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CONTENTS

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INDEX TO CONTENTS

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WESTERN CANADA MEDICAL JOURNAL

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ORIGINAL COMMUNICATIONS.

THE ROLE OF THE GENERAL PRACTITIONER IN THE ADVANCEMENT OF MEDICAL SCIENCE.

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BURNLEY, ENGLAND.

When a young man qualifies and enters into general practice, as most graduates do, he starts his work with a profound belief in the authority and knowledge of his teachers and text books. He is not very long in finding out that disease very frequently does not accord with text book description, and presents itself in very different aspects from what it did in hospital practice. To begin with, he finds that his work and livelihood depend not in the unravelling of obscure and rare diseases, but in the treatment of ailments so slight that no self-respecting student would waste his time over them. He may be able to locate the precise spot of a degenerative lesion in an obscure strand in the spinal cord, but he cannot tell the cause or cure of the simple aches and pains which constitute the bulk of his practice. In course of time he acquires a certain ability in treating these simple ailments, though in many instances the causes remain obscure. The majority of illnesses he has to treat rarely end in being of a serious nature, so that, accurate diagnosis not being called for,

some superficial explanation suffices. As a consequence the examination of the patient is apt to be carried out in a somewhat perfunctory manner, and as a further result there arises too often an indifference in regard to the patient investigation of the nature of disease.

I have had the opportunity of discussing with many able medical men, who have gone into general practice, the question of research by the general practitioner. Practically all have abandoned any idea of prosecuting inquiries into the exact nature of disease, because the opportunities are denied them; the impression being that without a hospital or a laboratory it is impossible to do any good work. Day by day treatises upon every subject are issuing from the press, compiled by men who have had the advantages of all the scientific methods that surround a school of medicine. These treatises deal with all the features of disease so dogmatically that there appears no more to be said upon any subject. It seems a hopeless task to the general practitioner to do anything of an important nature in the investigation of disease, and his enthusiasm for his profession is thus damped and his faculties practically paralyzed.

If, however, a close inquiry be made into the matter, it will be found there awaits an immense field of research for the general practitioner, that there are great questions that never will be solved until he takes his share in systematic research. Scarcely an ailment exists which is fully understood, and many will never be understood until the general practitioner joins in the inquiry.

I will mention a few instances that await his advent as a scientific investigator. How is it possible that all the changes that take place in the course of a chronic ailment can ever be understood unless the gradually progressing changes are duly noted? The opportunity for doing this can only be taken by one who is in constant contact with the patient. These changes are so numerous and so varied that no suspicion of their nature is found by those who only see the patient when serious trouble arises. Take as an instance cases of rheumatic endocarditis. Considering the enormous amount of literature and observations published on heart matters, our knowledge of the progress of a simple endocarditic process might be considered to be fairly com-

plete. As a matter of fact we are still far from recognizing, let alone understanding, a great variety of signs and symptoms that arise in the slow progress of this affection. The changes are so gradual and so varied that the connecting links between the early rheumatic attack and the subsequent heart failure have never been recognized. This is simply due to the fact that those who write about and study heart affections only see the patient when the breakdown takes place, the whole train of events that led up to the breakdown being absolutely lost. The family physician, on the other hand, has the opportunity of seeing the trouble begin, and, if he cares to keep his eye on the patient, by periodic examinations he can note the changes that are generally taking place.

The changes that are revealed by this continuous examination are more varied than ony one suspects, and the light they throw upon the subject of the action of the heart is almost incredible even to physiologists accustomed to experiment upon the heart. In fact, to a great extent the careful observation of the changes in the heart due to disease is opening up to physiologists and pharmacologists new fields of research and giving them new conceptions of the heart's action.

The whole study of heart disease has yet to be written, and it never will be done until the general practitioner joins systematically in the work. Not only in heart affection is the time waiting for the general practitioner to participate in the research, but in all other ailments that run a protracted course, as arteriosclerosis, renal disease, chronic pulmonary and digestive disease, and so forth.

Another field that waits the general practitioner to explore is the recognition of that stage of disease when the prospect of a cure has passed. When text books are consulted, directions are generally given for treatment. That a stage is reached in every disease when recovery cannot be looked for, is generally ignored, and from some writer's statements one would fancy that his patients never die. If the advice of a consultant be sought, energetic means are too often recommended in the vain hope that recovery may follow. These being unsuccessful, the patient wanders from doctor to doctor, trying methods and remedies for

a complaint that cannot be cured. Now, if it were possible to recognize a stage when recovery was hopeless, much might be done to render the patient's life bearable and even interesting with his crippled faculties. What energy he has might be directed into useful channels, and he would be spared the exhaustion and disappointment that result from chasing the shadow of renewed health. Every general practitioner can recall cases where money and strength have been spent in the delusive attempt to find a cure, where the patient has not only been exposed to needless suffering but the family has been hard pinched by the useless waste of money. A few months ago I saw an old friend of mine who a year ago had an attack of heart failure. One doctor after another, finding the usual remedies of no avail, with one accord urged him to go to Nauheim. He spent three days of much suffering and discomfort in reaching the place, arriving at Nauheim in a state of great exhaustion. He was put through the treatment—sometimes spoken of as the "cure"—and returned to England in a worse state than when he set out, bearing a letter of the description that we all know, that the patient had been greatly benefited by his stay and treatment at Nauheim. This expedition undoubtedly hastened his end, besides wasting a sum of money that he could ill afford. Had the consultants who saw this man lived in daily attendance upon such cases and noted every symptom, there were signs present which would have told them that such treatment was not only useless but fraught with danger. Had this man been advised to live according to his strength, he might have been alive to-day; but we cannot get the information when to give up energetic measures unless the general practitioner joins in the systematic study of disease.

But not only have we to look to the general practitioner for the recognition of the stage beyond which recovery is impossible, but to him also must we look for instruction as to the management of hopeless cases. It is all very well treating patients in hospitals or in comfortable homes, where all nursing requisites can be had. Writers of text books do not recognize the fact that the vast majority of medical men have to treat their patients in small houses with nursing accommodation of the most meagre

description. I read not long ago how to treat cases of enfeebled hearts, and the celebrated physician gave minute directions regarding the delicacies suitable for digestion and the special brands of expensive wines that could be given. The crying needs of the majority of sufferers received no notice. If one general practitioner would but note with care his difficulties and the best way to overcome them, a beginning would be made to supply a most urgent want, for others, following his observations, would continue the quest and extend the information.

I have so far briefly alluded to some fields that lie open to the general practitioner. A little reflection will call to your minds many other ways in which he can usefully extend medical knowledge. As I have said, the impression is widespread that no useful work can be done without elaborate apparatus involving some laboratory experience. I do not wish to decry laboratory work. It has done, is doing, and will do, a great deal for medical science. But what I object to is the assertion that no good work can be done except in hospitals and laboratories. How many young spirits, eager and keen, have had their energies wasted because of the erroneous idea that it is necessary to spend their time solving some problem which may be insoluble, and, even if solved, to be of no practical use? Once I believed I had interested a clever young man in clinical work, when suddenly he left me because he had been asked by a therapeutic authority to come back to his laboratory to institute a research on the medical properties of the strawberry leaf. I expostulated with him, telling him he would waste his time in a fool's chase. He was, however, enamoured of the idea, and spent six months in a fruitless quest. Some years after he sadly told me he wished he had followed my advice. A wide and fruitful field lies open for the general practitioner by the means of examination that he daily uses. To read text books on physical diagnosis, it might seem that the field of clinical examination had been exhausted. So far from this being the case, the physical examination of patients has not yet been satisfactorily undertaken, and no text book exists that is not sadly lacking in efficiency. I would like to see text books written in such fearless manner that the writer should be more urgent in pointing out where information is lacking, instead of exalting the minute amount of knowledge he possessed. Read-

ers would then be stimulated to supplement the deficiencies, instead of being narcotized into the belief that beyond what was contained in the book nothing could be known.

I would now like to draw attention to a fundamental principle which must be observed if this inquiry should ever be seriously undertaken. This principle is merely the necessity for mal ing *accurate observations* I can imagine when I utter this statement that some of you may say that my remarks so far have been of the most obvious kind, and that this particular principle is the most obvious platitude of all. To this I agree. We become so familiar with platitudes like this that we treat them with the greatest contempt, indeed, with a contempt so great at times that we ignore their existence. Now this is just what has happened to this particular principle or platitude—medical observers have quite forgotten its existence. Why is it that so many people hold so-called medical science in the greatest contempt? For no other reason than that the exponents of medical science ignore this very obvious platitude. Although they may talk of their careful methods of observation, a critical study of medical writings will reveal the fact that they bristle with evidences of inaccurate observations. What they call observations are frequently but a mixture of imperfect observation and unwarranted assertion. While they imagine that they are stating a fact, they are actually at the same time recording an opinion. To take a simple illustration: A patient has an enlarged liver, and on pressing over the liver the patient complains of pain. The statement made by the medical examiner is invariably that "the liver is tender to pressure." Generally this is not a true statement; it is, in fact, a record of a bad observation and an erroneous deduction. Had the statement been that the patient felt pain when pressure was made over the liver, then a plain unvarnished fact would be recorded; but to say that the pain was felt in the liver is to make an assertion that may or may not be true, but which is not warranted by the evidence. The tendency to embody unwarranted assertions in the record of a fact is one against which we cannot be too much on guard. We all fancy ourselves free from superstition, but the same inherent mental qualities that led to superstition in our ancestors are present in us, and these lead us to

deductions no less erroneous than the deductions that gave rise to what we call superstition in the ignorant. When something strange happened which was beyond their knowledge, our ancestors attributed it to spirits—usually malignant. An attack of colic was the working of an evil spirit. Nowadays we have discovered the location of certain of our viscera, so when the colic is felt somewhere in the neighborhood of a viscus, we unhesitatingly refer the pain to that viscus—a method of reasoning not much removed from that of our superstitious ancestors. What I want to impress upon you is, never to record anything beyond what the actual facts warrant. If a pain is felt in a given region, note that fact first. If your knowledge tells you an organ is in the neighborhood, do not assert the connection between the organ and the pain until you have evidence of their direct connection. The search for such a connection will reveal to you things of which you have never dreamt. Let me recur to the socalled tender liver again. If the size of the liver can be mapped out, it will be found that the tenderness to pressure extends to parts beyond the liver, and that the same tenderness can be found in the tissues superficial to the liver, when no pressure is exerted on the liver. This result should immediaetly cause the observer to pause and consider things, and when he beings to think of the meaning of these things, there is hope for him and he will work out his own salvation. The failure to observe accurately is not limited to the physician. You will find surgeons describing how tender and sensitive an organ is before they cut down upon it, and when it is reached they can cut it, tear it and stretch it, and no pain is felt. Some surgeons have no difficulty in palpating from the outside an appendix, and yet have the greatest difficulty in finding it when the belly is opened. I have repeatedly seen the abdominal cavity opened to remove a tumour that had palpated but which had no existence in the abdominal cavity. Some little time ago I saw a patient with gall-stones. A celebrated physician also saw her, and found a tumour which he said was due to a thickening around a duodinal ulcer. An equally eminent surgeon said the tumor was an enlarged pancreas. When the abdomen was opened there was no tumour or enlargement of any kind. Do you think that the surgeon would pause and consider

what it was that he had mistaken for an enlargement of the pancreas? No; he evidently thought it was his duty to cut and not to think. It is an extraordinary thing that the fact that the muscles of the abdominal wall have the faculty of contracting and of remaining contracted in small sections, has never been recognized by any surgeon or physician as far as I know. This faculty is evidently due to a reflex stimulation from viscus that is irritated or inflamed. The semblance of these portions of contracted musculature to an intra abdominal tumour is so great that, although I have been familiar with the fact for many years, I am constantly meeting cases where I cannot be sure of distinguishing between muscular contraction and abdominal tumour. In passing I may remark that the patient observation of areas of tenderness and of muscle contractions is one essentially for the investigation of the general practitioner. The connection with the viscera is so definite that there is an admirable field for accurate observation waiting exploration. The requisites are simply careful observation, the noting of all associated phenomena and patient watching, for it may be years before the real meaning of the symptoms is revealed.

