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EDITORIAL

THE CANCER CURE

THE CANADA LANCET expresses the sincere hope that the serum discovered by Dr. Glover shall prove to be a genuine cure for cancer. We have no intention, at this moment, of going into the theories as to the origin of the disease. If a microbe is the cause, the serum may destroy it; or, if some abnormally growing cell, then this may be arrested in its method of proliferation.

The point we wish emphasized is that no time should be lost in making the methods of preparing the serum known. All the world over there are cancer victims, all of whom are entitled to the benefit of such a discovery. Steps should be taken to produce the serum in such quantity as would be able to meet the demand. The method of preparation should not remain a secret, nor should it be held in the interest of any person or institution.

If the discovery should prove to be a genuine cure, we hold that Dr. Glover should be well rewarded. The country should recognize its obligation for such a boon to suffering humanity. This reward should be generous; and, this done, the remedy should be made public with the least delay consistent with safety and sound observation of cases.

FAITH HEALING

A short time ago the public ear was to the ground listening to the many statements about the cures that were being wrought by Mr. James Moore Hickson. He visited Toronto, and many grievously afflicted persons sought relief at his hands. For two days he met such persons in St. James Cathedral, Toronto.

Time enough has now gone by to enable conclusions to be drawn from the results of his visit. In the interest of truth there should be no delay in the making of a thorough investigation into these cases. For this

purpose we would suggest a committee composed of some well known physician and surgeon, two ministers of the Gospel, and a High Court judge. This committee would hear the story of the persons who had been treated and their friends and acquaintances. It would also have power to call expert witnesses to test the real condition of those who suffered and sought relief.

If the cures are real and numerous Mr. Hickson should be the first to welcome this enquiry, and no church should raise any objection. The truth, the whole truth, and nothing but the truth, is what is demanded.

CONTROL OF VENEREAL DISEASES

The Federal Government, through the Department of Health, plans to take an active part in a Dominion-wide campaign against venereal disease. To this end an order-in-council has been passed, which was tabled in the Commons to-day, by Hon. N. W. Rowell, Minister presiding over the Department of Health, providing for the distribution of \$200,000 among the nine provinces, to assist in combating venereal disease. The grants are to be made on a basis of population, and in two payments. The first of these will be made when the province has given assurance that it will spend an equal amount in the fight, and submitted an outline of its plans of campaign. The provincial departments of health must also sign agreements which will provide for the establishment of approved clinics, under the care of specialists with assistants, hospital beds with free treatment; diagnostic laboratories and efficient inspection and treatment of patients in jails and other public institutions. The second payment is to be made in six months if the Federal Department of Health is satisfied with the vigor being shown in carrying out the campaign.

Grants to the provinces will be as follows:—

	Population	Amount
Ontario	2,581,000	\$ 57,473.68
Quebec	2,326,000	47,388.80
Manitoba	619,000	12,611.20
Nova Scotia	519,000	10,573.86
New Brunswick	369,000	7,517.83
Saskatchewan	754,000	15,361.63
Alberta	588,000	11,979.62
British Columbia	718,000	14,628.19
Prince Edward Island	94,000	1,915.11
Totals	8,808,000	\$179,449.92

The balance of the \$200,000 will be used for incidentals.

ORIGINAL CONTRIBUTIONS

THE VALUE, INDICATIONS, AND TECHNIQUE OF
URETHROSCOPY.

NOAH E. ARONSTAM, M.D.

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THE value of urethroscopy can no longer be disputed. To practise urology without the aid of a urethroscope or cystoscope would be similar to practising diseases of the thoracic organs without the aid of a stethoscope. A great many facts can be elicited by the intelligent use of the urethroscope, that would otherwise escape our closest scrutiny. Urethral lesions are no longer regarded as those of *continuity*, but are known to invade the urethral tract *focally*. It is true that in acute cases we can readily dispense with this instrument, as the urethral mucosa is invariably invaded in its entirety to a greater or lesser degree; if anything, instrumentation of any kind is emphatically contraindicated in acute affections of the urogenital tract.

