently I had under my care a hysterical patient, suffering from this affection, associated with urticaria factitia.

## A FEW REMINDERS.

By James S. Sprague, M.D., Stirling, Ont.

"Experience teaches," is an old maxim. Yet, when one observes that the best practice is that of the first ten years in rural sections, and that if one continue twenty years longer in the same community, no matter how faultless his work and his morals have been, yet he will note that, whereas he counted friends and patrons by the hundred in the first decade, and probably by fifties in the later part of the second decade, he, in the third decennial period, is fortunate if even by tens he holds or he counts his patrons and friends, and that if experience teaches, certainly, too often, it was the doctor who was taught, and the lesson was a sore one. He learns, too, that to grow up with the town is another fallacy, as far as popularity is concerned, for in the first ten or twelve, even less, years, after his arrival, his popularity was at its height; in fact, in most instances, any young M.D., if any way alive to the credulity of the people, can within one year have all the work he wants in a village. The fresher he is, and the more blunders he makes, will give him a widely honored notice, and greater patronage, which, if taken advantage of by him, would be to his best interest, provided he was wise enough to remain in such a community for ten years, or even less. To practice for a few years in several of the villages or small towns tributary to, and finally settle in, the near metropolis, is most worthy of consideration, and illustrations of the wisdom of such movements can easily be produced. Sometimes I have thought that to follow the example of ministers, who but for three or four years reside in one place, were desirable and decidedly profitable.

However, one fact is this, that to remain more than ten years in one locality, unless it is progressing, and unless one has other interests whereby his living is assured, and prospects are inviting, is a mistake, one too often made. Something new is what the dear people want, and you can, if you are a wise man, give them, in less than ten years, full doses, and very profitably for yourself.

Anyway, it is well to remember that the cake and wine period—in fact, the golden period, as it well may

be termed in practice—is in your first ten years. The wrinkled purse and disappointed hopes will scornfully await you, and which you may hug at your leisure in the third decade, provided you, in the first ten-year dreams in medicine, have not taken advantage of every opportunity, and many there were, that lead to financial success, and the greatest of these opportunities, life-long as a blessing or as a curse, are those that relate to the selection of a proper help-mate—the wife, who, if she possess, in addition to desirable womanly graces, such rare gifts as are required for a doctor's wife and his professional success (not forgetting the value of her possession of a fair bank account), will fill the cup of all that is worth living for even to the brim, for no greater blessing on earth is there than your wife.

"And she was beautiful, they said,
I saw that she was more—
One of those women—women dread,
Men fatally adore."

some anonymous writer has said, or named, as the ideal. Such a companion, educated, refined, not given to hypocrisy or deceit, being early selected, no fears of ordinary success and happiness need be entertained, if you act manfully and professionally in the early life.

To revert to the introductory sentence of this article, "Experience teaches," on very close inspection it would appear a fallacy, especially in other iatric considerations not herein named, for too often have we seen the young Dr. Newcome pass the door of Dr. Senex, to visit an only child, and too often have we secretly admitted that the good-will of Providence has intervened when recovery is established. Would the intelligent father of the said sick child consult the youngest, consequently the least experienced, jeweller, provided his costly watch needed careful regulation? No! He would enquire particularly among his friends who among the oldest jewellers, far and near, was the most capable for the work needed. Yes, experience teaches that many old sayings are very erroneous as to the morals of the doctor.

The nice young doctor, who conducts the Epworth League, or the Christian Endeavor, or temperance society, need not expect to stay long in town, unless he has an income, or is running some side line business, for his co-workers and the church will starve him out. They will give for the blasphemer and the drunkard—will open their doors to him and will uphold him.

In fact, I am led to believe that a good, moral character has no weight, but is a detriment as regards popularity in practice. However, a careful study of the subject compels me to admit the truth of these statements, and which, too, has been confirmed by other observers.

More than five thousand graduates in medicine are yearly sent forth from the medical colleges of the U. S., and they, as our Canadian graduates, commence their life-work ignorant how to legitimately obtain practice; ignorant how to make a living; ignorant of the rules of ethics as relate to medical practice; and ignorant of the principles which relate to their personal and public duty, and of the necessity, while guarding their lawful interests, how to maintain and advance the organized interests of the corporate guild.

Thus, without economic chart or compass, do our young men commence their voyage, and to the ordinary observer it is no wonder so many shipwrecks in life are noted, and how few evidences are afforded that port is being made, unless chance or accident intervene and assist; and no wonder, too, that so many abandon medicine and are on the outlook for governmental positions, which ordinary tailors or cobblers could easily and satisfactorily occupy, if not so honorably. In reference to such interests as are thus presented, the University of Michigan has recently established a most practical course, and as this university was among the first American universities to raise its requirements in time and studies, it certainly is the pioneer in this long-desired and essential establishment of lectures, although "Long is the way by precepts, brief and short by examples" ("Longum iter est, præcepta, breve et efficax per exempla").

These considerations and the recollections of blighted lives by not well calculated marriages, in the history of several confreres is really the occasion of this article, and when I review my own early career and its many false lights and temptations, and to which every young M.D. is, and has been, exposed, the wonder is that so many of us, inexperienced, actually green, have escaped so honorably. My much respected friend, Dr. Mathews, the author of "How to Succeed in the Practice of Medicine," gives much space in his book to this subject.

Here are themes worth considering when subjects relating to medical ethics and kindred interests are being discussed and advocated by our college professors—provided they have ideal wives, and have been country doctors, and can talk from experience, not dreams.

# Clinical Department.

**The Management of a Case of Prostatic Hypertrophy in an Enfeebled Man of Advanced Old Age.** H. McC. JOHNSON, M.D., of St. Louis, in the *Inter-State Medical Journal.*

Mr. D. S., aged eighty-six, came under my care at Mullanphy Hospital, May 3rd, 1905. He was poorly nourished, markedly senile, and continuously asthmatic. Heart sounds were clear and pulse fairly strong. He was confined to bed most of the time, being able to take only a few steps from the bed to a chair.

About the middle of March, of the present year, he noticed some burning upon urination, with decided frequency, the frequency existing night and day. At times his efforts at urination were ineffectual. These symptoms increased until about a month later when he had complete retention and became entirely dependent upon the catheter. Catheterization was both difficult and painful, making his condition quite unbearable.

Digital examination per rectum showed the prostate to be bilaterally enlarged. The quantity of the twenty-four-hour urine was fairly good and the specific gravity 1.011. There was a small amount of albumen, considerable pus, and some hyaline and granular casts. Dr. Hemplemann, to whom I referred the case for physical examination, considered the asthma to be dependent upon deficient cardiac action.

Here, then, was a very much enfeebled old man to whom catheter life was a burden; as catheterization required the services of one trained in that line, and because of his family circumstances, it became evident that he would have to spend the rest of his life in the hospital if nothing further could be done for him. Operative measures seemed contraindicated on account of his extremely feeble general state, but he preferred to take the chances in hope of relief.

Following the lead of Smith and Telluride, I did an external perineal urethrotomy under local cocaine anesthesia and inserted a catheter into the bladder through the opening for drainage. This caused the patient little disturbance, and he improved somewhat afterwards, so that we were enabled to have him put in a chair and taken on the porch daily. However, we found difficulty in keeping the catheter in place during the night, because

the patient in his sleep would catch hold of it and pull it out. The drainage was done simply as a temporary relief, with the idea that, if the patient improved sufficiently, a complete prostatectomy would be done later. By June 1st his condition seemed to justify further intervention.

Accordingly, on that day he was given just sufficient chloroform to stupefy him, and a finger was introduced through the perineal wound. In a few minutes both lobes of the prostate were enucleated (there was no median lobe). It was surprising how little reaction followed this operation. It seemed to have no deleterious effect on his general condition. Two days later the gauze and tube were removed; there was no leakage of urine from the bladder, and the patient voided urine voluntarily, quite freely at first, but completely emptying his bladder. The operated wound granulated nicely and the bladder symptoms improved, allowing the patient to return home June 14th, thirteen days after the last operation. There remained a perineal fistula. His asthmatic condition was about the same and his general health seemed improved.

At the present writing the perineal fistula has headed. Frequency of urination is somewhat more than normal, twice at night, but is improving, and as the full benefit from prostatectomy is not reached for at least six months after the operation, I expect still further amelioration of the symptoms.