I may point out that it is not only clinical observers that go astray in these matters. We find in physiological text books continuous reference to certain visceral nerves as "sensory" nerves. I once asked an eminent physiologist what proof he had that these nerves were sensory in function. "Oh," he replied, "they are afferent nerves." "Admitting they are afferent, what proof have you that their function is to convey sensation?" He pondered for a short time, and looked up surprised and said, "I have no proof." It is a very curious fact that one physiologist has followed another and described the sympathetic nerves that pass from the viscera to the spinal cord as sensory in function, while there has not been a single fact recorded to support the assertion. When this matter is strictly enquired into it will be found that the manner in which sensations are produced by the viscera is by a totally different method from that employed in producing cutaneous sensation.

The necessity for accurate observation will help the general practitioner to determine the real cause of many obscure symp-

toms, but even before it does that it will be of great practical use in giving symptoms their real prognostic value. To know what course a disease will pursue is more than forearming against danger—in medicine, it is knowing when to expect danger. So little accurate work has been done in this field that we are ignorant of the meaning of some of the most common symptoms. I have already referred to the fact that our 20th century scientist is fundamentally the same as our superstitious ancestor, and nowhere is this more evident than when dealing with obscure phenomena. A comet, or any other strange manifestation of nature, was a portent of evil. Nowadays an obscure symptom is looked upon with dread. Let any one read our standard text books on irregular hearts, and he will note the timorous and fearsome way the subject is dealt with. Vague hints of sudden dangers are always more alarming than the realization of the actual nature of the danger. Our authorities, instead of stating that they know nothing about the cause and consequences of irregular hearts, throw out mysterious hints of impending disaster, the result being that the trusting general practitioner and his trusting patient are thrown into a state of the greatest distress on account of a danger whose gravity is aggravated by the fact that its nature is unknown.

In practice one is constantly meeting with patients whose lives are rendered miserable by the fear that some grave peril threatens them, and burdensome in the endeavor to avoid the hidden peril; while all the time the symptom that has given rise to all this trouble may be a perfectly natural phenomenon or one which is associated with no danger. The meaning of these symptoms can only be found out by patiently watching the life history of the individual who shows them, and that can only be done properly by the family physician. There is a man whom I occasionally meet in the streets of Burnley, and my uneasy conscience makes me fancy that a sardonic grin passes over his face when our eyes chance to meet. Twenty-five years ago, when I thought I knew more about the heart than I do to-day, I rejected him for life insurance because of a loud systolic mitral murmur. From that day to this he has followed his work as a mechanic without a day's illness.

I think it must be apparent to every one who seriously considers this matter, that the question of treatment is one that needs an enormous amount of research. We speak of the principles of treatment, but as a rule the lines upon which treatment is carried out cannot be called principles. They are in the majority of cases empirical—because a certain line of treatment has been successful in other cases, so it is worthy of trial in this particular case, forms the usual basis of treatment. There is a sort of quasi-scientific method very prevalent which appeals to many minds. Thus one man says certain forms of heart failure are due to arterial sclerosis which is caused by the deposit of lime in the the coronary arteries, therefore exclude all lime from diet and treatment. Another man says as lime is necessary for the due action of the heart, so in heart failure give lime. Or, take again what is called intestinal antisepsis. The surgeon, to render a piece of skin aseptic, rubs, scours and soaks it for hours with a strong antiseptic lotion. If there is an ulcer present he knows it is useless trying to render it aseptic. But in typhoid fever there may be a yard of ulcerated intestine, and we are instructed to render this aseptic by administering occasional drops of carbolic acid. These are not the babblings of ignorant general practitioners but are the serious reasonings and solemn conclusions of eminent therapeutic pundits. On matters external to the human body these pundits are sane and reasonable. Immediately they come to deal with something hidden from view, they lose all sense of proportion and deal with medicine as if it were a branch of speculative theology where faith and not reason is the essential principle.

Another curious point I have observed in some who pose as authorities is the standard they employ to guide them in their treatment. Many people imagine that they are the last effort of perfected creation, and this being so they look upon themselves as the model or standard from which they view their patients. As a general practitioner it has been my privilege to have had consultations with some of our most eminent colleagues. In prescribing, I have sometimes expressed surprise at the exclusion of some simple food from the diet or the objection to some simple remedy. "My dear fellow," exclaims the consultant, "if I take

that article of food, the next day I suffer tortures. On no account let patients have these things." I remember many years ago a man who has since become an eminent scientist, who had very plain features, and who walked with a slouching gait, telling me in a burst of confidence that his figure corresponded in every detail with that of the Apollo Belvidere. I was once called into a household where I found the family in a state of seething revolt. The father of the family had become a vegetarian, and had become convinced that the essence of good living consisted in restricting himself to one special brand of cereal food, and had given forth the command that the whole household must live upon this mawkish and unappetizing meal. I found him one of those self-righteous people who take a crooked view of life, and who are not only a law unto themselves but unto all over whom they have authority. As he told me the reason of the family discontent he talked of uric acid, and took the opportunity of impressing upon me the virtues of the unappetizing meal in question, and of how he had been a dyspeptic sufferer for thirty years and that this was the food that agreed with him, and consequently, he being a perfect man, the whole household must needs feed upon it. I examined him and found an enormously dilated stomach, and when I shook him he splashed like a half-filled beer barrel, and with a loudness that startled him. From the history there was evidently pyloric stenosis, and I had much satisfaction in pointing out that he was subjecting the healthy appetites of young men and women to the caprices of a man with a morbid stomach and a morbid imagination. Although this particular individual found that his particular diet afforded him, by and by, no relief, and that ultimately he had to submit to gastro-enterostomy, which has practically cured him, yet he clings to his morbid views and attributes his recovery to his latest dietic fad. But you all know this kind of man.

In making observations on treatment we should keep our minds clear in regard to the influences at work in promoting recovery. The majority of our patients get well, and many doctors attribute their recovery to the drugs they prescribe. The chief factor is often overlooked, viz., the Vis medicatrix naturæ. The natural power of recovery is often so great that all that is needed

is but to remove any unfavorable conditions. If this were recognized, much vaunting of different therapeutic methods would be uncalled for, and these methods employed would be estimated at their real value. Let me, for illustration, refer to some features in the treatments of heart affections. The majority of heart failures are simply due to the fact that the heart muscle has for a long time been working against difficulties that, in the long run, it has not been able to overcome; hence exhaustion sets in, and exhaustion of the heart muscle is the real and true meaning of heart failure, whether there be valvular defect or muscle degeneration. The essential step in treating heart failure is at once to ease the load, and if this be done and the heart given time to recover from exhaustion, sufficient energy is stored up in the muscle so that we get what is called restored compensation. When cases at the same time have drugs administered to them, baths and various movements employed, the essential factor in the cure is too often lost sight of and the recovery attributed to some adventitious method. In many heart patients there is a neurotic element which aggravates the cardiac condition, and it is often quite enough to attain recovery by treating the nervous excitability. When patients are treated by the Nauheim methods, for instance, the elaborate ceremonies that are used and the solemnity with which the ritual is carried out is so impressive that the patients and doctors alike imagine that there is some curative principle in the baths and methods. As a matter of fact, the whole system admirably provides bodily rest and mental complacency, and so far does good. But there is nothing specific in the system. During a week spent in Nauheim I did not see a single patient get any more benefit by all the elaborate methods than he would have done had he been treated at home by a sensible general practitioner.. The manner in which this so-called system of cure has imposed upon the credulity of the medical public is to me a most depressing sign of the want of sober reasoning and judgment in our profession. To a certain extent it may be due to that humility of mind which takes other people at their own valuation. The general belief in the potency of Nauheim methods is but a further illustration of what I have been contending—the absence of the faculty for making accurate observation.

In making these desultory remarks I feel I have not expressed my meaning as convincingly as I would have liked. Still I think, if you will yourselves reflect upon my contention, you will be able from your own experience to supplement what I have said. I have not gone into detail in describing any method or line of investigation. I find by experience that it is better for a man to find for himself what line of inquiry he should pursue. What I am most anxious for is that every practitioner should be an investigator, and in trying each one will find sufficient scope in pursuing his daily routine.

DISPLACEMENT OF THE UTERUS.

(Paper read before the Northern Alberta Medical Association, June 6th, 1907.)

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My justification for bringing before this Association a subject so hackneyed as that of Uterine Displacements is that it is one of every -day importance. There has been in the past much difference of opinion in connection with the subject, for whereas the family practitioner (speaking generally, of course) was inclined to attach too little clinical importance to displacements and attribute the symptoms to hysteria or what not, on the other hand the specialist had an altogether exaggerated idea of the importance of malposition *per se*.

Twenty-five or thirty years ago, if a woman's uterus were not in what the gynecologist thought a normal position, it was held responsible for all her trouble; and there is no doubt many patients were needlessly tinkered for uterine displacements when the real cause for their symptoms was something entirely outside the malposition. It is a fact that some of the so-called displacements may exist in healthy women without symptoms, and on the other hand similar conditions in other individuals are the direct cause of much suffering and invalidism. In fact, these cases must be approached clinically with an open mind and a clear understanding that displacements do not always cause symptoms—that some of them are normal or quasi-normal; while not losing sight of the fact that what is apparently normal in one woman may be pathological in another.

Having during a period of over twenty years had unusual opportunities of studying these conditions, both from the point of view of the family practitioner and the gynecologist in all classes of patients, from the fashionable society woman to the humblest

class of outpatient, it occurred to me that a summary of my views might prove of some interest, even though I allude to no fact which is novel or unfamiliar.

Displacements of the uterus are classified in the text books as Anteversion and Anteflexion, the backward Retroversion and Retroflexion, and the downwards Prolapse and Procidentia. The difference between a Version and a Flexion being that in the former the long axis of the organ is unchanged, while in the latter it is more or less bent upon itself. Now the normal position of the healthy parous uterus is one of anteversion. Anteversion is not a displacement at all. The normal position of the healthy nulliparous uterus is one of anteflexion. Anteflexion cannot be considered pathological unless it be exaggerated, and even then it is a malformation rather than a displacement. A pathological antiflexion is the result of imperfect development, and there are two varieties—one in which the "body" is in normal position and the cervix bent, the other in which the cervix is in normal position while the body is bent. This condition is the commonest cause of dysmenorrhœa and sterility, and these features are frequently associated with reflex nervous symptoms, especially bladder troubles.

But one must not assume without investigation that when a virgin complains of dysmenorrhœa and bladder trouble that nothing is present but antiflexion. I met with an instructive case on this point some years ago. An unmarried girl, well formed, robust and not inclined to hysteria, had considerable trouble from occasional retention of urine. She suffered from dysmenorrhœa, and it was naturally enough supposed that the whole thing was due to antiflexion. The condition became worse, and on two occasions caused great inconvenience by coming on while travelling, so that the patient had to break her journey for the purpose of obtaining medical relief.

On examination under anæsthesia, the cause of the trouble was found to be a tumour the size of a large orange, low in the pelvis a little to one side. It proved to be a dermoid.

An anteflexed uterus may become retroverted without change in the flexion and without change in the symptoms except that if it persist the symptoms of prolapse will be added.

In the treatment of anteflexion, pessaries are absolutely useless, and treatment by drugs is never more than palliative and is often harmful.

A large proportion of cases can be cured by a single thorough dilatation of the cervical canal with graduated sounds—sometimes the operation will have to be repeated once or twice, but not as a rule. Other cases will require, in addition, a division of one or both sides of the cervix. Surgical interference is indicated in unmarried women only when the dysmenorrhœa is severe, in which cases it is certainly less objectionable than treatment by drugs. The relief obtained from the use of alcohol or morphia in dysmenorrhœa is the foundation of many a case of chronic inebriety.

Retroversion is often physiological. It may alternate in the same individual with anteversion. Of itself it is of no clinical importance. When symptoms are present the organ will be found prolapsed, the version being the first step in prolapsus.