It may be axiomatically stated, that *the more chronic a urethral malady is, the greater is the indication of urethroscopy*. Excluding the possibility of prostatic and vesicular invasion, the urethra points toward the seat of the trouble, though in a number of cases the above conditions may be concomitant. The technique of urethroscopy is simple and could and should be mastered by every one. The following is a brief description of the technique in detail. The anterior tube has now been entirely discarded; what can be viewed through an anterior urethroscope, can be readily ascertained by means of posterior urethroscopy.

The patient is first instructed to urinate; he is then put upon the table in the recumbent position; some prefer the right angular position of the patient i.e., the patient's lower extremities hanging down at the foot of the table. I personally prefer the complete recumbent position. The genitalia are then thoroughly disinfected by lysol or bichloride solution. The instrument must be thoroughly sterilized by boiling; at no time should it be immersed in any antiseptic solution and used subsequently; such procedure does not render the instrument sterile. Before inserting the instrument, the urethroscopic lumen and that of the light carrier should be thoroughly dried with absorbent cotton, so as to render the field of vision as clear as possible. A chloretone oil may be used as a lubricant wherewith the urethroscope is well lubricated. *In inserting the instrument we must be very careful in not using force*. I employ three sizes viz, 20-22-24 Fr. Larger sizes than twenty-four are not required for complete inspection. If a number twenty is not readily ad-

mitted than there exists an obstruction or stricture, that must be primarily dilated before the urethroscope can pass. When the meatus is so small as not to admit a number twenty, a preliminary meatotomy must be performed with subsequent meata dilatation. Bleeding should be avoided as much as possible. The chloretone oil used as a lubricant also acts as a mild anesthetic. Cocainization of the urethra should never be employed, for very often shock supervenes in the mildest form of cocain anesthesia. The urethroscope with its obturator should be inserted to its shoulder; the latter is then removed and the interior of the urethroscope dried with a probe around which a pledget of cotton is wrapped. When no longer moisture appears on the pledget, the light carrier is inserted and the rheostat turned on. The first object that presents itself to our view is the distal end of the posterior segment of the urethra. By gradually withdrawing the instrument we can thoroughly and readily inspect the urethra in its entire length.

The following lesions may be observed either alone or in conjunction upon urethroscopy:

- A. Granular Lesions.
- B. Papillomatous Urethritis.
- C. Diseases of the Fossa Navicularis.
- D. Erosions and Ulcerations.
- E. Hypertrophic Urethritis.
- F. Enlarged Urethral Glands.
- G. Incipient Stricture.

Granular lesions consist of zones or areas of deeply congested mucosa from the bases of which spring minute punctuated lesions, the whole having the appearance of a strawberry; they are most commonly situated in the posterior urethra; though occasionally they may be found in the pendulous portion as well. There may be only one focus or a number of them irregularly distributed along the urethral tract.

The *treatment* is directed towards the destruction of those granular areas by means of various escharotics, preferably that of nitrate of silver in various strengths. I seldom use less than ten per cent. and not more than a twenty-five per cent. solution. The applicator is well saturated with the silver solution and cautiously applied directly to the lesions; there is very little discomfort occasioned by such treatment, as a film of silver chloride thus produced becomes localized to the area involved. A five to ten per cent. mercurochrome solution has been used by others to these areas, but it does not surpass the beneficial action of the silver solution. When the lesions are very pronounced we may resort to the use of a phenol-iodin solution (equal parts of carbolic acid and

tincture of iodin). The latter, however, should be used with great caution, for its tendency to scar formation is marked. *Every urethroscopic treatment should be followed by subsequent dilatation the day after.*

B—PAPILLOMATOUS URETHRITIS

As the term implies these lesions are wart like excrescences projecting from the mucosa, at times blocking the urethra; when not viewed urethroscopically and only explored by means of a sound they may stimulate stricture. On viewing them with an endoscope however, the clinical picture becomes apparent at a glance.