Preliminary drainage of the bladder through a perineal opening I regard as a decided advantage in cases of old men who are too feeble to stand immediate prostatectomy, and do not do well on the catheter. In fact, the danger of catheter life in prostatics is no small consideration. A perineal section may be easily and quickly done under local anesthesia and is followed by a minimum of shock. With a large catheter through the perineal opening in the bladder, drainage is good, and infection and inflammation may be reduced through irrigation, preferably with silver nitrate solution. It gives one time, too, to build up the patient's general condition, and should be employed in emergency cases, at least for temporary relief.

The perineal route is far superior to the suprapubic route for temporary drainage, because it is efficient, there is less shock, less danger of urinary infiltration, less danger of sepsis. It may be done under local anesthesia, which is safer than a general anesthetic.

If the patient builds up and his general condition seems to justify it, a secondary operation may be done. It is not a dif-

ficult procedure to introduce the finger through the cut in the perineum and enucleate the obstructing lobes, nor does it add much to the gravity of the situation. In other words, we do half of the operation of prostatectomy at one sitting, subsequently getting the bladder and patient in condition, and the bladder tolerant of manipulation, later doing the second and last part of the operation.

By fitting a urinal to the perineal tube, as recently practised in a case by Dr. Burnett, often a patient may be quickly gotten out of bed and given the benefit of being up and about in the fresh air. If the patient's condition is too serious to allow of further operative procedure—which is not the rule—we have, at least, relieved him of the pain and difficulty of catheterization, and allowed him to spend the last days of his life in comparative comfort.

It may be said that the Bottini operation is the one of choice for these cases, but the Bottini incision is made necessarily in an infected field without sufficient drainage, and is, to say the least, unsurgical. Moreover, statistics show that not a few serious mishaps follow its use.

On the other hand, the establishment of good drainage from the beginning by perineal section and its lessened dangers, seem to establish it as the operation of choice in these old, enfeebled cases.

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## Some Remarks on Head Injuries, with Report of Cases.

W. S WIATT, M.D., East St. Louis, Ill., in the *International Journal of Surgery.*

In the last five years the pendulum of opinion among our leading surgeons has swung several degrees toward the side of immediate surgical intervention in many cases of head injuries. The recognition of the importance of such intervention is our greatest surgical gain in this direction in recent years. It has been frequently observed that the slightest concussion accompanied by only momentary unconsciousness is followed by serious sequelæ, such as intracranial hemorrhage. The conservative treatment of such injuries often results in cerebral abscess, necrosis of brain tissue, epilepsy, intracranial hemorrhage, insanity, which conditions might have been avoided had proper surgical care been given the patient at the time of injury.

We report the following cases of head injury as they present

some especial points of interest and show the necessity for immediate operative intervention, both for diagnostic purposes as well as rational treatment:

CASE 1.—Luther ——, colored, while engaged in a crap game was shot by a comrade. He saw him draw his revolver, and, anticipating the danger, threw his head downward and forward, turning the top of his skull toward the muzzle of the pistol. The bullet of 22-calibre entered the skull through the anterior fontanelle, passing a little to the left of the superior longitudinal sinus between the hemispheres of the brain, behind the corpus callosum, striking the inner surface of the occipital bone and being deflected at an angle so that it lodged in the substance of the medulla. The accident occurred at 5 p.m., and the boy was able to walk to my office, a block and a half distant. On arriving at the office I found that he was rational and could answer questions intelligibly. His pupils were widely dilated; he complained of nausea and was faint. The patient was immediately sent to the hospital, but the parents would not consent to any operative procedure until the following day at 11 a.m. Within an hour after the accident Cheyne-Stokes respiration began and gradually became more pronounced and well-defined until death the following day. At 10 a.m. a trephine opening was made, the trephine surrounding the bullet wound in the skull. With a Fluhrer's aluminum probe an effort was made to follow the bullet track to its end; but as the bullet had passed between the hemispheres of the brain it left no track, and no knowledge could be gained of its whereabouts with the probe. There was no hemorrhage, and the post-mortem revealed the presence of the bullet in the medulla. No wound of either hemisphere of the cerebrum nor of the corpus callosum could be found, but a depression of the dura on the inner surface of the occipital bone was thought by the physicians present to be the point at which the bullet struck and rebounded, lodging in the medulla.

This case is remarkable in that the superior longitudinal sinus was not wounded. It also illustrates the difficulty of locating a foreign body in the brain without the aid of the X-ray. We more frequently search for foreign bodies in the brain substance than we find them, and a skiagraph requires a long exposure and the patient is generally in no condition to undergo such an ordeal.

CASE 2.—A. G., blacksmith, had been seized with an epileptic fit while in a saloon. The patient was conscious when I

arrived, and gave the following history: Twenty years prior to this date he had been struck on the head with a hammer, causing a depressed fracture of the skull at a point corresponding to the upper end of the fissure of Rolando on the left side. The epileptic paroxysms were general, and not of the Jacksonian variety, as would be expected from an injury in this locality. He was sent to the hospital and trephined over the point of depression. The removed button of bone was not returned, and nothing was put in its place. The dura was opened and adhesions between it and the skull and the brain were carefully separated. No excision of the cortex was made, since the epilepsy was not Jacksonian. The dura was closed and the scalp wound sutured without drainage. The paroxysms did not recur for some weeks after the operation. The first one, appearing the ninth week, was described as being much less severe than those occurring before operation. At the end of the first year the patient said that the paroxysms were fewer in number than they had ever been before. During the second year he declared, when I tried to collect my bill, that the attacks were as severe and frequent as ever. The man was lost sight of at this time. This case is a good illustration of a bad result following the conservative treatment of a depressed fracture of the skull. It also substantiates the doctrine of Victor Horsly that general epilepsy following traumatism cannot be cured by relieving the pressure.

CASE 3.—B. S., aged eleven years, on September 1st, 1900, was carrying water to workmen on the Arcade building, when he fell from the first floor to the basement and struck his head on a sleeper. This happened at 5 p.m., and when I saw the patient, fifteen minutes later, he was able to answer questions, but was dazed and unable to tell how the accident occurred or where he was. The patient had the first epileptic seizure one hour after the accident, and a paroxysm about every half hour, lasting from three to five minutes, until operated on at 8 p.m. He bit his tongue and frothed at the mouth during these paroxysms. At 8 p.m. a flap was dissected from the side of the scalp, the incision being entirely within the edge of the hair to avoid leaving a cicatrix in the forehead. A compound, comminuted, depressed fracture of the skull was found, extending from just in front of the ear up through the squamous portion of the temporal bone across the anterior inferior angle of the parietal bone, and through the frontal to a point corresponding to the edge of the hair. The detached piece of bone was driven

into the substance of the brain cortex. There was overlapping of the comminuted fragments at the lower end of the fracture. Since the piece of bone was entirely isolated and great damage had been done to the pericranium, it was decided to be the wisest policy not to replace it, for fear of necrosis following. As the fracture was compound and we were not sure of the wound being absolutely aseptic, we thoroughly cleansed the parts, but did not fill the gap the bone had occupied with anything. The wound was closed without drainage and the patient made an uneventful recovery, leaving the hospital on September 8th, 1900.

Many surgeons advance the idea that if the gap in the skull is not filled by replacing the button of bone, or by sterile celluloid, gold-foil, etc., that adhesions take place between the dura and the brain and the scalp, and cause epilepsy or insanity later. Four years have elapsed since this injury took place and no symptoms have occurred.

CASE 4.—Charles S., Laborer, on March 20th, 1899, fell 42 feet down the shaft of an elevator, the fall being caused by the breaking of a scaffold. Patient fell with the left arm against the left side, striking a 2 x 6 feet timber, 7 feet from the bottom of the elevator shaft, and then was thrown violently against the side of the shafe, hitting the side of his head. He was unconscious for a few minutes, and blind for one hour after the accident, but was able to hear voices during that time. There was considerable hemorrhage from the nose, mouth and ears. Deafness was almost complete for three months, and the patient has never been able to hear well with the left ear since the injury. The bleeding from the left ear continued for several days, the flow of blood alternating with a straw-colored fluid at times. On examination of the nose and ear with specula, no definite knowledge could be obtained, but the persistence of the hemorrhage, followed by cerebrospinal fluid, justified the diagnosis of fracture of base of the skull. The external auditory canal, nose, mouth and pharynx were antisepticized frequently, and the patient made a good recovery, the deafness in the left ear being the only unpleasant symptom remaining.

This case illustrates the difficulty in making a positive diagnosis of fractures at base of the skull, even though straw-colored fluid follow hemorrhage from the ear or nose. This fluid may be cerebrospinal, but only a chemical analysis will differentiate it from blood serum, the liquor Cotunnii, or the fluid from the mastoid cells.