Retroflexion is sometimes congenital and apparently normal. It may cause dysmenorrhœa just as anteflexion does, by interfering with the circulation in the uterine mucosa, or it may cause no symptoms and exercise no adverse influence on fecundity. When retroflexion is pathological it very soon becomes retroverted as well. The symptoms are those of pelvic congestion and pressure. The degree of congestion and the severity of the symptoms depends to a large extent on the form and consistence of the utero-sacral ligaments. These folds of peritoneum form the lateral boundary of Douglas's pouch and stretch between the uterus and the sacrum. They vary in different individuals in shape and tension. Sometimes they are curved with rounded edges and a good space between; sometimes they are narrow, sharp and straight, and closer together.

When the utero-sacral folds are sharp and tense naturally, or have become so from inflammation should the body of the uterus fall between them, the veins in the broad ligaments become constricted by pressure, leading to engorgement of the body of the uterus and also to congestion of the uterine appendages. A retroflexed and retroverted uterus is always prolapsed. In fact, it

might be more correct to designate the condition as prolapse aggravated by retroflexion.

Prolapse is of varying degrees, from a slight dependence lower in the pelvis than normal to a complete procidentia in which the uterus is outside the vulva. A certain amount of descent is physiological, and occurs during respiration. The conditions tending to produce prolapse are:

1. Increase in intra-abdominal pressure, whether continuous, as in the case of tumors or ascites, or transient, as in violent muscular effort, straining or chronic cough.

2. Relaxation of the floor of the pelvis, especially the pelvic fascia and the Levator Ani muscle. Schatz, in 1884, and Skene, in 1885, described independently a condition of submucous laceration of portions of the Levator Ani in parturition. Both observers described gaps or spaces in the muscle fibres felt through the vagina. So far as I am aware, no one has demonstrated this fact by dissection. Personally, although I have examined hundreds of cases of relaxatic I have never succeeded in feeling the gaps so described.

3. Laxity of the vaginal walls by general weakness or from too frequent parturition and ruptured perinæum.

4. Relaxation of the broad ligaments.

5. Congenital anatomical peculiarities, the only explanation of cases of procidentia occurring in healthy virgins with no history of laborious work.

These cases are considered a kind of hernia.

The uterus, in its descent, follows the curve of the axis of the pelvis exactly like the foetal skull in normal parturition, and each step in the descent, by increasing the bulk of the organ from congestion and causing a further weakening of the already relaxed tissues, favors the occurrence of the succeeding step.

Prolapse or procidentia may be simulated by hypertrophic elongation of the cervix, and this condition, by the additional dragging weight, may be a factor in the production of true prolapse. The hypertrophy may be confined to one lip, usually the anterior, but more commonly the enlargement occurs in both lips simultaneously. The causes of the condition are not understood. It appears to be a true hypertrophy, but when a pro-

lapsed and elongated uterus becomes truly extruded, the organ tends to return to its normal length.

With regard to treatment:—

Pessaries are not so much used now as formerly, because there are many good and safe operations in vogue for the radical cure of these conditions. But patients sometimes refuse operations or there may be reasons contra-indicating operation, and it is satisfactory to realize that many cases can be entirely cured by the judicious use of pessaries. Given a freely mobile uterus with no external complications—"external" being used as in relation to the uterus—a fair amount of tone in the vaginal walls and a perineum that is not deficient, a good result may be anticipated. The principle underlying treatment by pessaries is to afford mechanical support to the uterus until such time as the relaxed ligaments and pelvic floor recover their tone.

To insure success in any but the slightest forms of displacement the treatment must commence with absolute rest in bed for ten or twelve days, while means are taken to relieve pelvic congestion. Saline aperients, copious douching with water at 112° Fahr., and the continuous use of the glycerine tampon. This tampon, to be efficient, must be of large size and thoroughly saturated with glycerine. Left in situ for twenty-four hours it depletes the parts by causing a profuse watery discharge. It is introduced daily after douching. The next step consists in restoring the uterus to its normal position. This is best done by the uterine sound. Properly performed, with due precautions, reposition by this means is absolutely safe and is much less painful than the bimanual method. The end of the sound should not be curved but bent at an obtuse angle to the shaft. After it has been passed with the point backwards the organ is straightened and anteverted by making a turn of the handle through a wide circle. Mere rotation of the instrument on its axis only causes a twist of the uterus. A moderate amount of fixation by adhesion is no bar to successful treatment, for it will be found that by careful daily manipulation the adhesion can be gradually stretched, only, of course, the treatment will be more prolonged.

Having reduced the displaced uterus, it only remains to ad-

just a well fitting pessary. The Hodge pessary, or some modification of it, is the only one to be tolerated. The Butterfly pessary of Zwancke, the Ring pessary, the Cradle, the Cup, and the Stem, and all the rest of the abominable implements, are worse than useless. Vulcanite is the best material, but as the shape cannot be altered easily it is necessary to keep a somewhat larger variety than is the case with block tin or Britannia metal.

Prolapse, it is true, can be treated by the Cup and Stem pessary, but there are inconveniences in the use of it, and when made of soft rubber, as in the Napier pessary, the only kind a patient is likely to find really tolerable, it causes an objectionable vaginal discharge, and I have seen one case of epithelioma of the vagina caused by irritation of the edge of the cup of a Napier pessary. I prefer Albert Smith's modification of the Hodge pessary, which is applicable to any case which can be treated by mechanical means; in fact, I may say my rule is, the Smith-Hodge pessary or none. The beneficial action of a pessary is obtained not by a support which is jammed between the pubis and the uterus, but by one which floats free in the vagina and exerts during respiration a gentle leverage, supporting the organ and keeping it well forward by the pull exerted on the back of the cervix at its juncture with the body.

The instrument must be exactly fitted to the length and curve of the vagina, and when properly adjusted it causes no inconvenience and the patient should be unconscious of its presence.

When there is a tender prolapsed ovary complicating matters the ordinary rigid pessary cannot be tolerated. The modification of Hodge's pessary having a cushion or pad of glycerine, answers admirably and saves time, but it should be exchanged for the regular pessary as soon as possible. Being of soft rubber, it soon sets up irritation and causes an objectionable discharge.

A pessary should be retained for at least one year. When pregnancy occurs the instrument can be quite safely left in situ till the end of the fourth month, after which it will not be needed. It should be reintroduced after parturition before the patient leaves her bed. When the uterus is adherent and the adhesions will not yield to gentle traction, depletory measures should be continued, and should pregnancy occur, as it does sometimes, the

adhesions will gradually soften and the gestation may go on to full term.

I had one case of the kind in private practice where operation was declined, and it was remarkable the way everything cleared up with the progress of pregnancy.

In the case of a firmly adherent uterus, of course a pessary would be harmful—in fact, no good can be expected in any case without first getting the displaced organ into a good position. In the case of a flexion, it is quite possible to antevert the organ without reducing the flexion, and care is required to avoid doing this. Cases with a lax vaginal outlet, a deficient perineum, a cystocele, and, perhaps, a rectocele, will require surgical measures before a pessary can do any good.

Repair of Perineum, Anterior Colporrhaphy, and Perhaps Perhaps Posterior Colporrhaphy as Well

In connection with Perineorrhaphy, I may be allowed to refer in passing to two important points:

1st. The female perineum is not a flat surface but a pyramidal body whose base extends from anus to fourchette, and whose apex is situate in the recto-vaginal septum one and a half inches from the base.

2nd. A rupture of the perineum always occurs anterio-posteriorly, while cicatrization when the injury is left to head spontaneously always takes place transversely.

No method of repair which fails to regard these two points can be surgically sound. In hypertrophic elongation of the cervix amputation is often necessary, and the operation is, in my judgment, best done with the knife. The ecraseur is liable to cause constriction of the cervical canal, and if the incisions with the knife be made V-shaped, one lip at a time being dealt with, hemorrhage is readily controlled by uniting the cervical mucous membrane to the outer edges of the incisions. In complete procidentia the most rational treatment in many cases is total extirpation by vaginal hysterectomy. The operation is easy, and in competent hands should involve little risk to life—probably less than the risk of parturition; but as the main pathological feature

is not so much procidentia uteri as descent of the pelvic floor, it will be necessary to take steps to narrow the vaginal outlet after removal of the uterus, otherwise the vagina will come down as before.

In other cases of complete prolapse, or in lesser degrees where mechanical treatment is unsuitable, or where an operation is indicated as the best treatment, some one of several procedures, having as their aim the maintenance of the uterus in a position of anteversion or supporting the fundus, or both, will have to be selected. There is no one operation which is applicable to all cases.

Alexander's operation of shortening the round ligaments fulfils the indication of maintaining the uterus in a position of anteversion, and it is applicable to prolapse with or without retroflexion, provided there be no cystocele, or provided the cystocele has been previously dealt with and there be no pelvic adhesions. Further prolapse is then rendered impossible.

This operation, introduced some thirty-five years ago, did not become very popular with British gynecologists, but it has been largely practised on the continent of Europe and in America. In recent years it appears to be coming more into favor in Great Britain, and with improved methods is likely to be established a firm footing. I have made use of this operation in a number of cases, a series of which I published in 1889. The operation consists in exposing and opening the inguinal canal on each side, finding and isolating the round ligaments, drawing them out for two inches or so and fixing the shortened ligaments to the pillars of the ring and closing the canals as in a simple herniotomy.

It is a sound operation, giving a permanent result, and there should be no mortality.. The disadvantages are:—

1. Its difficulty. It is never easy to find the round ligaments, and sometimes a prolonged search with much handling of the parts is necessary. Personally I have always been fortunate enough to find them, but many cases have been reported where good and experienced operators have failed to do so.

2. The handling of the parts in isolating the ligaments militates against a first intention result, and should one fail to secure

immediate union much subsequent suppuration and distress will follow.

3. The inguinal canal may be weakened and predispose to hernia. One of my cases developed hernia two years after operation.

Vaginal Fixation.—This operation is largely practised by modern gynecologists, and is growing in popularity. Its results are excellent, it is not difficult and should be safe. It has the advantage over ventro-fixation in not weakening the abdominal wall.

There are two methods, one without opening the peritoneum, which should be regarded as a risky and dangerous procedure. The other consists in incising longitudinally the anterior vaginal wall at its reflection on the cervix, stripping the bladder forwards, opening the peritoneal cavity, guiding a needle carrying stout silk ligatures through the anterior uterine wall, transfixing the incised vaginal wall, rethreading the needle and tying the sutures in the vagina. Cases have been reported where difficult labors have followed the operation.

Ventrofixation.—In one of my first cases I had an opportunity of seeing the result a year and a half after the operation.

The patient was a young widow who had an adherent retroflexed uterus, together with a hydrosalpinx on the left side. She was about to be married, and desired to be left capable of bearing children if possible. The fundus was separated from its bed of adhesion and the left tube, much distended with the ovary, which was a mere shell, removed. The fundus was fixed to the lower angle of the wound by two transfixing sutures of silk, which were removed on the eighth day. The right appendages, apparently healthy, were left alone.

Now it is a pretty well established maxim in gynecology that where one tube is sufficiently diseased to require extirpation, the other, even if apparently healthy, is already infected and should be removed as well. This was well illustrated in that case, for about eighteen months afterwards, no pregnancy having occurred, she got back a lot of her old symptoms and the right tube was found distended. The abdomen was opened through the right rectus and I found the uterus suspended by a thin,

fibrous band about two inches long. It is easy to conceive that this band would eventually be entirely absorbed, or at any rate that it would cease to afford any support, and whilst it existed it was a source of danger from possible strangulation of intestine. This observation led me to adopt a modified method which I have since followed and have found satisfactory. It consists in fixing the fundus to the peritoneum and aponeurosis by two buried sutures of silkworm gut, and also sewing the parietal peritoneum to the previously scarified visceral peritoneum of the fundus. By this means a broad surface of adhesion is secured, and the buried sutures insure a permanent hold and remain indefinitely. Immediate union is essential, for if the buried sutures become septic they will eventually cut out and cause a sinus and give a lot of trouble.