Treatment calls for excision and can best be done through the urethroscope. A long spear-shaped blade attached to a long handle about eight inches in length and considerably smaller than the lumen of the urethroscope is the instrument to be employed. These lesions are mainly situated in the anterior urethral segment. The endoscope is inserted, the lesions are exactly located, the rheostat is turned on, the blade is then introduced, and by a series of horizontal and vertical movements the papillomata are scarified. Considerable bleeding ensues, that may be checked either by pressure or by the instillation of adrenalin solution. At this juncture it may be remarked that prior to operating on these lesions, it is advisable to fill the bladder with four to six ounces of a ten per cent. boric acid solution, so as to enable the patient to urinate after these lesions have been excised, the tissue debris being thus washed away upon evacuating the bladder. Some employ electrocautery in treating the above lesions. But unless one is an expert in its use, the method of scarification suggested above is preferable.

C—DISEASES OF THE FOSSA NAVICULARIS

Within a half to one inch of the meatus is situated the Fossa Navicularis. It is not infrequently the seat of pathological conditions. On examining it urethroscopically we may detect a deeply congested longitudinal zone with a few bleeding points and plugs of secretion tenaciously clinging to the ducts of the follicles. The *treatment* consists in applications of a saturated solution of arygrol or fifty per cent. ichthol in glycerine; a five per cent. solution of mercurochrome may also be used in this condition. En passant it may be remarked that the Fossa Navicularis is not infrequently the seat of small papillomata that require surgical interference for their eradication.

Large ulcerations as a rule are very rarely met with in the urethra. As a rule superficial erosions may be occasionally encountered in the bulbous portion of the urethra. I have never observed them in the an-

terior urethral tract; these lesions are readily distinguished from other urethral lesions by their *glistening appearance and extreme sensitiveness* upon instrumentation, thus indicating superficial surface loss.

Treatment: Strong solutions of silver nitrate, urethroscopically applied will yield excellent results in a vast majority of cases.

E—HYPERTROPHIC URETHRITIS

The above variety is a type, *sui generis*, being found only in about four per cent. of all cases of chronic urethritis. When a sound is inserted in the urethra, the seat of an hypertrophic mucosa, it will readily give the impression of a stricture, but when viewed urethroscopically an entirely different picture presents itself to our view. Aside from the difficulty experienced in the introduction of an endoscope in such cases, the field of inspection presents a pathognomonic picture; a *lax, spongy*, and rugous mucosa projects in the fenestrum that closely resembles indentations or folds made in wax, the whole having the appearance of vaginal rugae. This condition is extremely chronic and very seldom yields to treatment. While the etiologic factor is undoubtedly of venereal origin, the gonococci are not always demonstrable; in fact no organisms whatever can be discovered in such instances. Microscopic examination of the secretion will elicit squamous epithelia and occasional pus cells, but no organisms.

Treatment—As intimated above it is very unsatisfactory; the electrocautery has been attended by some results; the application of strong solution of silver nitrate has in some cases affected a reduction of the hypertrophy. Urethroscopic treatment must be supplemented by the insertion of sounds, which must be kept in situ for at least fifteen minutes. Scarification of the involved mucosa has yielded excellent results in a few cases.

F—ENLARGED URETHRAL GLANDS

While not of common occurrence, we occasionally encounter at various intervals in the urethra, minute, pale, slightly elevated and indurated follicles. In such cases we must refrain from the use of caustics and rely upon *Expressions*, wherever these lesions are located. The handle of the spear-shaped blade is introduced and pressure brought to bear upon these follicles both from within and without, the finger outside in juxtaposition to the instrument within. A few of these treatments will suffice to eradicate these enlarged follicles.