CASE 5.—Raleigh ——, aged fourteen, an January 9th, 1902, while trying to jump on a moving coal car, missed his footing, and in falling struck his occiput on the corner of the granite sidewalk. Patient was unconscious for fifteen minutes, and when I arrived, one-half hour after the accident, he was still dazed, with widely dilated pupils, talked incoherently and could give no history of the injury. The boy was immediately sent to the hospital, and on dissecting down a flap, an incomplete depressed fracture was found a little above and to the left of the external occipital protuberance. The fragment of bone on one side was depressed, so that its outer surface was on a level with the inner surface of the skull. It was removed and the scalp wound closed without drainage. The boy made an uneventful recovery, and has had no unpleasant sequelæ.

This case is unique, on account of the proximity of the depressed fracture to the centre for sight in the occipital lobe. If this fracture had been treated expectantly, the patient in all probability would have had hemi-anopsia or half-blindness in the opposite half of both retinæ.

CASE 6.—I. S., aged thirty-five, on September 23rd, 1904, while crossing a street-car track was struck by a car. He turned a somersault, alighting on his occiput. He was rational one hour after the injury, and able to recognize friends two days after its occurrence. He then became delirious and remained so until his death. On the morning of the 26th, Dr. Applewhite, his physician, and myself decided to raise a scalp flap and inspect the skull under the site of contusion. We found no fracture of the skull, and as no pressure symptoms were present justifying the opinion that a motor area was involved, we investigated no farther. The patient died on the morning of the 27th, and the post-mortem revealed the following lesions: A contusion over the left occipital lobe involving an oblong area, possibly two inches in its longest diameter. Ecchymoses over the entire area were present. In the parietal lobe of the opposite hemisphere two lacerations were found, the brain substance in and around these lacerations being necrotic. This patient was addicted to the use of alcohol and told me several times within the last few years that he averaged taking fifteen drinks of whiskey per day. With lacerations in this part of the cerebral cortex we would expect some involvement of the motor areas along the fissure of Rolando. No symptoms indicating such involvement were, however, present, the patient using his left arm and leg as well as his right.

This case substantiates the observation of Keen, that a contusion or concussion of any severity is accompanied by laceration of brain tissue. It also illustrates the difficulty in differentiating between coma or delirium due to head injury and coma or delirium due to alcoholism. This case was diagnosed by a good surgeon as one of delirium tremens, he expressing the opinion that the injury was not much concerned in the production of the delirium.

CASE 7.—This case is not reported as one in which a positive diagnosis of head injury, followed by cerebral abscess, was made. There was possibly no relation existing between the injury and the brain compression, but the history is worthy of study. In August, 1904, the patient, a child, fell down the stairs, striking the right side of the forehead just above the eye against the edge of a step. The child was drowsy for two or three hours afterwards, and then resumed its play. Two weeks after the injury, the right ear began to suppurate, the discharge continuing for a few days and then stopping for some days up to the time of the final illness. There was no history of scarlet fever or any of the exanthemata within the last year. During the period that the ear was not discharging the child had fever, was flighty at times and very excitable, easily losing its power of self-control. As soon as the discharge was re-established, these symptoms would disappear. On October 28th, the patient became unconscious. Temperature normal; pulse ranging from 60 to 70; respiration labored; right pupil dilated and fixed; right eyeball bulging; constant movement of the left leg, foot and toes; some movement in the left arm and hand, but not so much as in the foot. A diagnosis of possible cerebral abscess was made, which was confirmed by the consulting surgeon, and it was decided to trephine over the upper end of the fissure of Rolando, as symptoms in the left leg and foot pointed to this as the area involved. When the button of bone was removed the dura bulged into the opening; when the dura was opened the brain bulged. The brain was probed in different directions with a grooved director, but no pus was found. The brain tissue was necrotic or disintegrated to such an extent that a grooved director was carried by its own weight through it. Immediately on incising the dura and relieving the compression, the child's pulse and respiration became better. An opening was also made in the mastoid region, no pus being found in this locality. A post-mortem could not be held. If it had been, I believe it would have revealed the presence of an abscess somewhere in the brain

substance, possibly in the cerebellum. The child began having Cheyne-Stokes respiration a few hours after the operation and continued to have it up to the time of death.

This case, as well as Case 1, substantiates the belief of Horsly, Nicoll, and others, that lesions of the central nervous system produce death by paralysis of the respiratory centre rather than by paralysis of the cardiac centre. Horsly and Nicoll both report cases in which the breathing stopped as soon as anesthesia was begun, artificial respiration being kept up as long as an hour without any effort on the part of the patient to breathe spontaneously. The operators became desperate, opened the skull, and immediately the patient breathed.

Some improvements have been made in the surgical technics of brain surgery in recent years. Keen, in exposing large areas of brain cortex, makes trephine openings, passes a probe from one opening to the other between the dura and the skull, threads the end of the probe with a piece of silk and pulls a Gigli saw through from one trephine opening to the other. In sawing through the skull he bevels the edges of the bone so that the fragment will not become depressed or slip down on the brain cortex when it is replaced.

The application of a pnumatic rubber tourniquet, as suggested by Cushing, just above the ears makes operations on the scalp practically bloodless. The tourniquet must be inflated with air, else pressure neuritis may follow its use.

As to closing the opening in the skull with the fragment of bone removed, or with celluloid, gold-foil, or silver plate, there is much difference of opinion among surgeons. Some contend that either of the three substances named acts as a foreign body and causes sepsis; others that if the fragment of bone be replaced, necrosis and septic infection frequently follow, and that if some substance is not used to separate the brain and dura from the scalp to prevent adhesions between them, these will inevitably take place and cause troublesome sequelæ.

## Summary.

*First.*—All cases of head injury, no matter how slight, are liable to be followed by intracranial hemorrhage, as much as thirty-six days having been known to elapse between the time of injury and the formation of a clot large enough to produce marked symptoms of compression.

*Second.*—Any case of severe concussion is liable to be accompanied by laceration of brain substance and cerebral hemorrhage.

*Third.*—Immediate surgical intervention, if there is compression, is the only means in most instances of getting a clear conception of the conditions present and of remedying them.

*Fourth.*—Since lesions of the central nervous system produce death by respiratory, rather than cardiac, paralysis, an anesthetic is to be given cautiously in any case of brain compression. Most cases of compression can be operated on after dissecting the scalp flap without anesthesia, since the skull, dura and brain are insensible to pain.

*Fifth.*—Rigid asepsis is essential to success and the prevention of unpleasant sequelæ in the surgical treatment of any case of head injury.

# Therapeutics.

**The Obstetrical Binder.**

Dr. W. Gilbert Povey, of Cleveland, writes: In endeavoring to answer this question as it is stated, I shall confine my remarks to *my own personal experience* gained from several hundred cases in both hospital and private practice, and shall *not* quote the opinions of others, as their opinions are not asked, neither shall I refer to text books or reported cases. One of the most salient among the principles of success in the private practice of medicine is to relieve pain and suffering and render the patient as comfortable as the means placed within one's power will permit. Viewing the obstetrical binder in the light of this principle, I believe most heartily in its use. In its universal use? No. for there are many cases where its use would be detrimental, but these are only the exceptions which prove the rule,

*The Binder Itself.*—This consists merely of a piece of unbleached muslin long enough to surround the abdomen and broad enough to extend from the pubes to the sternum ; two pieces of the same material, three inches wide and eighteen inches long, are securely *sewed* to the posterior border (to avoid use of safety pins, upon which the patient would have to lie), so that when the binder is applied they hold it down in position, and, being pinned anteriorly above the pubes, hold the vulvar pads in position. Several of these simple binders should be on hand, so that as one becomes soiled another may be applied.

*When Should the Binder be Applied?*—It is my custom to apply the binder as soon as the room has been straightened, the bed clothes and night clothes changed, and the patient bathed and rested. In other words, its application completes the obstetrical toilet.

*How Should the Binder be Applied?*—The proper application of the binder is the most important step in the whole procedure. Upon its proper or improper application depend the avoidance or occurrence of immediate complications, the comfort or discomfort of the patient, and her future good or ill health. To state it briefly, upon its correct or incorrect application depends success or failure.