Another method which is largely employed consists in fixing the body, not the fundus, to the lower angle of the wound. As in vaginal fixation, cases of difficult labor following it have been reported.

Dr. Hermann, of the London Hospital, sews the fundus to the inner surface of the recti muscles, pulling it out of the peritoneal cavity. He claims that the union of peritoneum to muscle is more permanent than the union of peritoneum to peritoneum.

Recently I had the opportunity of witnessing another method by Dr. Jones, of Victoria. He opened the abdomen in the middle line and transfixed each round ligament an inch and a half from its uterine origin. Then, dissecting back the skin and fat to the outer edge of each rectus, a small opening was made through the aponeurosis and peritoneum, through which a knuckle of round ligament was withdrawn by means of the transfixing sutures. The ligaments were then permanently fastened to the aponeurosis by a ring of sutures of kangaroo tendon, and the transfixing sutures removed. This method strikes me as particularly sound and good. It is conceivable, however, that there may be risk from internal strangulation of intestine. When the fundus is adherent in the pelvis the greatest care is necessary in separating the adhesions. In old cases it is a difficult procedure, and the extreme Trendelenburg posture and a good light are essential. As much as possible of any raw surface left on the

uterus should be brought into apposition with the parietal peritoneum.

There is one displacement—inversion—to which I have not alluded because I have never seen a case either in hospital or private practice, and I desired, as far as possible, to confine my remarks in this communication to matters within my own personal experience. Recently reported cases go to show that when an inverted uterus cannot be reduced by taxis, the best procedure is to open the abdomen and split both folds of the posterior uterine wall as far as may be necessary to allow of reduction. Subsequently the wound is closed by suturing, or the uterus removed by hysterectomy, according as it is healthy or not.

The plan formerly advocated of amputating the inverted organ by eraseur should be discarded as unsurgical, because it is not possible to know what may or may not be contained in the inverted cup.

Reference to displacements complicated by tumors, either in the walls or cavity of the uterus or in other organs, or to cases complicated by pelvic inflammation, has been avoided as being beyond the scope of the subject of this paper. In all such cases the displacement is entirely secondary in clinical importance.

In conclusion, to sum up in a few words the treatment of uterine displacements resolves itself into the means, mechanical or surgical, which are employed for the relief of prolapse either with or without retroflexion.

Dr. H. C. Wilson remarked that the paper opened up a wide field for discussion, which was doubtless the intention. For his part he did not coincide with the condemnation of drugs in the treatment of diseases of women.

Dr. Duncan Smith referred to a case of difficult labor after a ventrofixation in which he performed Cæsareon section. He found the anterior wall of the uterus firmly adherent to the belly wall over a surface of 4x2 inches.

Dr. Harwood thought that as it was necessary to wear a pessary for a year with prospect of cure, the simple fixation of the uterus by peritoneal adhesion was probably the most rational treatment. He also remarked that the genupectoral posture

was, in his opinion, a better method of reducing a retroflexion than by means of the sound.

Dr. Ella Synge asked Dr. Cobbett what he thought of the operation of colporrhaphy, stating that she had performed the operation with success.

Dr. Park thought that after the menopause a pessary would be little likely to succeed. He agreed with Dr. Harwood's remarks on the genupectoral position.

Dr. Sloane related a case in which four members of the same family suffered from retroversion of a pronounced type.

Dr. Dunn asked what Dr. Cobbett's views were on the method of gradual tamponage. He asked why, if as stated, pregnancy had the effect of softening down adhesions and restoring the parts, it was considered necessary to reintroduce a pessary after parturition?

Dr. Ferris regretted that he had not heard the paper, but asked what, if any, means had been recommended by way of prophylaxis.

In reply, Dr. Cobbett said that he did not intend a wholesale condemnation of drugs in the treatment of diseases of women. What he intended to convey was that, in a case of severe dysmenorrhœa in a young girl, requiring strong narcotics to relieve, he considered an operation less objectionable.

He was much interested in Dr. Duncan Smith's case, which he thought tended to confirm an idea which had been taking root in his own mind, viz., that fixation of the anterior wall of the uterus, whether by vaginal fixation or ventrofixation, was more passing from the origin of one Fallopian tube to the other. He did not consider that these permanent sutures would have any ill effect on gestation or parturition. He regarded colporrhaphy as a most useful means of narrowing a lax vagina and remedying a cystocele or rectocele.

He did not endorse Dr. Park's remarks about pessaries after the menopause, but considered that the senile changes in the parts, the narrowing of the vagina with general atrophy of the uterus, would be rather in favor of successful treatment by pessaries than otherwise.

Dr. Sloane's experience pointed to a hereditary predisposition, perhaps some anatomical peculiarity. He had no experience of gradual tamponage, and with regard to introducing a pessary after labor, that was a precaution analogous to applying a light truss after a herniotomy.

He fully approved of the genupectoral posture both as an aid to treatment and as a means of reposition, but for his part he preferred to use the sound. In spite of all that had been said and written against it, he considered that with due aseptic precautions and in careful hands the method was absolutely safe, and was much less painful than the bimanual method, whether aided or not by the genupectoral position.

With regard to the time required for successful treatment by pessaries, he had stated "at least one year," but four or five was nearer the mark in most cases. He thought that the method of ventrofixation, which aimed at a permanent result, fulfilled the indication for treatment better than one which lasted only temporarily.

He thought that the best prophylaxis was care and sufficiently long rest during the puerperium. For his part he firmly believed in the old-fashioned rule of three weeks in the recumbent posture.

CLINICAL MEMORANDA

Ectopic Gestation

Case I. Mrs. B., age 38; married eight years ;no children; two miscarriages, last six years ago. Came under my care Nov. 19th, 1906. She complained of pain in the right side and of a swelling in this location. On examination I found a large ovoid swelling extending from just below the costal margin in line with the anterior fold of the axilla to the right iliac fossa, and laterally from the median line to the interval between the 12th rib and the crest of the ilium. There was considerable tenderness and dullness over mass. T. 98 1-5°F., P. 88, R. 20. Breasts normal; no sign of augmentation. A vaginal examination showed mass distinct from the uterus, which was deflected to left.

The patient lied in giving a history of the case. She said she had not been living with her husband for five years, and that it was impossible that she could be pregnant; that there had been no enlargement of the breasts, and no vomiting; and that she had menstruated every month as usual. About three months before coming to Calgary she felt some pain in the right inguinal region, and noticed a slight swelling at this point. As the pain continued and the swelling increased, she applied plasters of various kinds and painted the side with iodine. About three weeks before coming to Calgary, she said, she had a severe attack of pain, after which the swelling increased rapidly, and fearing something was seriously wrong decided to come to Calgary for attendance.

The history pointed to a diagnosis of ectopic gestation with a rupture of the tube three weeks previous to her admission to the hospital, but her positive statement that she had not had coitus for five years made this diagnosis impossible. The possibility of it being an ovarian tumour could not be excluded, as it was impossible to palpate the ovary. A positive diagnosis was not given, but an exploratory laparotomy advised, to which the patient consented.

Operation.—An oblique incision about four inches in length was made about one inch internal to the summit of the mass. On opening the peritoneum the omentum, enormously congested, was found adherent to the abdominal wall, and to a mass made up of coils of small intestines which were also adherent together, so as to completely wall this region from the remainder of the abdomen. Adherent to the intestines on the inner side to the omentum above and the lateral wall of the abdomen on the right side, was a firm mass which could be traced from the liver to the right tube. This was found to be ruptured, and there were large, firm clots of blood in the pelvis. The tube and the ovarian artery were tied with a heavy silk ligature. Considerable difficulty was experienced in dissection out the mass on account of the congested condition of the omentum, so that it was necessary to tie it off piece by piece before cutting it, leaving the tied end free and the cut end adherent to the mass. The adherent intestines were then separated, and as they, too, were greatly congested, there was considerable oozing of blood. The upper extremity of the mass was found to be adherent to the under surface of the liver. This was broken down and the mass separated from the lateral wall of the abdomen. Then the Fallopian tube was severed and the entire mass removed. The site was swabbed with hot cloths and the oozing checked as much as possible, and the whole packed with gauze. The different layers were sutured separately and a drainage tube inserted.

The patient made an uninterrupted recovery, but there was a discharge from the drainage tube for about five weeks, when it ceased and the patient went home perfectly well.

Case II. Mrs. H. A. S.; age 4; married two years; no children; one miscarriage, one and a half years ago. Came under my care May 1st, 1906. Patient thought she was pregnant, as the breasts were enlarging considerably and she was getting very "fat," especially about the abdomen. Had not menstruated for one month. Suffered from morning sickness and frequent desire for micturition. Had no pain in pelvic region.

Examination showed breasts much enlarged, line of pigmentation from umbilicus to pubes; an excessive amount of fat over abdomen. External genitalia slightly swollen and discolored;

uterus slightly enlarged and tender. No tenderness or enlargement of either tubes could be made out.

A diagnosis of probable pregnancy was made. On June 4th, 1906, I again saw the patient. In the interval there had been an enormous amount of adipose tissue formed. The breasts were very large and pendulous, and the abdomen in the erect posture was protuberant. On lying down, however, this disappeared and the abdomen was flat. Uterus not palpable through abdominal wall. Bimanual not made. No pelvic pain. Patient said she "came unwell" May 25th. Flow lasted one day, very scanty and said it was "light colored." Vomiting only occasionally. Temperature 98 2-5°F; pulse 72.

On July 10th again saw patient. Breasts still enlarging; no vomiting, no pain in pelvic region; uterus not palpable through abdominal wall, and on bimanual examination appeared only slightly larger than in May. In the left tube there was a small enlargement about the size of an English walnut. It was hard, firm and not painful on pressure. Temperature and pulse normal. Patient said she had again menstruated on June 21st for one day only.

Did not see patient again until Sept. 5th, when an examination showed everything to be about the same is at the last examination except that the swelling in the left tube had slightly increased in size and was tender on palpation. Had menstruated every 28 days. Temperature and pulse normal.

Sent patient to Holy Cross Hospital on Sept. 10th and had a consultation the following day and operative interference advised. Explored uterus, which was empty and only slightly enlarged.

On Sept. 20th made an exploratory median incision. Omentum and small intestines found adherent to left tube, about the centre of which and apparently within it was a small hard mass about as large as an egg. An effort was made to remove the entire mass, but on account of the adhesions and the fact that pus was found made it impossible. A counter opening was made through the vagina, and the pus with fragments of bone in it was drained away. The cavity was then scraped and packed with gauze. The abdominal opening into the tube was then sutured and the abdomen closed with drainage. A sinus persisted in this case, and for several months the patient refused to have it explored. Finally this was done and the whole tract cleaned out. The patient made a rapid recovery.

E. G. MASON.

WESTERN CANADA MEDICAL JOURNAL

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EDITORIAL

Medical Fees

At the recent meeting at Prince Albert of the Saskatchewan Medical Society, it was gratifying to see one of the questions well discussed was the vital one of fees for medical services. A committee was formed to go into the matter. The fee for insurance and fraternal society examinations was fixed at $5 for full examination and $3 for examination without urinalysis. This is certainly a question of common interest, and the advantage here of co-operation can be easily seen. For what is the good of societies passing resolutions unless the individual members carry them out to the letter! A proposal was made that a tariff be decided on and each member have one framed and hung up in his consulting room. The patient would then see that the Medical Council had decided it,

and that the practitioner was charging the just amount. Bothering remarks regarding what another man would charge would thus be prevented. The general opinion of the meeting seemed to be that the time had come to charge *higher fees*. We are told that the physician who attended Louis XV. of France for some fever received as payment an estate with a number of villages and 207 farms. Those were apparently good old days in some respects! The medical laborer is still worthy of his hire. Five dollars is not too much to charge for an insurance examination, especially when one compares the fees of the medical advisory board and their labors. One point in support of raising the fees is that of late years the cost of living in the West has gone up by leaps and bounds, and the cost of labor in proportion. Even teachers' salaries, which are said to be always last to move, have increased—but the medical fees have remained *stationary*. The cost of living in Winnipeg is as high as Johannesburg nearly. There the general practitioner gets $2.50 for his lowest office fee. It is said that the man who depends on fees for a living works harder than the one who is paid a wage or salary. Certainly the wage-earner has not the anxiety regarding the certainty that he will get his money that the man of fees experiences. Neither does he have to wait so long. There is, unfortunately, a class of individual who considers it the duty of the doctor to be a philanthropist, irrespective of the question as to whether he depends entirely on his medical work for a living or not. Truly to such the following applies:

"Three faces hath the doctor: when we're ill
He seems an angel; when he's cured the evil
God's self we deem him; when the little bill
Comes in after, he's the very d——!"