G—INCIPIENT STRICTURES

By means of urethroscopy, an incipient stricture may be recognized. Even a fully matured stricture, if not exceeding a certain calibre, may

be distinctly viewed on endoscopy. The fenestrum of the urethroscopy impinging upon the anterior ring of the strictured area and the latter, lying behind the distal end of the instrument, projects a clear and distinct picture to our inspection. The parts posterior to the instrument, the intermediory ring, resembles an actual crescent, a semicircle, glistening, pale, slightly elevated and imparting to a probe inserted in the lumen of the endoscope a perceptible crepitation. When the stricture is of small size, by inserting an endoscope into the urethra and by holding the penis at a right angle to the scrotum, one may, by means of *transillumination*, discern the difference in the relative transparency of the preceding and adjoining parts. The normal urethra gives a perfectly pinkish and well transilluminated appearance; when thus extragenitally viewed; in case of stricture the transparency is obscured or diminished; a haziness takes the place of the brilliant illumination.

The diagnostic value of urethroscopy and transillumination as a supplementary step to bougies and sounds in the detection of strictures is a well established fact now, and should never be omitted when examining for stricture of the anterior or deep urethra. Therapeutically the endoscope may be utilized as a means of multiple scarification of the strictured ring, accompanied by gradual dilatation; yet the benefits derived from this method have not been very satisfactory to warrant much reliance upon this procedure.

In conclusion I desire to reiterate the statement expressed in the prefatory lines of this article, that the value of urethroscopy as a diagnosis and therapeutic agent can no longer be denied, and that it affords one of the most important and reliable prerequisites in the proper

WHAT TO KNOW ABOUT ACUTE ANTERIOR POLIOMYELITIS, AND MEANS OF EARLY RECOGNITION*

(INFANTILE PARALYSIS)

By Dr. Harry S. Berman, Detroit, Michigan.

“**E**XPERIENCE is a good teacher.” This being true we are fortunate by being in a position to look back and profit by others. Here I have in mind the epidemic of infantile paralysis experienced by the City of New York during June and November (1916) inclusive, which caused severe alarm throughout the country. This latter epidemic made its appearance by attacking New York City, commencing in Brooklyn, extending rapidly to various parts of New York State.

Later, epidemics crept up in the various nearby states and cities, involving mainly the southeast, northeast, and eastern parts. Fortunately,

the central and western states were attacked very little, with a total of thirty-nine to fifty cases having been developed in Detroit.

Just as other contagious and infectious diseases are communicated and transmitted to others by the sick or carriers, so is infantile paralysis. Unfortunately, we are still at sea as with what means this disease is communicated, but we do know that all discharges of the patients with the disease is infectious. I shall not attempt to dwell on this disease in this paper at length, but will discuss the characteristics in brief.

DEFINITION

Infantile paralysis or Poliomyelitis is an acute infectious and communicable disease characterized, at times, but not always, by involvement of the central nervous system, as a result of which it is frequently followed by paralysis.

Infantile paralysis is a disease attacking all ages, mostly children under five years of age, no one being exempt. With the advancement of age to sixteen years the number decreases. Over sixteen it is not very common. The malady is always ushered in by the usual symptoms of an acute infectious diseases, such as fever, which varies from 101° to 105° , coryza, headache, pains in back of neck, vomiting, constipation, or diarrhoea, the forerunner being more common.

*Read before the Maimonides Medical Society.

Associated with these symptoms are irritability, headaches, pains about the body, drowsiness, the latter not being constant, for the patient can be aroused to talk and take nourishment, but falls off into drowsiness when left alone, and becomes very irritable when disturbed. Hyperesthesia. Contractions of the muscles about the body and neck causing rigidity of the head, which is not constant as in meningitis.

The deep reflexes may be in the early onset exaggerated but are practically always diminished or absent. It may be noticed that there is extreme pain along the spinal column. Owing to these aches and pains the patient may be noticed to move about in bed, and change position frequently.

I shall not attempt to elaborate on signs and symptoms in this description, but give a resume of the disease during the onset. Clinically seen without the examination of spinal fluid, and in the face of an epidemic, one is justified in making a diagnosis of infantile paralysis.