*Method of Proper Application.*—Every practitioner of experience knows, if he has used the Credé method of expressing the placenta, how easy it is to place the hand posterior to a recently emptied uterus. The abdominal walls being relaxed and the uterus being sufficiently large to be well above the pelvis, a good sized pad of absorbent cotton or other suitable material is placed

in this artificially produced sulcus, posterior to the uterus, and held in place by the hand of the obstetrician; the uterus is held quite firmly forward and not pushed downward into the pelvis. As this pad is held in place by the hand of the obstetrician, the previously arranged binder is pinned snugly and firmly by the nurse, beginning at the *sternal* end and pinning *downward*, and *not* from the pubic end and pinning upward. The hand of the obstetrician is removed gradually as the binder is applied over the pad, which is thus securely held in position *behind* the uterus, and not on top of it. The nurse completes the pinning over the fundus of the uterus down to the pubes, but not nearly so tightly as was done above. The vulvar pad is placed in position and the two posterior straps are drawn up and pinned anteriorly, thus holding the binder down and the vulvar pads in position. Sometimes two additional straps are needed to hold the binder securely around the hips; these can easily be adjusted. The binder may be tightened as the uterus contracts, and by the tenth day, when the uterus is within the pelvis, the pad may be entirely removed and the binder applied firmly throughout its entire length. A little experience in this simple method of application will soon teach one where to place the pad, how much of a pad is necessary, how to hold it in position behind the uterus, how tight to bind, and how loose to bind.

The advantages of the binder thus applied are:

1. The patient is thus made comfortable. After the uterus has been delivered of his burden, the patient feels, necessarily, a tremendous relief from weight, presure, and distention, and, as many of my patients have expressed it, it is as if *everything* within had passed out; owing to the relaxed condition of the abdominal walls, no one but the patient herself can realize the comfort of support and tone which the binder affords.

2. It stimulates the uterus to contract, thus avoiding in many instances, I believe, the much dreaded post partum hemorrhage.

3. It permits the patient to be moved and turned in bed without the fear that something terrible is going to happen. For a patient to be turned from one side to the other, her position being changed when she becomes wearied, is of very great advantage in guarding against retroversion, descent, and prolapse of the uterus.

4. It has a decidedly beneficial effect upon the mental state, for the patient is of the opinion, whether the profession is or not, that her maidenly contour will thus be restored. Thus her mind is placed at ease, and this is no small factor in the establishment of an uneventful convalescence.

The objections to the binder are few:

1. Does it stimulate "after pains?" All I can say is that I have seen just as many cases of "after pains" where the binder was not applied as where it was, and in some cases where I have removed the binder the pains continued. I do not remove it now

in cases of "after pains." These pains can easily be controlled by a more sparing use of ergot and a little more judicious use of morphine.

2. Does it cause retroversion, descent, or prolapsus of the uterus? When not properly applied, I am of the opinion that it does; but when applied as I have outlined, thus allowing the patient to be turned and *not* allowing her to remain upon her back, it possesses advantages far above the objection raised, and even is a great factor in preventing the mentioned sequela.

3. Does it actually help to restore the maidenly contour? In answer to this question, all I can say is that the patient is of the opinion that it does, and surely no professional man can say that it does not. All in all, it seems to me that the obstetrical binder is a rational, feasible, and simple device, when in the hands of a judicious obstetrician a decided help, comfort, and blessing to womankind.

Dr. Henry B. Hemenway. of Evanston; Ill., writes:

For the first decade of my obstetric practice I used a binder in all cases. Then, having moved into a community in which professional opinion seemed opposed to such treatment, I permitted each patient to follow her own inclinations in that regard. During the last decade I have adhered to the routine use of the bandage.

Statistics are frequently misleading, especially where there are many elements to be considered, and a relatively small number of cases. The general conclusions of a close observer are often more reliable than figures. It is my experience that patients are more comfortable with the binder, and that they are less liable to have post partum hemorrhage, and other complications.

During the later months of pregnancy the intra-abdominal tension is great. When the womb is suddenly emptied there is a strong tendency toward congestion in the abdominal viscera. The blood vessels are enlarged and relaxed, and pressure upon them is removed. The engorgement thus resulting favors hemorrhage and relaxation of the womb, and thus makes a quiet nest for the development of bacteria. If the uterus is contracted and relatively bloodless, the outflow of lochia may more perfectly wash out any possible germs. A broad bandage, applied as soon as the placenta is expelled and drawn as tight as it can be conveniently, to some degree replaces the tension present before confinement. It is well known that the hand applied to the fundus uteri tends to produce contraction of that organ, and it seems that the binder has a similar effect.

If the foregoing reasoning covers the rational use of the bandage, it follows that the bandage should be applied as soon as possible, and it should firmly compress the abdomen. I can see no sense in the practice of a midwife who told me that she always

put on a bandage the *second* day. The first twenty-four hours is the most efficient time for the binder.

A binder around the pelvis makes little pressure upon the abdomen. Though that is the only portion covering the womb, I regard the portion above the ilia as the more important, for this portion gives direct pressure on the abdomen. I therefore prefer a bandage extending from pubes to the ribs.

A roller towel makas a good bandage. Sheeting is harder to pin. When the bandage is specially prepared I find that tapes sewed on to each side facilitate the ease and perfection of the application. Any portion may then be tightened or loosened without disturbing the rest. In a similar manner, using strong thread and a long running stitch, the band may be perfectly and quickly applied.

The value of the binder "to preserve the form" is exceedingly doubtful.

Dr. Theresa Bannan, of Syracuse, N.Y., writes:

The obstetrical binder, though not a necessity, is a most comfortable and valuable adjunct of the obstetrical toilet. Labor, by diminishing the abdominal contents, leaves the muscular walls too loose to fulfil their function. The patient has a sensation of emptiness and a consciousness of tumbling intestines. For comfort she demands a binder to hold the abdominal walls and contents snugly together until the muscles have regained their tone. The nerve supply is thus stimulated, favoring involution and peristalsis. Moreover, the patient believes that a binder is necessary to regain the original beauty of her form. This it does probably by calling attention to the need of abdominal exercise and correct poise, training the muscles to meet the abdominal contents rather than allowing the contents to distend the lax muscles. The binder should encircle the patient from the pubes to the waist. Its disadvantages are not apparent.—*N. Y. Med. Jour. and Phila. Med. Journal.*

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**Acute Anterior Urethritis of Gonorrheal Origin.**

The following outline of treatment to be followed in cases of acute anterior urethritis of gonorrheal origin is recommended by E. G. Ballenger in *Southern Medicine and Surgery:*

For the successful outcome of the treatment a well-regulated method of living is of the greatest importance. The patient should avoid all sexual excitement, alcohol, coffee, highly seasoned food, condiments, gravies, excessive use of tobacco and any violent exercise. The diet should consist of milk, buttermilk and other light, easily digestible substances that do not overload the urine. Large quantities of plain or lithia water, or lemonade, are of value, and the bowels should be regulated by mild laxatives or aperient mineral waters.

It should be kept in mind that the great feature of gonococci is to linger and to recur.

Internal medication is of great value. The author recommends balsam of copaiba and oil of sandalwood as of great benefit when given in doses of five minims (.30) each, three or four times daily, if no stomach disturbances arise.

In using urethral injections of the silver preparations the patient should be instructed to pass urine before the injection. The sides of the meatus are so pressed as to retain the fluid after the syringe has been removed. The fluid should be retained for five or ten minutes after each injection. The injections should be repeated once in three hours during the first three days, and gradually reduced to three a day and continued until the quantity of pus is very small. A saturated watery solution of hydrastin muriate should then be substituted for the silver and continued for from ten days to two weeks. If shreds and discharge are still present at the end of two or three weeks a more astringent preparation may be given, but always avoiding one that burns.

For this stage of the disease the author recommends the following combination:

℞ Acidi carbol ..... gtt. vi
Cupri sulph ..... gr. x-xv
Plumbi acetatis ..... gr. x
Aquæ dest q. s. ad ..... ʒviii
M. Sig.: To be used as an injection.

If a burning sensation appears the injection should be diluted. The meatus should be anointed with vaselin during the acute stage to prevent its being glued together or to stick to the protecting cotton and thus create a damming back of the discharge in the urethra. The patient should be urged to attend to proper hygiene, diet and medication until the shreds disappear from the urine.—*Journal A. M. A.*

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**Tabes Dorsalis.** The general and symptomatic treatment of tabes dorsalis, according to *Med. News*, consists in: 1. Avoid carefully all physical and mental exertion as well as alcoholic and sexual excess. 2. Every day on arising administer friction along the vertebral column by means of a horsehair glove.

The following should be taken every other day before meals:

℞ Pulv. capsici ..... gr. ii
Pulv. ergotæ ..... gr. v
Pulv. glycyrrhizæ ..... gr. x
Mellis q. s.
M. Ft. pil. No. xxx. Sig.: One pill before each meal and repeat every second day.

During the alternate days the following is recommended:

℞ Potass. iodidi ..... gr. xx
Aquæ ..... ʒiv
M. Sig.: One to two teaspoonfuls after each meal, in a glass of milk.