To have the tariff of fees hung up in one's office would be greatly appreciated by the man who hates to ask for it. Often, too, one is handicapped through lack of a definite scale; also the majority of patients would doubtless prefer to know exactly what was expected, without any questions. Regarding cash or credit, the doctor would have to use his discretion, as others have to do. It is not to be doubted that people value what they pay a *ju* price for. In this discussion we are not thinking of deserving

indigent cases. We all would give our help to such. But the others, if they get medical advice either free or at a reduced rate, simply do not value it, and as often as not fail to carry out directions given for that reason, going finally to a man who is known to insist on his fees—and good ones.

We spend about $5,000 on our medical education before we are entitled to practise, give five or six good years of our life to the study to qualify us, have to buy expensive books and instruments, and even after all this, to keep pace with the advance of science, must go periodically to the centres of medical education and continually be expending money. Surely a return in proportion is rightly expected! There is no question that as a class, in spite of all this, physicians are underpaid all over the world, and they are kicking. Of course we can be told of some eminent men everywhere who receive immense fees. If true, what are their incomes compared to those of eminent business men who have been able to earn money from boyhood probably. One would like very much to know, when one hears of a wealthy medical man, just how much came from his life work and how much from other sources. How many in the West are even moderately rich from practice alone? We hear of how wealthy Dr. So-and-So is, but on enquiry one hears he has made various lucky real estate deals, etc. Yet to the really hard-working family doctor, how much time is there left for studying the real estate market or any other?

We hear that fees, instead of rising with other things, have *really lowered*—if not here, they have in some countries, and from the same cause which will ultimately lower ours if not looked to. The cause is *club practice*. Medical men in Germany have been nearly ruined by their medical clubs. Clubs of 1,000 to 2,000 men, with two to three doctors! These posts were made for certain doctors, who through them got the wives and families of the men at proper fees. Forty patients in two hours; ten to fifteen visits! The quality of the work done need not be discussed! Think how the public health is preserved in this manner! The doctors kicked; but for every post, because of lack of *co-operation*, there were scores of applications. Result in the end—the lowering of the pay of the club doctor. The evil in

such a case is not only *lowering of pay*, but the *social status* and influence of the medical profession by this wholesale doctoring. The members of the club look down on scamped work in medicine as in other matters, and consequently a profession that permits it loses the public respect. This evil spreads verp rapidly. It spread in Vienna till, in 1905, out of 1,600,000, there were 500,000 members of clubs. And so in many older countries; so that now the relationship between the benefit societies and physicians can hardly be termed harmonious. There is now a movement on all sides to try and redress the evil. In Vienna the doctors have succeeded in getting their Medical Council at last to look into their financial position and do what they can to improve it, and the High Court of Justice there has decided that a doctor's fees are due the moment he ceases to attend and that the credit system in force is not justifiable. Also, where fees have to be recovered in a law court, five per cent. interest is to be charged. Uniform public notices have been put in the public press giving reason for this, and so far little objection has been raised.

In these older countries the evil was allowed to grow before the profession realized what it meant to its members. Their experience can be a useful lesson to this young country. We have the chance to nip it in the bud before it overwhelms us. That it is with us is evidenced by the various societies taking the matter up. We have another advantage in Canada. The members of such clubs are not, as is often the case in the older countries, composed of ignorant, uneducated people who could not understand the harm to the public, as well as the physicians, of such a condition of affairs. Here in Canada it would be quite easy to place this before them so that they themselves would not desire it as at present carried on.

To return to the question of the tariff of fees, perhaps it is well to look for a moment to charges elsewhere. Let us take Berlin, one of the cheapest towns in Europe as to cost of living, with many advantages for the professional man with a family. There they have arranged a tariff. The lowest charge for medical advice is given as 3 marks—about 75 cents.

The College of Physicians and Surgeons of Manitoba, in their report, refer to a schedule of fees last year which has not

yet been printed. We should be glad to see it soon hanging in all the doctors' offices.

* * *

Reciprocity

Although, as we stated in our last issue, Nova Scotia has obtained reciprocal privileges with Great Britain, the matter is not such clear sailing as it looks, since a man may be licensed to practise in Nova Scotia and yet unable to obtain such privileges, owing to the fact that he has not taken *an examination in Nova Scotia.* This shows that until Canada obtains inter-provincial reciprocity it seems useless to think of Imperial. Does it not seem well that we should "put our own house in order" before we ask to interchange privileges with our brethren abroad! England, Scotland and Ireland are one medically, though three different countries and nations. So much more should Canada be. Nothing surprises the outsider more than to hear this is not the case with the professions here. The great extent of territory is no argument, nor the fear of over-stocking the profession. Even if the latter were the reason there are better ways of providing against it than by "the closed door." A glance at what is taking place in the world at large shows that the tendency is towards reciprocity more and more between state and state and country and country. Only lately the Transvaal Medical Council decided to approach the various South African colonies regarding having *one registration for the whole of that immense continent.* There they have much greater difficulties than face the profession in Canada, and certainly at the present time are having far from prosperous times. Yet their Council consider that one registration would be best for the future of the profession!

Another sign of the trend of the times medically is that, at the American Medical Association meeting in June, the question of a National Board of Health was discussed, and the desire expressed to have inter-state sanitary regulations established, as they felt such would be a national blessing. They are feeling now all the bad effects of state against state regulations. As a general rule, what concerns one member of our profession concerns all in all countries. Think of the strength we should have to

fight evils such as quackery, club practice, and others; and on the other hand, what a power for the improvement of the Health of the world the Profession could be. "So let us pray, that come it may, as come it will for a' that; That (medical) man to man the Empire o'er, shall brothers be for a' that!"

* * *

May we again remind our readers of the meeting of the British Columbia Provincial Medical Association at Victoria, August 1st and 2nd. For any information write to Dr. Eden Walker, New Westminster, B.C. We trust there will be a large gathering.

LETTER TO OUR SUBSCRIBERS

Now that we are issuing our seventh number we feel it is due to our subscribers that we say something of how we stand. We can say we have every reason to be satisfied with the way the subscription list is growing and the number of men taking an active interest in the success of the Western Canada Medical Journal increasing. In what way has the *medical profession of the West* already benefited by having a *journal of its own?* The knowledge of the conditions under which the medical men are working has been greatly increased, and the efforts they are making to improve those conditions both for their own and the public's good has been brought before the medical brethren in other parts of the world, and in many instances before public men in this who read our journal. Publicity in most cases is a help. Suggestions can be received and efforts stimulated. The danger in an immense country with great distances between towns and mails, or means of travel none too good, is for the people to be self-centred and provincial, and all acknowledge *provincialism the great bar to progress.* Inter-communication—hearing of other's difficulties—knowing the efforts made to improve these, makes others take courage and to go and do likewise—makes also to be realized the harm individual apathy may eventually do some great movement for the general welfare. That the West is asleep or incapable of intellectual effort, as was said when the idea of this journal was mooted, has been utterly disproved. Our list of subscribers throughout the West shows many names of men highly qualified, and who before coming West have held important positions on their associations and councils. Materially, commercially, all agree the world is rapidly moving Westward. The consequence should follow that it move also *intellectually* if the progress is to be maintained. This seems probable when we hear of proposals for a splendidly equipped university to be started in the Last West. We feel very encouraged that in spite of the well-known fact that the Western medical man is very busy, taking a great interest in the educational as well as

the sanitary conditions of his district in addition to his medical duties, that we have through all the recent hard winter, with its many trials, received reports and papers from the men to help us carry on the Western Canada Medical Journal. Besides these we have had many personal letters. One point in those letters we should mention—that is, the general opinion that the Journal, to fill the want, **must be independent**, and not run by any association. This opinion was given not by men opposed to associations, but by men who are active supporters and often important members of their various associations, societies and colleges. The reason given was that it was essential the Journal be perfectly *impartial*. This seems beyond question. The West, from the Lakes to the Coast, is comprised of four provinces. Now three, soon four Colleges of Physicians and Surgeons, more Associations, at present one Medical School and University, but soon the new provinces are to have their own University, and the energetic and capable way they are going into the matter promises well. Dame Rumor says there is to be co-operation of funds and control. One can well imagine that this Last West University, able to profit by the experience and mistakes of others, by the increased prosperity of the country, by the increased intelligence and capital of the settlers now coming West, should be all we can wish.

It stands to reason that if any one journal is to represent all these various interests it **must be independent**—that it should not be run and controlled by any one association or school but in touch with all. Hence our system of local editors. These men, all workers for their societies, can report to us the desires, news and progress of the various districts and the work of their associations and colleges. Mistakes at headquarters must be made sometimes, especially starting—we cannot know of all matters in as full detail often as we wish; but these faults can be put right by our local Editors and subscribers when they see us going astray writing at once to us and leading us to the right path. That we can all be in accord regarding matters we each think of common interest is impossible—but *there* comes the use of our Western Canada Medical Journal. It should be an educational factor in the discussion of questions of Western and Dominion

medical interest. This we have every faith it will be in time. The more we discuss our needs the more united we shall become and, being united, gain just legislation for those needs. Till a paper and publicity comes, the outside world is practically in the dark regarding the conditions of any profession, people or place. That the outside world's knowledge of Western Medical Canada has increased since the appearance of the Western Canada Medical Journal is shown by the fact of the increased space given now to Western medical news by other journals. Read and see and compare with space devoted to same territory before it appeared. That the Journal should be independent, let us take for argument one run for the whole West by Winnipeg Association, College, or any other. Consider the result! Consciously or unconsciously the end is special aggrandisement of the men of that association or college. History proves this true. While strongly in favor of societies and associations, and fully realizing that on them depends to the greatest extent the good or ill of their profession, we saw the impossibility of such a journal fulfilling the felt want in the West, and hence this enterprise. With regard to bringing it out; some said, "John, print it," others said "Not so;" some said "It might do good," others said "No." We felt sure it would do good, and printed it. The good it will do will depend on the help, hints and assistance we get from our subscribers. On our part no effort or expense will be spared to make the Journal the best possible, and to meet the wishes of the profession. The Journal has no bias—no purpose to serve other than the good of the profession—to be the Voice of the Medical West. That we have the good-will of our contemporaries is shown by the kind and complimentary notices given us by the Lancet (England), The British Medical Journal, The Journal of American Associations, The Medical Record, The Canada Lancet, The Journal of Surgery and Medicine, and others. Also that our Journal is read by not only Western men but others outside is shown by discussions in our columns having been noticed by other medical journals—one literary journal and a newspaper. This shows there is an active interest—certainly not apathy—with regard to us. We beg that all our subscribers will not weary of their well-doing, but continue. To what may matters discussed in our columns

lead for the profession and the men! Truly, "Behold how great a matter a little fire kindleth." There is plenty of fire of enthusiasm capable of burning long and strongly behind this enterprise. *Of this let the West be assured.* Having put our hands to the plough we shall not turn back. Help us to plough well. Plenty of hard work has been tackled more especially because we felt it would be the wish that all work should be done in the West—printing, etc. It is; hence cause of a little delay; paper not arriving to time, etc., etc. But all these difficulties will gradually disappear. The literary part is not all Western, with intent. At the start we promised our subscribers to get the interest of the leading men in the world in our Journal. We have. We feel a paper by one helps us to attain the standard we all desire. Here, we may say, the response of these busy prominent men with no "axe to grind" has been cordial in the extreme, showing that in the higher ranks of our profession there is truly a feeling of *brotherhood.*

Our space is limited, but there is much we would tell our helpers, and several individual points we must just touch on. One objection raised to any journal in the West was that if a man in the West had anything worth publishing (which was much doubted) that he could easily get it published in the various Canadian, American and English journals now in the field. In reply to this, we suggest such believers read the address of the president at the recent annual meeting of the American Medical Editors' Association, in which he proves that of all the papers read at society meetings there are many that never can get published. What of the West and the papers not even getting a chance to be read!