ETIOLOGY

This is now being attributed to a small virus, which can only be seen by a high power oil immersion lens. Although there is much dispute as to whether this virus, as recognized by *Flexner* and *Noguchi*,¹ or the

various strains and sizes of the streptocci by *Rosenow*² is the cause of this malady, is still unsettled. However, the virus grown from culture, and followed by experiments at the Rockefeller Research has seriously been considered a direct cause. This virus has been isolated from the secretions of the nose and throat, and excretions of the intestinal canal. Therefore, one can readily see how the infection is transmitted by carriers, dust, vermin, and insects. It has been isolated from dust, floor sweepings,³ and lice. Carriers may be persons who are convalescing from an attack. Also such individuals who have never shown any signs of acute illness.⁴

SEASON AND CLIMATE

A disease making its appearance during the early summer months, its highest point reaching during July and August. Although no season is exempt, the epidemics have sprung up during the winter both in the United States and Europe, West Virginia having reported a small epidemic during the months of December, 1916, to January, 1917.

RACE AND SEX

No race is exempt. So far as sex is concerned, it is a question as to males being more frequently attacked than females. Statistics of the past New York epidemic of 1916, has shown a ratio of two to one.

INCUBATION PERIOD

This is regarded as being one to eight days, average three days, although cases have made their appearance after two weeks.

PATHOLOGY

It has been shown and described by research workers of Europe and this country, that the lesions are found in the central nervous system, the brain and spinal cord.⁵ Recent necropsies have shown inflammation of the mesenteric lymph nodes, and congestion of the spleen, the main pathology being localized to the nerve tissue itself, and not to the membranes as in meningitis. Secondly there develops congestion of the membranes of the brain and spinal cord.

SIGNS AND SYMPTOMS

The malady is ushered in by the usual symptoms of an acute infectious disease, such as *fever*, which varies from 101 to 105 degrees, *coryza*, *headache*, *pains* in back of *neck*, *vomiting*, *constipation*, or *diarrhoea*, the forerunner being more common. Associated with these symptoms are irritability, restlessness, pains about the body, drowsiness, the latter not being constant, for the patient can be aroused to talk and take nourish-

ment, but falls off into drowsiness when left alone, and becomes very irritable when disturbed. Hyperesthesia, a very important sign, especially the so-called spinal pain. Later, as the disease progresses, other signs and symptoms make their appearance, such as Kering's and MacEwen's signs. Paralysis of some part of trunk and extremities. There are no eye disturbances at any time as in meningitis. Urinary retention is a frequent symptom.

DIAGNOSIS

During the early onset of the disease, before paralysis has set in, the above mentioned signs and symptoms plus a lumbar puncture justifies the diagnosis.

BLOOD PICTURE

There is a Leucocytosis in all cases averaging from 8,000 to 40,000, with an average of 18,000, while the average Differential, shows

Poly's 55 Per cent.

S. L. 35 “

L. L. 11 “

Eos.—normal

Bas— “

SPINAL FLUID

A spinal puncture should be carried out in every questionable case, and bedside diagnosis from the characteristic appearance of the spinal fluid should be made; by so doing the extent and severity of an epidemic may be reduced or avoided. For the early diagnosis of the disease with the aid of spinal fluid, three bedside tests have proven of value^{6,7}

First sign noticed is the increased amount of pressure as the fluid is obtained on puncture.

Second. This fluid may take on a ground glass or slightly hazy appearance, the haziness being due to the increased amount of cells in the fluid. In a few cases there has been obtained a clear fluid⁸, simulating that of T. B., meningitis. By the aid of artificial light it will be readily demonstrated. There will also be seen floating particles suspended in the fluid. These particles are the lymph cells. Upon the slight shaking of the tubes, the cells will be seen to scatter about in the fluid.

Three—Normal fluid, upon shaking vigorously, will form a foam lasting about one-half hour upon standing, while the foam of the spinal fluid in this disease lasts between one and two hours. The microscope is an invaluable article at the bedside and laboratory. Chemical test demonstrates (1) albumin positive, (2) globulin positive, (3) Fehling's

reduction. The cell count is increased, varies from fifteen per c.m. to fifty or more per c.m., even as high as one thousand per c.m., with a predominance of mono nuclear. Lymphocytes—while at other times the fluid may contain a predominance of polymorpho nuclears. The total amount may be increased.