If the cause of the trouble is specific, mercurial inunctions are indicated.

If the pains are very severe the following combination is recommended:

℞ Morph. hydrochlor ..... gr. x
Cocainæ hydrochlor ..... gr. v
Aquæ dest ..... ʒi
M. Sig.: Fifteen drops to be injected hypodermically to relieve the pains.

To counteract the urinary and ocular affections one or two pills a day of the following combination is recommended:

℞ Ext. belladonnæ ..... gr. iii
Ext. gentianæ ..... gr. v
Pulv. glycerhizæ ..... gr. x
Mellis q. s.
M. Ft. pil. No. xx. Sig.: One or two pills daily.

The bowels must be kept active with glycerin enemata, or one of the following pills may be substituted:

℞ Podophyllin ..... gr. ii
Ext. cascaræ sagradæ ..... gr. x
Mellis q. s.
M. Ft. pil. No. x. Sig.: One pill at bedtime for bowels.—*Journal A. M. A.*

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**Saline Injections and Rectal Feeding in Gastric Ulcer.**

The treatment of acute gastric ulcer, according to F. D. Boyd in an abstract in *Med. Review of Reviews*, is rest for the stomach. An adult resting requires on an average 2,000 calories per diem to maintain the proper balance of nutrition, and it has been found that rectal absorption ranges from 300 to 500 calories daily. Rectal alimentation, therefore, means partial starvation and, in addition, it causes an increase in intestinal putrefaction. It is the common belief that substances injected into the large intestine reach only to the ileocecal valve, but, according to this author, particles under favorable conditions may reach the stomach. In this connection he quotes the experiments of Gützner, that if starch emulsion be injected into the rectum with a normal saline solution, the starch can be washed out of the stomach in from four to six hours afterward. This occurs partly through recurrent peristalsis or, more probably, by the action of the surface epithelium of the intestine. It is probable, therefore, according to this author,

that rectal feeding may interfere with gastric rest, as considerable pain and vomiting frequently follow nutrient enemata. He recommends, therefore, in the beginning a mild aperient. No food should be given by the mouth during the period of physiologic rest of the stomach. Every six hours one pint of warm normal saline solution is syphoned into the bowel by means of a soft catheter and a filter funnel. This relieves thirst. If irritability be present, a small amount of morphine may be introduced into the rectum.

No fluid should be taken by the mouth. Water is not absorbed by the stomach to any great extent, and must be passed into the intestine, and thus sets up peristalsis, consequently it must not be given, especially if gastric hemorrhage be present. The mouth and teeth must be properly cared for, as salivation and irritating secretions from the mouth are swallowed and gastric irritation is set up. In simple ulcer complete rest for from twenty-four to forty-eight hours will cause all pain and gastric hyperesthesia to pass away. If these symptoms continue under this treatment for three days it means that the healing process is not going on and that adhesions are probably present. The period of complete rest should continue for from four to six days, and after this milk in small quantities may be given. It is unnecessary to peptonize the milk, but it should be diluted with water, with the addition to a small amount of sodium bicarbonate or phosphate.

At the end of the second week the patient may take sufficient milk to maintain the nutritive balance and the diet may be gradually increased till at the end of four weeks the patient may be placed on a convalescent diet without discomfort.

The treatment of gastric hemorrhage is the same as that of acute ulcer. Severe or repeated hemorrhages may require more active treatment. Of the medicinal preparations recommended to check hemorrhage, Boyd recommends morphine hypodermically and adrenalin by the mouth. He recommends lavage in cases of hemorrhage, against the usual opinions, stating that its benefit more than counterbalances its dangers. The presence of coagulated blood in the stomach causes vomiting and increased peristalsis which is more likely to disturb clot formation than lavage when carefully carried out. He, therefore, recommends lavage, using water at a temperature of from 104 to 105 F. Iced water is not recommended, as it tends to induce shock.

F. P. Henry, in *Amer. Med.*, recommends rest, both general and local, in the treatment of gastric ulcer. He states that this may be carried out by putting the patient to bed and nourishing him by rectal enemata. He recommends Ewald's mixture for rectal feeding: two or three eggs beaten up with a tablespoonful of cold water. A small quantity of starch is then boiled with half a cupful of a 20 per cent. solution of grape sugar to which is added

a wineglassful of red Rhine wine; the egg mixture is then slowly added, taking care that the fluid is not hot enough to coagulate the eggs. Eight ounces is sufficient at one feeding, preceded by a simple saline enema. These nutrient enemata should be continued for three days, followed by small amounts of food, consisting of milk or gruel, by the mouth. When milk disagrees with the patient, buttermilk or boiled or peptonized milk is recommended, gradually increasing the diet to raw or soft boiled eggs, beef, mutton and chicken broths.

The medical treatment, according to this author, is of secondary importance. Bismuth subnitrate is recommended in half-dram doses three times daily, suspended in barley water or mucilage. Severe pain demands morphine. Vomiting may be checked by morphine or cocain. Hematemesis may be checked by hypodermic injection of ergot or adrenalin. Gallic acid and lead acetate are also of value. Some form of anemia frequently accompanies gastric ulcer. The blood should be improved by some bland form of iron after the acute symptoms have subsided. For this purpose Ewald recommends a 2 to 3 per cent. solution of the sesquichlorid of iron, taking one teaspoonful thrice daily in a wineglassful of egg water, making a solution of albumin by adding one part of egg albumin to two parts of water.

Some authorities recommend a combination similar to the following in cases of gastric hemorrhage:

℞ Acidi tannici ..... gr. xxx
Glycerini ..... ℥ xxx
Aquæ dest. q. s. ad ..... ℥i
M. Sig.: To be taken at one dose. Or:

℞ Bismuthi carb ..... gr. xii
Pulv. tragacanthæ ..... gr. v
Acidi hydrocyanici dil ..... ℥v
Liq. morph. hydrochlor (1 per cent.) ..... ℥x
Aquæ chloroformi q. s. ad ..... ℥ss
M. Sig.: At one dose and repeat three times a day.

Hyperchlorhydria not infrequently precedes ulcer formation. To counteract this condition bismuth subnitrate is recommended in large doses after meals, put up in wafers or suspended in mucilage.

The following combination is of value:

℞ Sodii bicarb ..... gr. viii-xv
Magnesiæ calc ..... gr. x
Bismuthi subnit ..... gr. xx
Cretæ preparatæ ..... gr. iv
M. Ft. chart. No. i. Sig.: One such powder after each meal.

Constipation may occur with the administration of the foregoing, and under such circumstances a saline laxative is indicated. —*Journal A. M. A.*

# Physician's Library.

*The Surgical Assistant.* A Manual for Students, Practitioners, Hospital Internes and Nurses. By WALTER M. BRICKER, B.S., M.D., New York City. With 123 original illustrations. Price $2.00. Published by The International Journal of Surgery Co., Medical Publishers, 100 William Street, New York.

A skilled assistant is of great benefit to all surgeons, but too often their assistants are general practitioners, untrained as regards technique. The object of this book is to make the surgeon's assistant an adept in his department, and as it deals with a subject not touched upon in works on surgery, it will prove of practical value to all, as it embraces many little " wrinkles " well-known to the surgeon, but before not set forth in print.

*American Edition of Nothnagel's Practice—Diseases of the Kidney, Diseases of the Spleen, and Hemorrhagic Diseases.* By DRS. H. SENATOR and M. LITTEN, of Berlin. Edited, with additions, by JAMES B. HERRICK, M.D., Professor of Medicine in Rush Medical College, Chicago. Octavo of 816 pages, illustrated. Philadelphia and London: W. B. Saunders & Company. 1905. Canadian agents: J. A. Carveth & Co., Limited, 434 Yonge Street, Toronto. Cloth, $5.00 net; half morocco, $6.00 net.

With the appearance of this, the eleventh volume of Saunders' American edition of Nothnagel's Practice, the work nears completion, the final volume on the Heart being now in active preparation. Like the others, this volume can be taken as the acme of knowledge on the subjects embraced. Professor Senator's clear style, systematic arrangement of facts, and logical reasoning make his articles on the kidney indispensible to the practitioner. The editor, Dr. Herrick, has enlarged on certain points whenever necessary, especially regarding treatment, diagnosis, urinary analysis, etc., so as to increase the value of the work to the general practitioner. He has also added articles on cryoscopy and phloridzin glycosuria.

The sections on the spleen and the Hemorrhagic diseases were written by Professor Litten, whose pioneer work in these fields is widely known. The articles on the mosquito and its

relation to malaria, on splenic anemia, on congenital icterus with splenomegaly, and on the X-rays in the treatment of leukemia, have been brought down to date by the editor. Indeed, the editor's interpolations add greatly to the practical value of the volume, and we are sure such an authoritative work on these subjects has never before been published.