Professor Osler, in an address to students, advised them to "start with no higher ambition than to join the noble army of general practitioners, for they form the sinews of the profession—learned in the wisdom not of the laboratories, but the sick-room." Dr. MacKenzie, in his interesting paper of this issue, points out that it is to such men we can look for new discoveries. Think of Jenner in his village! Without doubt in Western Canada there is a great *field for research in the Distribution of Disease and Effects of Climate.* May we some

day have the honor of publishing some discovery of world importance by a Western man. An ardent supporter from the Far West suggests we increase the size. Our answer is that we wish all printed *to be read* and we remember our Western doctor is a busy man, and our great object is to get him to write the results of those observations which he only is in a position to make on the spot. For this year at least we think we are big enough.

We cannot thank too much all those who have helped us in various ways with the Western Canada Medical Journal and its aim. We are, indeed, and should be, grateful to those who have helped us over the difficulties, till now we are in comparatively smooth waters. Nothing pleases us better than a letter of suggestion and criticism. We have received many, and in every instance can say they were helpful. We ask for your continued help in rousing the apathetic ones to send in their names for our *subscription list* and their *contributions* for our columns. This is a great help. The increase of subscribers means decrease of postage expense and the cheering effect on the editors can well be imagined! Continue as helpful and encouraging as you have been in the past, and we predict the influence of the Medical West will be great in the future.

GENERAL MEDICAL NEWS

MEDICAL SOCIETIES

Summarized Report of the Saskatchewan Medical Association — The members of the Saskatchewan Medical Association met in convention at Prince Albert on Thursday, June 20th, but so tempting was the entertainment provided by the local medicos and Kinistino Lodge, No. 1, A.F. & A.M., that business was not fairly commenced until Friday morning. On Thursday afternoon the medicos took part in a very pleasant river excursion arranged by the local Masonic Lodge and physicians, attended the reception and lawn party given by Mayor and Mrs. Cook, and also the concert and dance given in the City Hall in the evening.

Friday morning a business session was held under the presidency of Dr. J. W. Kemp, of Indian Head, and the following officers were elected:—Honorary President, Dr. J. W. Kemp, Indian Head; President, Dr. W. A. Thomson, Regina; 1st Vice-President, Dr. W. Hall, Fort Qu'Appelle; 2nd Vice-President, Dr. E. H. Munro, Saskatoon; Secretary-Treasurer, Dr. G. A. Charlton, Regina; Executive Committee—A. B. Stewart, Rosthern; Dr. H. A. L. Reid, Prince Albert; Dr. T. M. Leask, Moose Jaw.

The retiring president, Dr. Kemp, extended an invitation to the Association from the Board of Trade of Indian Head to meet at Indian Head early in September next. The invitation was unanimously accepted.

One of the questions discussed was that of a medical tariff. It was shown that there was a lack of uniformity in the fees charged, more particularly in the fees paid for the examination of candidates by fraternal societies and insurance companies.

A special committee was appointed to go into the matter and draft a uniform tariff. The report of the committee was received and adopted recommending a uniformity of fees throughout the Province, the fee for insurance examinations, both for faternal societies and insurance companies, being fixed at $5.00 for the full examination and $3.00 where urinalysis is omitted.

Friday afternoon the association was addressed by Rev. Dr. Wm. Moore, of Ottawa, secretary of the Canadian Association for the Prevention of Tuberculosis. The discussion which fol-

lowed had special reference to tuberculosis among the Indians, a subject which many of the delegates have had special opportunities to study.

Other papers read in the afternoon were:—"Medical and Surgical Treatment of Acute and Chronic Appendicitis," by Dr. W. Dow, Regina. "Sanitation," Dr. W. A. Thomson, Regina. "The Physician and Druggist, and their Relation to Each Other," Dr. A. B. Stewart, Rosthern. "Troubles in the Life of a Country Physician," Dr. J. W. Kemp, Indian Head.

The entertainment provided by the local members was acknowledged by the visiting members by a cordial vote of thanks proposed by the president, Dr. J. W. Kemp, Indian Head, seconded by Dr. W. Dow, Regina.

Friday evening the members of the Association were guests at a reception given in their honor by Mr. and Mrs. Galbraith. The host and hostess did not spare themselves in the endeavor to provide a pleasant evening for their guests. The result was that everyone had a royal good time.

The local physicians deserve much praise for their unremitting efforts both as to business arrangements and social functions. These attentions were highly appreciated by the visiting delegates, all of whom went away regretting that the holiday in Prince Albert had not been longer.

Programme

"Medical and Surgical Treatment of Acute and Chronic Appendicitis"—Dr. W. Dow, Regina.

"Sanitation"—Dr. W. A. Thomson, Regina.

"The Physician and Druggist and Their Relation to One Another"—Dr. A. B. Stewart, Rosthern

"Troubles in the Life of a Country Physician"—Dr. J. W. Kemp, Indian Head.

"A Case of Syphilis Insontium"—Dr. G. R. Peterson, Saskatoon

"Tuberculosis"—Rev. Wm. Moore, Ottawa.

G. A. CHARLTON, M.D., Sec.-Treas.
Regina.

Calgary Medical Society — At the June meeting of this society, Ectopic Gestation was the subject for discussion.

Dr. Wm. Egbert read a paper on the subject, after which an animated discussion followed. Dr. E. G. Mason was asked for a report on a couple of cases coming under his care.

After spending a very enjoyable and profitable evening, a vote of thanks was tendered Drs. Egbert and Mason.

VITAL STATISTICS

Winnipeg, June, 1907.

	Cases.	Deaths.
Typhoid Fever	17	0
Scarlet Fever	44	1
Diphtheria	29	2
Measles	52	0
Tuberculosis	2	0
Mumps	19	0
Erysipelas	7	0
Whooping Cough	3	0
Chickenpox	6	0
	179	3
Total number of deaths (from all causes)		93
Total number of births		235

Jan. 1 to June 30, 1907	Brandon	Edmonton
Marriages	103	56
Births	127	69
Deaths	92	19

Vancouver	From Jan. 1 to June 30	For June, 1907
Marriages	367	78
Births	559	76
Deaths	435	71

Cause of Death—		Cause of Death—	
Accident	11	Bright's Disease	1
Heart Disease	7	Stillborn	5
Pneumonia	6	Drowning	3
Consumption	7	Liver Complaint	1
Suicide	1	Dysentery	1
Children's Complaints	5	Pleurisy	1
Typhoid	2	Gastro-Entritis	1
Meningitis	2	Obstruction of Bowels	1
Natural Causes	2	Hemorrhage	1
Apoplexy	1	Asthma	1
Appendicitis	1	Infantile Weakness	2
Convulsions	1	Mercurial Poisoning	1
Cholera Infantum	2	Congenital Weakness	1
Diphtheria	1	Cerebral Tumour	1

MEDICAL NEWS

A circular has been issued to the physicians of Nelson and surrounding district asking for their views regarding forming an Interior Medical Association. If this is agreed to, an organization conference will be held at an early date. The W. C. M. J. wishes them all success.

A site is to be selected, probably at Departure Bay, Victoria, for a new biological station.

Phosphorus and carbolic acid are to be added to the list of certified poisons in Winnipeg. The death of a little boy from phosphorus poisoning due to sucking fireworks, and the numerous cases of attempted suicide from taking carbolic acid opened the official eyes to the danger, and it is said this step will be rigorously enforced.

Regina has passed a new health by-law requiring bread to be delivered covered in a special paper and fruit not to be exposed on the streets and sidewalks. If this is rigorously enforced it will be well for the inhabitants of Regina.

At the recent dental examination in British Columbia only four candidates passed. The candidates who failed do not consider justice has been done, and are not going to let the matter rest. Three of them have obtained legal opinion, and an appeal is to be made to the Provincial Government to obtain a Royal Commission to enquire into the matter. They request the production of their papers, claiming these will give proofs of the injustice of the results. They also say the charge of "copying" cannot be substantiated, as the examiners were absent from the rooms during the examinations.

Dr. Clarke, Medical Superintendent of Toronto Asylum, and Dr. Ryan, Medical Superintendent of Rockwood Asylum, Kingston, are soon to visit Europe in connection with the Ontario Government's intention to institute a new system of psychiatric treatment of the insane.

Dr. J. L. Todd has just been appointed Professor of Parasitology at McGill University. Dr. Todd has had a very distin-

guished career so far. He was born in Victoria, B.C., in 1876, took his B.A., McGill in 1898, and M.D., 1900. He worked first at the Royal Victoria Hospital, Montreal, then went to Liverpool, where he studied at the Tropical School of Medicine. In 1902 he went to Senegambia to study "sleeping sickness." In 1903 he went out to the Congo with Dr. Dutton to study tick fever. Returning in 1905, he was appointed Director of the Runcorn Research Laboratories, Liverpool. King Leopold decorated him for his work on this expedition.

Dr. Underhill, Medical Officer of Health, Vancouver, has recommended the appointment of an assistant medical health officer, whose duties would be the inspecting of dairies, analysing of milk and similar work. Dr. Underhill also made the very wise suggestion to the Vancouver School Board that a medical man be appointed to examine the schools at stated intervals.

The Board of Dental Surgeons of British Columbia successfully prosecuted J. W. McCready and J. V. Bingay for practising dentistry without a license. J. V. Bingay, who is licensed in Nova Scotia, has appealed against this decision.

A deputation from the Alberta Medical Council waited on Hon. C. W. Gross, the Attorney-General, on July 5th, to confer regarding the status of the medical men in the Province who registered in Alberta after the passing of the Alberta Medical Act and previous to the announcement of the judgment of the Supreme Court of Canada. It is likely that those who registered between these dates will have to pass the examination of the Medical Council and register again.

Reciprocity seems the desire of all the professions. The Dentists have Dominion reciprocity except for Quebec and British Columbia, and are taking up the question with Great Britain; the Lawyers are agitating; and now, at the Imperial Conference on Education lately held in London, interchange of Teachers was discussed.

The system of furnishing medical attendance to the men working on the G.T.P. on points east of Edmonton is that every fifty miles a doctor is stationed. Dr. Williams has charge of the section east of the Battle River; Dr. Steele, Innisfree, the section

as far as Hurry. He has also charge of the G.T.P.'s temporary hospital at Battle River. The health of the camps is said to be good.

The following is a list of the delegates to the meeting of the Medical Association of Saskatchewan at Prince Albert recently: —President, Dr. J. W. Kemp, Indian Head; Dr. Stuart, Rosthern; Drs. Charlton, W. A. Thompson, Dow, Regina; Drs. Brown and Sparling, Battleford; Drs. Munro and McKay, Saskatoon; Dr. Shaw, Regina; Dr. Field, Swift Current; Dr. Henderson, Qu'Appelle; Dr. Bouju, Sintaluta; Rev. Dr. Moore, Ottawa; Rev. Dr. Smith and Dr. Eaglesham, Weyburn; Dr. Peterson, Saskatoon; Drs. Shadd and Spence, Melfort; Drs. Matheson, Reid, Lebrechue, Kitchen, Chisholm, Hopkins, Connor, P. D. Tyerman, Prince Albert.

The Provincial Board of Manitoba has placed with the Medical Officer of Health a supply of anti toxin for use in diphtheria cases arising in the city. Any practising physician can get a supply by applying to the Health Officer. It is expected that, as far as possible, the application will be used for indigent cases and those requiring prompt action.

It is reported that diphtheria has been raging among the Indians of the Pelly River and that ten deaths recently occurred.