PROGNOSIS

This is variable, depending upon the variety of the disease, of which there have been named many. The death rate until the last epidemic in New York City has been four to ten per cent., having increased to over twenty-six per cent. during the 1916 epidemic. As to life, depends upon the class of case, and the early recognition. The so-called abortive cases are practically all cured when an early diagnosis is made. while the cases of the other types may be fatal or recover with some type of paralysis. On the whole an early diagnosis is most important in this disease. Unfortunately, this is a very difficult matter, and rests with the physician who is thoroughly acquainted with the disease.

I shall not endeavor to describe the treatment in this article, but will in a more lengthy paper in the near future. This article being a brief resume of infantile paralysis with its signs and symptoms, and means of early diagnosis, arranged for the interest of the physicians and the public, many of whom have unfortunately had difficulties in the recognition of this malady in its early stage, and at the onset of the disease. It is most necessary to recognize the disease at the early onset for two reasons.

First—To administer treatment before paralysis has set in.

Second—To avoid an epidemic by communication.

As for the public, I wish to urge the following: "Clean up and keep clean."

PROPHYLAXIS

Advise parents to call the doctor when the child shows any signs of being sick. Never postpone with the idea that it is only a slight disturbance of indigestion, and that a dose of castor oil will relieve the condition. For it is this mistake which is a grave one, both for the child and the community. With the co-operation of the Board of Health, public epidemics of any type can be avoided. An immediate campaign to clean up homes, yards, and cellars, to rid such places of all vermin, insects, and rodents^o is urged. Let us realize the urgent importance of such campaigns, since we know that all such undesirable conditions play a great role in the transmission of this disease, and not only in *infantile*

paralysis, but all infectious and contagious disease. Uet us not forget that the biting fly¹⁰ has been considered, and is still being discussed as one of the main insects transmitting this malady. Therefore do not fail to screen all windows from such insects, cover foodstuff and milk. Accumulate no garbage. See that the garbage cans are covered, also all vessels containing waste. Bathe your children frequently, every day. Clean the nose, mouth, and throat of your children; see that the bowels are kept open. Scrub your floors frequently, and allow no dust, or dirt to accumulate. When a child takes sick call your doctor. Do *not* wait or postpone for the next day. Do *not* allow children to visit public places unless it is absolutely necessary. Keep your children separated from other children, unless you know absolutely that there is no sickness in the homes of such children. Do *not* keep your children enclosed all day, but send them out to the parks where they can be in good air constantly. It is not necessary to take children to shopping districts, or on trolley cars, unless urgent. Do *not* allow your children to be kissed by anyone, for it is not safe to say that the individual is free from infection or disease. Wash well all fruits and foods that is to be eaten raw. The best means of prevention is cleanliness and strict observation of those rules.

The Public Health is the foundation upon which rests the happiness of the people and the welfare of the nation.

CONCLUSIONS

1. That infantile paralysis is an acute infectious disease transmitted by carriers, and direct contact.
2. That no person is exempt, but children under five years are most susceptible. Attacks both breast and artificial fed babies. Beyond sixteen years of age less susceptible.
3. That the disease is ushered in similar to all acute infectious diseases, with high temperature, except that paralysis of some type may
4. That carriers are those sick with the disease, persons convalescing, missed cases, insects, rats, dust, and other vermin. Although this has not as yet been definitely proven.
5. That there is no special season or climate, although it is more frequent during the warm season.
6. That the disease involves the nervous system, brain, spinal cord, and that the virus has not been found in the blood.
7. That it is a disease which is simple and difficult of a diagnosis, simple in the paralytic stage, and difficult in the abortive stage, but an early diagnosis is of great importance.