*The Treatment of Fractures; with Notes on a Few Common Dislocations.* By CHARLES L. SCUDDER, M.D., Surgeon to the Massachusetts General Hospital. Fifth edition, revised and enlarged. Octavo of 563 pages, with 739 original illustrations. Philadelphia and London: W. B. Saunders & Company. 1905. Canadian agents: J. A. Carveth & Co., Limited, 434 Yonge Street, Toronto. Polished buckram, $5.00 net; half morocco, $6.00 net.

Every year for the past five years it has been our pleasure and profit to review a new edition of this excellent work by Dr. Scudder. It is, indeed, a most remarkable book, and the author and publishers are to be congratulated upon its publication. In this, the fifth edition, Dr. Scudder has added some fifty new illustrations, many of them X-ray plates, illustrating the actual line of fracture. The text also has been very carefully revised, and new matter added throughout. Important changes have been made in the treatment of fractures of the neck of the femur, bringing this part of the book in accord with the latest advances. The 739 illustrations do what they should—they illustrate, showing the reader just what is intended. Undoubtedly this feature has aided greatly in the success of Dr. Scudder's work.

*International Clinics.* Volume II. Fifteenth Series. 1905. Philadelphia and London: J. B. Lippincott Company.

This volume is well illustrated, has a fine list of contributors and treats in an exceptionally able manner on subjects in medicine, surgery, gynecology, ophthalmology, rhinology, physiology, and pathology. There is also a splendid chapter on treatment. As is now generally well-known, "International Clinics" is issued quarterly, is a standard publication, has thousands of readers, and is one of the most up-to-date publications issued. One would think every progressive practitioner would be possessed of it.

# The Canadian Medical Protective Association

ORGANIZED AT WINNIPEG, 1901

Under the Auspices of the Canadian Medical Association

THE objects of this Association are to unite the profession of the Dominion for mutual help and protection against unjust, improper or harassing cases of malpractice brought against a member who is not guilty of wrong-doing, and who frequently suffers owing to want of assistance at the right time; and rather than submit to exposure in the courts, and thus gain unenviable notoriety, he is forced to endure black-mailing.

The Association affords a ready channel where even those who feel that they are perfectly safe (which no one is) can for a small fee enrol themselves and so assist a professional brother in distress.

Experience has abundantly shown how useful the Association has been since its organization.

The Association has not lost a single case that it has agreed to defend.

The annual fee is only $2.50 at present, payable in January of each year.

The Association expects and hopes for the united support of the profession.

We have a bright and useful future if the profession will unite and join our ranks.

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# Dominion Medical Monthly

And Ontario Medical Journal

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## COMMENT FROM MONTH TO MONTH.

The recent meeting of the Canadian Medical Association at Halifax was one of the best in the history of the organization. The total attendance was 222, but from the standpoint of actual attendance from our own profession in the Dominion, it appears to have been the third largest meeting since 1867. The papers were excellent; the discussions often animated, often extended, always interesting, always profitable. Looking back at the meeting and remembering particularly the social side, it would appear that the Halifax men had quietly laid themselves out to eclipse any and every thing along this line heretofore attempted; and in the judgment of the guests they succeeded. Most every one thought he was going to a slow town, but the rapidity of the week fairly swept one off his feet. The open-handed, free hospitality of the West was only equalled by the unbounded desire of the East to out-do last year's welcome. The profession of Toronto will find it a difficult matter in 1906 to get into the hot pace which has been set.

On all sides it was quite apparent that the idea of reorganization was paramount, and that it was time that a start be made towards putting the Association upon a properly organized basis. Towards this end a Special Committee was appointed, consisting of a member from each province, with Dr. McPhedran as chairman. This committee made an interim report, and will continue to act, and will make requests for suggestions as to the best methods to adopt, and will no doubt have much valuable material for a report for the next annual meeting. Some of the suggestions already made are: incorporation, the publishing of a journal, additional sections, an increased membership fee, permanent membership. A start has been made, and it is to be hoped that the entire profession will take a deep interest in the matter and co-operate heartily with the committee in attaining the desired end.

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The question of a Department of Public Health for the Dominion remains as it was last year. Nothing has been secured other than the ratification by the Minister of Agriculture that he agrees with the spirit of the movement. The Special Committee on this matter, which was appointed after the Montreal meeting, and consisted of Dr. R. W. Powell, Ottawa (convener), Dr. E. P. Lachapelle, and Dr. T. G. Roddick, Montreal, on their own request were discharged, and a new and larger, with power to add to their number, appointed, with Dr. E. P. Lachapelle, of Montreal, as convener. It is an important question, and it is to be hoped that the new committee will be able to more successfully prosecute the campaign.

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According to the reports of the Registrar-General for Ontario, there seems to have been more than the usual amount of whooping-cough throughout the province during the month of August. Whooping-cough is one of those diseases of supposed bacterial origin, but of which as yet there is no

absolute proof of the specific bacterium. Time and again different observers have described various bacteria, but no advance has been made towards establishing the exact cause of the disease; and its prevention is not established on the same precise lines as scarlet fever and other diseases of childhood. Being, however, a dangerous and at times a desperate malady, as evidenced in the August returns, it might be given better attention at the hands of the health officials, as although the law requires the reporting of all contagious and infectious diseases, it is generally made to read, scarlet fever, diphtheria and smallpox. It is often, too, a desperate illness to treat, there being no drug which can be recommended to in all cases reach the spot. Until such times as research shall establish a specific bacterium as the cause of whooping-cough, the treatment by antitoxic serum, which has been tried, remains empirical.

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The medical profession all over Ontario will receive with profound regret the announcement that Dr. Daniel Clark has retired from the active superintendency of the Toronto Provincial Hospital, and they will receive with equally strong regret the news that the Whitney Government will perpetuate that vicious policy of former governments in the Province of Ontario, namely, the appointing of superintendents and assistant physicians to these institutions from the party caucus. It was expected that there would be a radical change in this direction, and that no longer would medicine in this province be disgraced by such improper appointments. We are not saying one word about the professional qualifications of the gentleman who has succeeded to the position rendered vacant by the retirement of Dr. Clark. We only wish to reiterate once more our condemnation of the practice which passes over men trained in this special hospital service, for the man who knows absolutely nothing of the treatment of the insane as carried out in well-governed institutions. It seems to us, further, that if appointments of this character are to continue to obtain, men who have gained

distinction in their profession, other than as politicians, should be given a chance. How these unfortunate people must smile when they learn that their doctors are chosen for their political activity in behalf of the powers that be. The stump and the caucus are the great schools of training for the alienist in Ontario.

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The immediately foregoing paragraph was written after having read the now apparently false announcement in *The Globe* that a defeated candidate in a western constituency was to be appointed to succeed Dr. Clark. We are glad to learn that this is not the truth, but that a hospital administrator of the ability and capacity of Dr. C. K. Clarke has been chosen and promoted. This is on line with our views, but the new departure was short-lived, as apparently others have been appointed to the asylum service, not alone of their especially good professional attainments. All the press, in making announcements of these appointments, take good care to mention the political affiliations of the appointees. These appointments are purely political, and as such should be condemned by the medical associations.

# News Items.

## CANADIAN.

DR. WILEY, of Dresden, contemplates going into practice in Brantford shortly.

DR. N. F. FERGUSON, of Alliston, medical doctor for the C.P.R., has left for Byng Inlet.

DR. BOYD, has left for New Liskeard, having an appointment as assistant to one of the physicians there.

DR. W. G. REIVE, late resident physician at Huntsville Hospital, has bought the property of Dr. Philp, of Arthur, Ont.

DR. VAUGHAN MORRIS has left Warwick for Minneapolis on a visit and purposes hanging out his shingle in North Dakota.

DR. WILL PROCUNIER, a former student of the Aylmer C. I., has been appointed house surgeon at St. Michael's Hospital, Toronto.

DR. JAMES WEBB is about to locate in Niagara Falls, Ont. He has practised for several years in the Canadian Soo, and at Copper Cliff. At the latter point he was head physician of the *Canadian Copper Co. Hospital.*

DR. J. A. ROLLINS, of Exeter, has sold his practice there to Dr. A. F. Malloy, for some time house surgeon at the Western Hospital, Toronto. Dr. Rollins has practised in Exeter for about twenty years, and intends to retire from the active duties of his profession for a time.