Typhoid is said to be prevalent along the Tanana Valley. A number of the men have been seriously ill.

At an inquest recently held in Winnipeg on the body of a man found shot, the evidence brought out that he had been receiving treatment from an unqualified man, who admitted he knew the deceased was melancholic and had no will of his own, also that one of his brothers was an inmate of Brandon Asylum. The jury considered this a case for the College of Physicians and Surgeons to exercise their powers.

In Germany there is an Anti-Quackery Society, all members of which are expected to collect data to be used in the campaign against quackery. Especially do they endeavor to look into the past records of the charlatan. In this way they hope to protect the public against quackism. Could we not do likewise?

The jury at the inquest on the death of a man at Montreal who had been beaten by thugs, suggested that in every case where a prisoner was in a semi-conscious condition a medical man should be *at once* called.

The Committee on Papers and Business of the Canadian Medical Association desire that intimation of papers or other matters to be presented at the coming Conference be submitted *three weeks before date of meeting.* The secretary is Dr. Ridley Mackenzie, 192 Peel street, Montreal. Papers must be limited to fifteen minutes.

At the recent meeting of the German Society for Prevention of Venereal Disease at Mannheim, the meetings were open to the public. In this way it was hoped to educate the public and cause the government to take adequate steps for its protection.

The "Voice" publishes a letter from Mr. Stewart, recently Dominion Commissioner of Forestry, in which he points out the great need of skilled medical men, especially surgeons, in the Mackenzie River district. A district of 1,854 square miles, with a population chiefly of Indians and half-breeds, also a few whites, is without a medical man. A hospital at Fort Simpson, he points out, would save many lives and much suffering. May we ask what the Hudson Bay Co. is doing to let such be the case?

A special general meeting of the Royal Medical and Chirurgical Society of London was held June 14th, 1907. The Fellows and members of 14 societies have agreed to amalgamate, to be called the Royal Society of Medicine.

The Provincial University of Alberta is to be located at Strathcona in Central Alberta, and 258 acres have been purchased for $150,000.

In investigation was held into the cause of death of a girl of 16 at Dubuc, whose parents believed in faith healing. It is felt that a further inquiry should be held, and a report of the case has been forwarded to the Attorney-General's Department.

The members of the Alberta Provincial Board of Health, provision for the organization of which was made by the Public Health Act recently passed, are as follows:—Dr. Mewburn, Lethbridge; Dr. Corbett, Edmonton; Dr. Lafferty, Calgary; R. B. Owens, sanitary engineer, Toronto; Dr. Irving, Edmonton. The Provincial Inspector, Dr. Irving, is the Secretary of the Board.

Dr. Claude Kilbourne, speaking on medical work in China at Grace Church, Winnipeg, said there was a great scarcity of doctors. In China the average is one physician for every two million of population. He also deplored the scant knowledge possessed often by those practising in China, owing to the fact that anyone wishing to practise medicine in China did not need to pass any examination. They suffer, too, from shortage of equipment.

The Hon. Dr. J. S. Helmcken was the recipient of many congratulations on June 5th, his eighty-second birthday. He was born in London, England, and educated at Guy's Hospital, London. He came out to Canada as an official of the Hudson Bay Company. Later he was appointed clerk and colonial surgeon to the Hudson Bay Company. At the first Legislative Assembly, 1855, Dr. Helmcken was elected Speaker. For long he was a prominent figure in the political life of the province. May he have many more years given him.

Dr. Montizambert, who entered the public service as a quarantine officer the year before the union of the Provinces, has been paying a short visit to Victoria. Dr. Montizambert has served under every Dominion Government, holding many positions of trust, thus having forty-one years of service to his credit.

Dr. Underhill, the Medical Officer of Health for Vancouver, has just issued a set of regulations for the government of the city scavenging system, which will come into operation at once. There are rules relating to the duties of inspectors, scavengers, drivers and householders. With such a system as outlined strictly carried out, no fault will be possibly found with Vancouver's sanitary condition.

HOSPITAL NEWS

Dr. Galloway, of Winnipeg, has been appointed Orthopœdic Surgeon to the Winnipeg General Hospital, and Dr. Field to the Dispensary Department.

Dr. Fagan considers the land and the surroundings near Fish Lake, Kamloops, B.C., the most suitable for the sanitarium and for the proposed smaller hospital a site near North Bend. The committee have four sites from which to select.

The City Council of Calgary have now to look after the Isolation Hospital, the Board of Governors of the General Hospital refusing to continue the management as the city did not

carry out its part of the contract. The city promised to furnish the hospital and make payments for its maintenance. The furnishing part of the contract was carried out but not the allowance.

It is expected that the site for the Manitoba Sanatarium for Consumptives will soon be decided and the building st . The institution will be for the whole Province.

The following have been appointed coroners:—Dr. Ralph T. Maclaren, Moosomin; Dr. Gilbert Robertson, Stoughton; Dr. John H. Cole, Gull Lake.

In Dr. Hassell's report of the Royal Jubilee Hospital at Victoria, B.C., he makes a special plea for more accommodation in the private wards, also for a nurses' home, a diet kitchen, an infirmary for chronic cases, and a new X-ray apparatus, a Maternity ward and an assistant resident physician. The demands of the hospital have increased to such an extent during the past year.

The report of the Hospital for the Insane, New Westminster, B.C., shows the following:—

	Males.	Females.	Total.
In Hospital, June 1st	297	109	406
Received during month	13	2	15
Returned from probation	1	1	2
Discharged without probation	1	1	2
Discharged on probation	4	2	6
Discharged at expiry of probation	5	5	10
Died	3	0	0
Escaped	3	0	0
In Hospital, May 31st	300	109	409
On probation	28	19	47
Total under treatment	328	128	456

Plans for the construction of the new modern hospital at Calgary are being called for and must be in August 1st. The main building is to consist of Maternity hospital, Isolation hospital, Nurses' Home, and is to be constructed of red brick with stone trimmings, cost not to exceed $140,000.

The first graduates of McKellar Hospital, Fort William, were awarded their diplomas June 28th. Seven nurses graduated. The lady superintendent is Miss Banks. Dr. Bruce Smith, inspector of Publis Hospitals and Charities for Ontario, addressed the graduates. Two beautiful medals were given by the president, Mrs. W. Stevenson. Dr. Birdsall also made a speech.

A $12,000 hospital is to be built this year at Souris, Man.

The work is to shortly begin on the new Maternity Hospital and Nurses' Home in connection with the Royal Columbian Hospital, New Westminster, B.C.

On July 1st the Lieutenant-Governor of Manitoba laid the foundation stone of the new hospital to be built at Selkirk.

The Park Sanatarium, recently taken over by the Grey Nuns, Regina, was opened by Lieutenant-Governor Forget. It will now be called the Regina Hospital. There is accommodation for thirty patients—public, private and semi-private beds.

Dr. Dundas has opened a cottage hospital at Rathwell for medical, surgical and accouchement cases.

The Salvation Army's Hotel Welcome, Vancouver, was recently opened by Dr. Underhill.

Another hospital is proposed for Prince Albert, to be built under the auspices of the Roman Catholic Church and managed by the Sisters of Charity of St. John, N.B. It will be a hospital open to all denominations.

The Board of Directors of the Winnipeg General Hospital consider that either a second hospital must be erected in Winnipeg or the present General Hospital must be considerably enlarged. The city makes a yearly grant of $30,000. They are asked to increase it to $40,000, and also are urged to build an isolation hospital of sufficient size.

At a meeting of the Gladstone Board of Trade, July 5th, a resolution was passed that the locality was in urgent need of hospital accommodation, and the board recommended that the Seventh Day Adventists be given the most hearty encouragement in their proposal to establish a public hospital and sanatarium at a point near Gladstone, and that the Council assist with grants for the building and maintenance.

Nearly $60,000 has now been subscribed towards the funds for the British Columbia Sanatarium for Consumptives.

The number of patients treated in the public wards of the Winnipeg General Hospital last year was 2,255, at a net cost to the hospital of $59,181. The demands on the hospital this year are much greater than ever. The hospital has been so crowded that patients have had to be placed in the part that used to be the Nurses' Home before the alterations were made. The accommodation of the Hospital—exclusive of Isolated, Maternity and Emergency Hospitals and tents for tubercular patients—is as follows:—Public wards, 152; semi-private, 63; private, 31.

NOTICES

The examination of the College of Physicians and Surgeons of the Province of Alberta wil be held at Calgary on the first Tuesday of August next (the 6th.) Examination fee, $50.00.

Applications, with credentials and fee, to be in the hands of the Registrar two weeks before the examination.

J. D. LAFFERTY,
Registrar C.P. & S., Prov. of Alberta.
Calgary.

List of men who passed the examination of the College of Physicians and Surgeons, Northwest Territories, at Regina and Calgary, on Feb. 26, 1907, at 1.

Dr. J. W. Auld, Calgary.
Dr. W. Allen Bapty, Langdon, Alberta.
Dr. J. T. Brander, Ponoka, Alta.
Dr. A. D. Calbeck, Hardisty, Alta.
Dr. R. G. Duggan, Hamilton, Ont.
Dr. C. Houston, Stettler, Alta.
Dr. A. E. Kelly, Swift Current, Sask.
Dr. C. Learn, Claresholm, Alta.
Dr. F. H. Mayhood, Calgary, Alta.
Dr. H. G. Taylor, Bankhead, Alta.
Dr. H. A. Stewart, Saskatoon, Sask.
Dr. D. W. Gray, Bowden, Alta.
Dr. R. L. Hutton, Hague, Sask.
Dr. J. H. Storry, Tuxford, Sask.
Dr. Roy D. Nasmyth, Sedley, Sask.
Dr. William McLeod, Kisbey, Sask.
Dr. H. D. McLean, Lang, Sask.
Dr. W. B. Cassels, Brandon, Man.
Dr. A. N. Hardy, Tyvan, Sask.
Dr. R. Stipe, Milestone, Sask.
Dr. A. C. Phillips, Indian Head, Sask.
Dr. K. C. Cairns, Lumsden, Sask.
Dr. J. H. Code, Gull Lake, Sask.
Dr. J. H. Galloway, Glen Ewen, Sask.
Dr. Alex. Mitchell, Macoun, Sask.
Dr. A. R. Munroe, Langham, Sask.
Dr. C. W. Doran, Saskatoon, Sask.

PERSONALS

Dr. J. H. Conklin, a graduate this year of the Manitoba University, has secured Dr. Little's practice at Alexander, Man. Dr. Little is going to the hospitals of New York for post-graduate course.

Dr. and Mrs. McGavin, of Plum Coulee, Man., are spending a few days in the city.

Dr. R. McCutcheon, of Quill Lake, paid a visit to Edmonton.

Dr. and Mrs. Hart, of Vancouver, spent a few days in Victoria.

Dr. and Mrs. G. A. Kennedy, of MacLeod, have been visiting Calgary.

Dr. V. E. Casselman, Napinka, Man., has taken Dr. R. C. McGee into partnership with him.

Dr. Tunstall, of Kamloops, has gone for a voyage to Japan.

Dr. Newton Greer, of Peterboro,' spent a few days at Edmonton.

Dr. and Mrs. Taylor, of Golden, B.C., have gone for a holiday into the Interior.

Dr. Gillespie has returned to Edmonton after attending the military camp at Kingston, Ont.

Dr. D. J. Bechtel, Calgary, visited Edmonton.

Dr. McLeod has returned to Regina from his visit to the hospitals of the States.

Dr. Rush, Vegreville, Alta., is going to Europe for post-graduate work and a rest.

Dr. R. H. Carter, Victoria, who has been taking post-graduate work in the Eastern States, has gone to Europe to further prosecute his work.

Dr. and Mrs. Gordon Cummings have settled in Vancouver.

Dr. Barrow, Edmonton, left for Fort Smith to relieve Dr. West, of the R.N.W.M.P., for three months.

Dr. and Mrs. Lineham have returned to Dauphin.

Dr. and Mrs. Bentley, Port Moody, spent a few days in Vancouver.