HARRY WATSON, M.D., Winnipeg, Man., has been appointed acting assistant surgeon, Public Health and Marine Hospital Service for the U. S. Government, and will have full charge of *medical examination of all aliens passing through Winnipeg en route* to the United States.

Dr. M. A. V. Armstrong has sold his residence, drug store and practice at Fordwich to Dr. Foster, of Providence Bay, Manitoulin Island. Dr. Armstrong has been practising in Fordwich for nearly three years. He is undecided as to what he will do, but has some intention of going to the West.

Canadian Medical Association—General Secretary's Report.—Two hundred and sixty-seven names were inscribed on the treasurer's register at the thirty-seventh annual meeting of the Canadian Medical Association, held in Vancouver, B.C., from the 22nd to the 25th of August, 1904. It was the third largest meeting in the history of the association. Of this number sixty-one were guests, several distinguished members of the profession being present from Great Britain and the United States. Two hundred and six were from the Dominion of Canada; and the fact bears some significance, that our guests at that meeting numbered nearly one-third of the attendance from our own profession in Canada. In detail the attendance may be grouped as follows: Vancouver, 40; Victoria and the province, 40; Ontario, 56; Quebec, 21; N.W.T., 19; Manitoba, 18; New Brunswick, 3; Nova Scotia, 6; P.E.I., 3; England, 3; Scotland, 1; United States, 55; R.M.S. *Athenian,* 1; *Empress of China* S.S., 1. One hundred and one new members were added to our lists, that number having been elected to membership; and there were present forty-three members of the profession from Canada who did not seek membership in our association, which number was about one-half of the previous year. Amongst this number were some who took a prominent part in the proceedings of the meeting, such as delivering addresses of welcome, acting on the Nominating Committee, etc. This seems rather anomalous, and I respectfully call your attention to it. I call your attention to a notice of motion handed in by Dr. H. B. Small, Ottawa, at the last meeting: "That the members from each province, present at an annual meeting, elect from themselves three representative members, who, together with the President, Secretary and Treasurer, shall constitute the Executive Council of the Association." This is a radical

step towards amending the Constitution, appears like the thin edge of the wedge towards reorganization, and is deserving of your most careful and serious consideration. Although no official acceptance of the invitation sent by this Association to the British Medical Association, to convene in Canada in 1906, has been received, it is understood that that Association has accepted this invitation, and the additional invitation forwarded by the profession of Toronto, to meet in the Queen City of Canada. The meeting of this well-organized body in Canada will, I trust, excite some interest in the reorganization of Canada's national, medical organization. It is with sorrow that I report the death of one of our past-Presidents, Dr. James Thorburn, Toronto, since our last meeting. Dr. Thorburn filled the office of President in 1895-1896.

CANADIAN MEDICAL ASSOCIATION—REPORT OF SPECIAL COMMITTEE ON PUBLIC HEALTH.—As convener of your sub-committee in *re* the creation of a Department of Public Health as a Dominion measure, I have the honor to report that practically no advance has been made since we first presented your views to the Federal Government on this important question three years ago. Strong resolutions have been passed by your Association containing the views of the profession on this matter, year after year, and they have been duly forwarded to the proper authorities at Ottawa, to say nothing of the personal representations of your sub-committee, conveyed to the Government by way of deputation and personal interview. On the last occasion on which I waited upon the Hon. the Minister of Agriculture, he pointed out to me that he was familiar with the views of our Association as contained in the several resolutions referred to above, and that it appeared to him to be unnecessary to call the committee to Ottawa to reiterate what we had so clearly laid before him. He assured me that the whole question had his entire sympathy and that he trusted to see such a scheme as had been outlined to him brought into operation. And he further said that it was his intention to bring the matter again to the attention of the Prime Minister,

he hoped at a date sufficiently early to enable him to give something rather definite for our meeting at Halifax. Your committee feel that they have done what they could to induce the Government at Ottawa to create a Department of Public Health, under one of the existing ministers, in order to place this important branch of the public service on the same footing as it stands in nearly all progressive countries. We regret, however, to be obliged to report that so far our efforts have been unavailing, and as we believe that a more powerful and influential committee is needed from this Association to more seriously impress the Government with the great importance of this question, we respectfully ask to be discharged. (Sgd.) R. W. POWELL, *Convener.*

CANADIAN MEDICAL ASSOCIATION—RESOLUTION *re* PUBLIC HEALTH.—*Resolved,*—That a committee be appointed from this Association to wait upon the Dominion Government and lay before them the several resolutions now on the books of this Association in reference to the creation of a Department of Public Health, in order that all matters pertaining to the public health, over which the Dominion Government has jurisdiction, may be administered under one official head. That the committee be requested to impress upon the Government the great importance and public utility of this matter, and that it is the wish of the medical profession in the Dominion, as represented by the Canadian Medical Association, that such an advance should be made in this branch of the public service. That the committee consist of: Dr. E. P. Lachapelle (convener), Montreal; Dr. R. W. Powell, Ottawa; Dr. Daniel, M.P., St. John; Lt.-Col. Carleton Jones, Halifax; Dr. H. A. Bruce, Toronto; Dr. H. H. Chown, Winnipeg; with power to add to their number.—Carried.

CANADIAN MEDICAL ASSOCIATION—REPORT OF NOMINATING COMMITTEE.—Place of meeting in 1906: Toronto, at same time as British Medical Association meeting. President: Dr. Alexander McPhedran, Toronto. General Secretary: Dr. George

Elliott, 203 Beverley Street, Toronto. Treasurer: Dr. H. B. Small, Ottawa. Vice-Presidents: Dr. H. D. Johnson, Charlottetown, P.E.I.; Dr. G. Carleton Jones, Halifax, N.S.; Dr. Emery, St. John, N.B.; Dr. H. S. Birkett, Montreal, Que.; Dr. J. D. Courtenay, Ottawa, Ont.; Dr. S. P. Prowse, Winnipeg, Man.; Dr. H. G. McKid, Calgary, N.W.T.; Dr. R. E. McKechnie, Vancouver, B.C. Local Secretaries: Dr. Simpson, New Glasgow, P.E.I.; Dr. J. R. Corston, Halifax, N.S.; Dr. J. A. Scammell, St. John, N.B.; Dr. Ridley McKenzie, Montreal, Que.; Dr. Harold Parsons, Toronto, Ont.; Dr. J. R. Davidson, Winnipeg, Man.; Dr. J. Hislop, Edmonton, N.W.T.; Dr. W. H. Sutherland, Revelstoke, B.C. Executive Council: Dr. W. P. Caven, Toronto; Dr. A. A. Macdonald, Toronto; Dr. F. LeM. Grasett, Toronto. (Sgd.) F. N. G. STARR, Chairman Nominating Committee.

CANADIAN MEDICAL ASSOCIATION.—The following attended the thirty-eighth annual meeting of the Canadian Medical Association, held at Halifax from the 22nd to the 25th of August: H. Beaumont Small, Ottawa; George Elliott, Toronto; F. W. Goodwin, Halifax; A. Leitch, St. Thomas; A. Stewart, Palmerston; M. D. Morrison, Old Bridgeport, C.B.; J. Fred. Lessel, Halifax; Geo. M. Campbell, Halifax; J. St. Clair McKay, Earltown, N.S.; W. H. Hattie, Halifax; M. A. B. Smith, Dartmouth; W. P. Chisholm, Brockton, Mass.; Jos. J. Doyle, Halifax; A. I. Maider, Halifax; F. A. L. Lockhart, Montreal; A. Mather Hare, Halifax; B. S. Thorne, Havelock, N.B.; C. Dickie Murray, Halifax; D. A. Campbell, Halifax; M. E. Armstrong, Bridgetown, N.S.; C. A. Webster, Yarmouth, N.S.; John J. McKenzie, Toronto; J. Ross Miller, Amherst, N.B.; R. L. Langstaff, Richmond Hill, Ont.; Duncan Campbell, W. B., Pictou Co., N.S.; R. A. Reeve, Toronto; F. R. Eccles, London; A. B. Atherton, Fredericton; F. P. Drake, London; H. L. Reddy, Montreal; W. Bruce Almon, Halifax; Charles Verge, Quebec City; J. D. Page, Quebec City; Thomas W. Walsh, Halifax; William Rockwell, River Hebert, N.S.; W. S. England, Winnipeg; W. Tobin, Halifax; Andrew Love, Sydney Mines, C.B.;

Murray MacLaren, St. John, N.B.; F. H. Wetmore, Hampton, N.B.; H. S. Birkett, Montreal; Clarence L. Starr, Montreal; H. Meek, London; F. L. Burdon, London; Howard M. Church, Montreal; N. E. Mackay, Halifax; W. H. Eagar, Halifax; T. C. Lockwood, Lockport, N.S.; Ridley McKenzie, Montreal; F. G. Finley, Montreal; Chas. C. Gurd, Montreal; J. Price, Campbellton, N.B.; J. H. MacKinnon, Brooklyn, N.Y.; F. B. Day, Westville, N.S.; H. A. March, Bridgewater, N.S.; E. N. Hogan, Halifax; E. O. Hallett, Waymouth, N.S.; Francis A. R. Gow, Halifax; R. W. Powell, Ottawa; J. D. Courtenay, Ottawa; J. V. Anglin, St. John; E. N. Payzant, Wolfville, N.S.; R. E. Mathers, Halifax; L. W. Johnston, Sydney Mines, C.B.; J. J. Roy, Sydney, C.B.; R. F. O'Brien, Elmsdale, N.S.; R. D. Rudolf Toronto; A. McPhedran, Toronto; G. J. McNally, Fredericton, N.B.; R. A. H. Mackeen, Glace Bay, C.B.; W. H. Irvine, Fredericton, N.B.; A. G. Ferguson, Dalhousie, N.B.; E. H. Kirkpatrick, Halifax; Robert King, Halifax; William D. Forrest, Halifax; F. Montizambert, Ottawa; W. J. Bradley, Ottawa; C. P. Bissett, St. Peters, C.B.; John McMillan, Pictou, N.S.; D. J. Macdonald, Sydney, N.S.; W. W. Alexander, Lachute, Quebec; B. F. Boyce, Kelowna, B.C.; J. J. Cameron, Antigonish, N.S.; G. E. Armstrong, Montreal; John E. Somers, Cambridge, Mass.; Frank R. England, Montreal; F. V. Woodbury, Halifax; A. F. Buckley, Halifax; Edward D. Farrell, Halifax; M. A. Curry, Halifax; Alex. Taylor, Goderich; D. H. Taylor, Londonderry, N.S.; R. B. Nevitt, Toronto; A. McD. Morton, Bedford, N.S.; H. M. Jacques, Canning, N.S.; Thos. Trenaman, Halifax; Wm. Warwick, Westfield, N.B.; A. T. Shillington, Ottawa; L. M. Murray, Halifax, N.S.; J. L. Chabot, Ottawa; Osborne Morris, Vernon, B.C.; A. D. Blackader, Montreal; F. LeM. Grasett, Toronto; Freeman O'Neill, Louisburg, C.B.; David Alex. Shirres, Montreal; James Ross, Halifax; D. G. J. Campbell, Halifax; C. H. Dickey, Halifax; W. G. Morrow, Montreal; A. J. Cowie, Halifax; J. W. McLean, North Sydney, C.B.; F. S. Creelman, Maitland, N.S.; J. W. T. Patton, Truro, N.S.; C. Randall Gates, North Brookfield, N.S.; J. Clyde Macdonald, Westville, N.S.; F. N. G. Starr, Toronto; F. J. A. Cochran,

Halifax; M. Chisholm, Halifax; E. E. Bissett, Port Morrice, C.B.; E. Douglas, Halifax; Francis M. Caird, Edinburgh, Scotland; W. N. Wickwire, Halifax; H. K. McDonald, Lunenburg, N.S.; A. M. Hebb, Chester, N.S.; F. S. Yorston, Truro, N.S.; Howard A. Kelly, Baltimore; H. E. Kendall, Sydney, N.S.; H. Geo. Addy, St. John; G. L. Foster, Halifax; Herbert A. Bruce, Toronto; Charles S. Morton, Port Greville, N.S.; Edward Archibald, Montreal; Joseph Hayes, Nelson, N.B.; J. S. Bentley, Truro, N.S.; Mary L. Randall, Sydney, C.B.; J. H. Bell, Halifax; W. Grant Stewart, Montreal; A. P. Reid, Middleton, N.S.; D. J. Gibb Wishart, Toronto; W. W. Goodwin, Boston, Mass.; Alex. Murray, Deer Island, N.B.; J. A. Turnbull, Clark's Harbor, N.S.; H. V. Pearman, Halifax; S. R. Jenkins, Charlottetown; H. D. Johnson, Charlottetown; W. F. Hamilton, Montreal; W. T. M. MacKinnon, Amherst, N.S.; D. MacKintosh Pugwash, N.S.; R. D. Bentley, Wallace, N.S.; A. S. Simpson, New Glasgow, P.E.I.; P. M. Balcom, Aylesford, N.S.; J. A. Sponagle, Middleton, N.S.; L. R. Morse, Lawrencetown, N.S.; Geo. H. Cox, New Glasgow, N.S.; S. C. Primrose, Annapolis Co., N.S.; G. F. Dewar, Southport, N.S.; A. J. Murchison, Clyde River, P.E.I.; C. J. Miller, New Glasgow, N.S.; W. B. Moore, Kentville, N.S.; H. R. Munro, Stellarton, N.S.; C. J. Margeson, Hantsport, N.S.; J. B. Black, Windsor, N.S.; P. McLaren, Montague, P.E.I.; Robinson Cox, Upper Stewiacke, N.S.; J. A. Sutherland, Springhill, N.S.; W. G. Putnam, Yarmouth, N.S.; H. A. Lafleur, Montreal; James Bell, Montreal; J. Appelbe, Parry Sound, Ont.; F. F. Eaton, Truro, N.S.; J. W. Stirling, Montreal; S. A. Fulton, Truro, N.S.; H. E. McEwen, O'Leary, P.E.I.; Fred. J. White, Moncton, N.B.; Joseph Hayes, Parrsboro, N.S.; A. F. Norton, Oxford, N.S.; C. A. McQueen, Amherst, N.S.; W. S. Woodworth, Kentville, N.S.; W. M. Mather, Tweed, Ont.; L. C. McLeod, Newfoundland; Louis H. Morse, Digby, N.S.; Thos. W. R. Flinn, Halifax; A. C. Jost, Guysboro, N.S.; C. Kennedy, New Glasgow, N.S.; J. H. Mack, Halifax; H. V. Kent, Truro, N.S.; J. O. Calkin, Sackville, N.B.; Thomas Walker, St. John; J. M. Elder, Montreal; F. S. D. Ford, New Germany, N.S.; C. B. Trites, Liverpool, N.S.; A. A.

Schaffner, Halifax; A. E. Doull, Halifax; C. F. Freeman, Folly Village, N.S.; H. P. Clay, Pugwash, N.S.; S. E. Shaw, Berwick, N.S.; St. C. J. Gallant, Kirkwell, P.E.I.; A. C. Hawkins, Halifax; M. C. Smith, Lynn, Mass.; Walter E. Boardman, Boston, Mass.; G. B. Kennedy, Tangier, N.S.; W. J. Kennedy, Musquodoboit Harbor, N.S.; G. W. T. Farish, Yarmouth, N.S.; C. S. Marshall, Bridgewater, N.S.; E. T. Gaudet, St. Joseph, N.B.; J. Howard Slayter, Halifax; F. C. Lawlor, Dartmouth, N.S.; H. D. Weaver, Halifax; L. M. Silver, Halifax; G. C. Jones, Halifax; J. R. Corston, Halifax; J. W. Daniel, St. John; F. N. Stephens, Mahone, N.S.; E. W. Dunlop, Port Dufferin, N.S.; N. F. Cunningham, Dartmouth, N.S.; Albert A. Macdonald, Toronto; J. W. Reid, Windsor, N.S.; L. M. Curran, Fairville, N.B.; A. Lapthorn Smith, Montreal; F. Fisher, Bay of Islands, Newfoundland.

DISTRICT MEDICAL ASSOCIATION.—An enthusiastic and representative meeting of the medical men of Collingwood and the surrounding towns and villages for the purpose of forming a Medical Association for this district, was held in the new wing of the Collingwood General and Marine Hospital, on Friday, August 11th. Advantage was taken of holding the meeting the same day as the formal opening of the new building. The Association was organized with the following officers elected: Hon. Pres., Dr. A. R. Stephen, Collingwood; President, Dr. G. M. Aylesworth, Collingwood; 1st Vice-Pres., Dr. F. D. Kent, Thornbury; 2nd Vice-President, Dr. J. McCullough, Alliston; Sec.-Treas., Dr. D. McKay, Collingwood; Executive Committee, Drs. Arthur and McFaul, Collingwood; Dr. Pearson, Stayner. The objects of this Association are not only mutual social benefits, but also professional. At the regular meetings, medical papers will be read and discussed by members of the Association. The first regular meeting will be held in Collingwood on October 5th.