Dr. J. A. Tierney, of St. Albert, is visiting Edmonton.

Dr. Bonnell, Fernie, B.C., has returned from a holiday in the Skeena River district.

Dr. and Mrs. Mulvey, Edmonton, have gone to Europe for a holiday.

Dr. Stuart MacKid has returned to Calgary after taking six months' post-graduate work in Europe.

Drs. Brett, Banff; Lafferty, Calgary; Kennedy, Macleod; Simpson, Innisfail, attended the Medical Council meeting at Edmonton.

Dr. Mewburn, Lethbridge, paid a visit to Calgary.

Dr. and Mrs. Livingstone, Winnipegosis, have gone on a visit to Listowell, Ont.

Dr. and Mrs. Kerr, Victoria, are visiting Alberni, B.C.

Dr. Fagan is spending about two weeks in Vancouver and the mainland in connection with his work for the Anti-Tuberculosis Sanitarium.

Dr. and Mrs. Mansell and family are taking a month's holiday at the coast.

Dr. Davis, of Nanaimo, spent a few days in Seattle.

Dr. Braithwaite, of Edmonton, was in Winnipeg recently attending the Grand Lodge of A.O.M.

Dr. May has opened an office in Foxwarren.

Dr. Wilkinson, Roland, and Dr. Smythe, Medicine Hat, visited Winnipeg last month.

Dr. Gillespie has gone on a visit to Toronto.

Miss Mansell, Duck Lake, has been appointed matron of the City Hospital, Saskatoon.

Dr. W. G. McGuigan, Vancouver, is, we regret to say, seriously ill at St. Paul's Hospital, Vancouver.

Dr. Simpson, Lacombe, visited Edmonton recently.

Dr. H. R. Smith, Edmonton, has returned from a visit to the Eastern hospitals.

Dr. C. Kilbourne, a recent graduate of Manitoba University, is going out to the mission field in China.

Dr. and Mrs. Gibbs, Victoria, have gone to Vienna, where the doctor is going to take post-graduate work.

Dr. and Mrs. Baucher, Vancouver, have gone to Germany for a holiday.

Dr. and Mrs. Johnson, of Walla Walla, spent a few days in Vancouver.

Dr. Monro, Vancouver, has returned after a trip East.

Dr. Costello, Calgary, has gone East for post-graduate work.

Dr. Argue, M.L.A., Grenfell, visited Regina.

Dr. Culbertson, Dauphin, had the misfortune to have his summer cottage on the Wilson River burnt.

Dr. R. Gibson, Vancouver, went to visit his parents at Nanaimo, B.C.

Dr. F. C. Harwood, of Moose Jaw, was married June 27th to Miss Galbraith, and he and his bride have now returned from the East.

Dr. K. C. MacDonald, Okanagan, spent a few days in Vancouver.

J. D. Hunter, Victoria, took his M.D., C.M., at McGill, last examination.

Dr. Davis, coroner for the Nanaimo district, spent a few days in Victoria.

Dr. Latimer, Brandon, spent a few days in Winnipeg.

Dr. Rolls, who has been resident physician at Clayoquet for the past two years, has gone to Toronto, after spending a day in Victoria.

Dr. W. J. Knox, of Kelowna, has been visiting the Coast cities.

Dr. Frank Hall, Victoria, has gone for a trip to England and the Continent.

Dr. Mackay, late of Winnipeg, has taken over the practice of Drs. Dickson and Allum at Rapid City, Man.

Dr. R. M. Simpson, Winnipeg, has gone to Europe for a holiday.

Dr. C. E. Johnson has returned to Winnipeg after a visit to the States.

Dr. Hart, Indian Head, spent his holiday and made the ascent with the Alpine Club.

Dr. Hill, Swan River, who has been seriously ill, is, we are glad to hear, getting better.

Dr. and Mrs. Coles, Regina, paid a visit to Winnipeg at the beginning of July. Mrs. Coles will spend the summer at Prince Edward Island.

Dr. Kemp, Indian Head, spent two days in Regina during the first week of July.

Dr. and Mrs. Seymour, Regina, have gone to Lebret.

Dr. H. S. Monkham has gone into partnership with Drs. Rush and Field, Vegreville.

Dr. and Mrs. Riggs, Vancouver, have returned from their visit to the old country.

Dr. Raynor now has charge of the Methodist Hospital at Clayoquot, having succeeded Dr. Rolls.

BORN

Underhill—June 25th, at Vancouver, the wife of Dr. Underhill of a son.

Hislop—At Edmonton, on June 15th, the wife of Dr. Hislop of a son.

Herald—The wife of Dr. Wilson Herald of a son.

Thomson—At Brookdale, the wife of Dr. R. B. C. Thomson of a son on June 13th.

MARRIED

McGavin—Bryans—June 19th, at Grace Church, Winnipeg, Emily Christina Bryans, of Morden, to Dr. Hugh McGavin, of Plum Coulee.

Mustard-Chambers—at Los Angeles, June 19th, Dr. Jack Mustard, formerly of Stony Mountain and Winnipeg, to Dr. Flora Chambers, of Los Angeles.

Waugh—Potts—At Carberry, June 21st, Dr. R. J. Waugh to Miss Kathleen Potts, of Carberry.

Hamilton—Gourlay—June 15th, Dr. William T. Hamilton, of High River, Alta., to Miss Edith Gourlay.

OBITUARY

Madore—Dr. G. Madore, surgeon to the R.N.W.M.P. at Prince Albert, died June 10th of heart disease.

REMEMBER!

that the

British Columbia Medical Society

Meets at

Victoria, B. C.

—ON—

August 1st and 2nd

Experiences with Alphozone by Canadian Practitioners

These incidents have been related to our representatives and are merely a chance collection to bring home to you the immense range of Alphozone and the many ways you could employ it to advantage in your every day work.

In every case cited, the reason for its action is readily apparent, when you consider the high oxidizing power of Alphozone and the gradual release of Oxygen in nascent condition.

OTTAWA, ONT. DR. M.	"Consider it a specific in fermentation, both in intestines and stomach."
KENORA, ONT. DR. C.	"Treats many cases of eye injuries resulting from dynamite explosions in railway construction work. Uses Alphozone Solution freely in such cases. Has no suppuration now, but was a common complication before."
PORT ARTHUR, ONT. DR. M.	"Treated several Carbuncles successfully, and find Alphozone excellent to check Suppuration in these conditions."
BERLIN, ONT, DR. K.	"After carefully watching a series of cases of Typhoid treated with and without Alphozone, am firmly convinced that Alphozone affords the only proper treatment."
GALT, ONT. DR. M.	"Have used Alphozone with excellent results in Ring Worm and Barbers' Itch—nothing like it."
TORONTO, ONT. DR. A.	"Treated 'a pus hand' for weeks with very discouraging results. Commenced with Alphozone and it immediately improved, healing up beautifully."
ST. THOMAS, ONT. DR. L.	"Nothing else of any value in Barbers' Itch."
PLUM COULEE, MAN. DR. M.	"Used Alphozone as a dressing for severe scald, extending from patient's knees to feet. The scalded surface healed up beautifully."
HANOVER, ONT. DR. T.	"Depend entirely upon Alphozone as an intestinal Antiseptic in Typhoid. Never disappointed."

[OVER]

VANCOUVER, B. C. DR. H.	"Successfully treated many cases of Gonorrhea with Alphozone. Some cases, chronic in character, had resisted all other treatment."
WATERLOO, P. Q. DR. C.	"Had a remarkable case of Tubercular abscesses in side with very excessive discharge. Patient very emaciated. Other agents, H_2O_2, Iodoform, Iodol, $HgCl_2$, etc., seemed utterly without effect. Responded promptly and remarkably to Alphozone. Abscesses healed up in a very short time, and patient began to gain steadily and had no return."
HAMILTON, ONT. DR. G.	"Had two cases of knee abscesses sent by general practitioner who had given them up. Knees were covered with abscesses and both cases recovered promptly and completely under Alphozone local treatment."
CALGARY, ALBERTA. DR. E.	"Alphozone the best agent for middle ear complications."
HAMILTON, ONT. DR. W.	"Finds Alphozone a most satisfactory treatment for Bladder Irritation."
EDMONTON, ALBERTA DR. M.	"Had ten cases of Typhoid in Hospital last fall. Used Alphozone as practically the only treatment. Never before saw Typhoid patients make as satisfactory recoveries. Unusually prompt and no complications."
CALGARY, ALBERTA. DR. G.	"Pleasantly surprised at results from Alphozone in a case of 'Stitch Abscess' following an operation."
KENORA, ONT. DR. E.	"Alphozone specially useful in Eye work and all mucous membranes, requiring Antiseptic treatment."
HAMILTON, ONT. DR. A.	"Use Alphozone entirely for any mouth trouble of a Syphilitic nature. Have used about everything else suggested, and a varied experience convinces me that nothing else compares with Alphozone."

These physcians would no doubt be pleased to correspond with you if you are interested, and we would be happy to put you in communication. Samples and full literature cheerfully supplied. You can hardly afford to be without Alphozone in your kit bag.

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[OVER]

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CONTROLS the DIARRHEA of TYPHOID FEVER and other infectious diseases and inhibits the development of the micro-organism and astringes the congested and inflammed mucosa, including the infected and ulcerated peyer's patches, thus, it greatly limits the possibility of hemorrhage and perforation.

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The only powder which liberates Free Iodine, Formaldehyde, Thymol and Phenol.

An efficient local Antiseptic, Alterative, Astringent, Analgesic and Dermal Tonic.

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Is greatly superior to Phenol preparations, in addition to it being less toxic and decidedly more active as an antiseptic it possesses lubricating properties, especially valuable in the lying-in state, vaginal and intrauterine douches, also, in urethral and vesical irrigation in urethritis and cystitis, in preparing the field of operation, the hands of the operator and instruments used.

Samples to Physicians on request.

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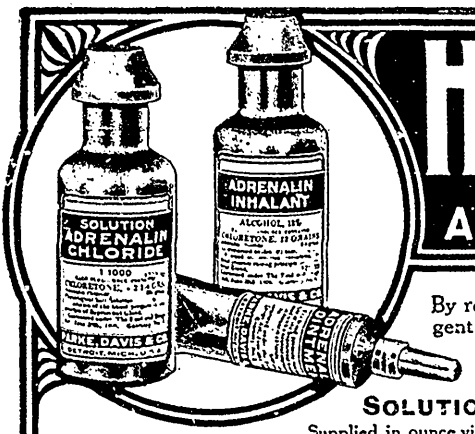

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Supplied in ounce vials. Should be diluted with four to five times its volume of physiological salt solution and sprayed into the nares and pharynx (*see Glaseptic Nebulizer adv. below*).

ADRENALIN INHALANT.

A bland oil solution, ready for immediate use. While not so prompt in effect as the foregoing, it is more lasting (owing to its oleaginous nature). Supplied in ounce vials, and administered by means of our Glaseptic Nebulizer or other atomizer suited to oily liquids.

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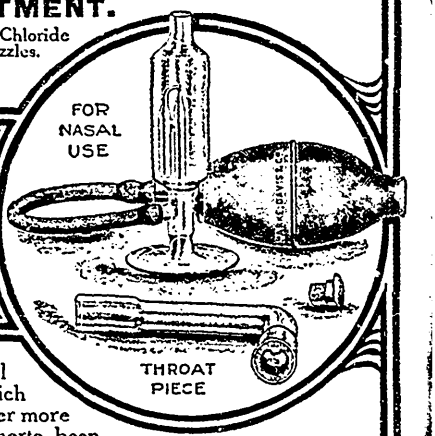

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The *Glaseptic Nebulizer* (P., D. & Co.)—with the exception of the tube and bulb, which are rubber—consists wholly of glass. It is easily sterilized. It is adapted to solutions of any density, whether ethereal, spirituous, oily or aqueous. It produces a fine spray that may be readily inhaled. It is well suited to expensive solutions and to solutions of an oxidizable nature, affording excellent results with but a few drops of liquid.

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