8. That a lumbar puncture is a most important procedure, easily done, and invaluable for diagnostic purposes.

9. That owing to the many varieties of carriers, and means of communicability by direct contact, it is of most urgent importance to abide by the mentioned rules.

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THE SIGNIFICANCE OF SYPHILIS IN PRENATAL CARE AND IN THE CAUSATION OF FŒTAL DEATH

BY J. WHITRIDGE WILLIAMS

I THINK that it may safely be said that the propaganda for the development and extension of prenatal care, which has been conducted during the past few years in this country, constitutes one of the most important advances in practical obstetrics; as it has taught us to appreciate the unnecessary wastage of foetal life which has occurred in the past and to consider seriously how it may be diminished.

Unfortunately, this movement is not of medical origin, except in so far as the efforts of the pediatricians to popularize maternal suckling had led to some supervision over pregnant women. Years ago Budin instituted consultations for pregnant women in Paris, and Ballantyne of Edinburgh did important pioneer work concerning the production of foetal abnormalities and insisted upon the benefits which might follow intelligent antenatal care, yet real interest in the prophylactic supervision of pregnant women originated with laymen. Indeed, I do not think that I shall go far wrong when I state that the greatest credit in this respect belongs to Mrs. William Lowell Putnam, who some years ago organized at her own expense in Boston a small service in which women could be supervised during the latter half of pregnancy for the purpose of instruction in the rudiments of the hygiene of pregnancy, of seeing that they were properly nourished and not overworked, of teaching the importance of suckling their children when born, and particularly of preventing the

occurrence of eclampsia by the early recognition and treatment of the toxæmias of pregnancy.

One of the most important agencies in bringing about the reform in this country has been The Association for the Prevention of Infantile Mortality—now the American Child Hygiene Association; for at its meetings each year philanthropic laymen, social workers and trained nurses, as well as occasional medical men, read papers upon the subject and gradually aroused popular interest in it, and it was not until after the movement had attained considerable momentum that obstetricians became generally concerned with it, and even at present many of them still treat the subject in a lukewarm manner.

In its broadest sense, prenatal care may be defined as such supervision of the pregnant woman as will enable her to go through pregnancy safely, to bring forth a normal living child with minimal danger, and to be discharged in such good physical condition as to be able to care for her child efficiently and to suckle it for at least the first months of its life. This means that the women must be under medical supervision from the earliest possible period of pregnancy, so its various abnormalities may be recognized at their inception and treated prophylactically. It also means the application of the best methods of obstetrical diagnosis during the weeks immediately preceding labor, so that abnormal presentations, disproportion due to contracted pelves, as well as other complications may be recognized, and corrected if possible before its onset. It further means the proper conduct of labor, and such supervision during the weeks immediately following it, that the woman may be discharged in such physical condition as to be able to carry on her usual avocations efficiently, and to give her child the necessary care. Finally, it implies medical supervision of the child during the first year of life, so that the effort expended during pregnancy and at the time of labor be not wasted; as it should be realized that the object of pregnancy is to secure a child which will have a reasonable prospect of reaching adult life, and that every preventable foetal or infantile death means biological and economic waste.

It is evidence that such a program requires not only first-rate obstetrical care, but such supervision of the patient before and after delivery by trained nurses and social workers as will make it possible for her to realize the importance of following closely the various regulations laid down for her guidance. In other words, efficient prenatal care must be regarded in great part as a campaign of education for physician and patient, in which both must be taught to realize that ideal obstetrics implies not merely intelligent care at the time of labor, but that it has a

much wider scope and should begin as soon as the woman realizes that she is pregnant and continue until she is discharged in ideal physical condition and suckling a normal child. As the majority of hospital patients belong to the less intelligent classes, it is only by means of education through prenatal workers that they can be induced to make the necessary visits to the dispensary before and after delivery, and consequently I have become convinced that efficient prenatal and postnatal care cannot be carried out by physicians alone, and is feasible only when the requisite number of trained nurses and social workers are available.

In the earlier work, attention was principally concentrated upon three points: (1) The recognition and earliest possible treatment of the toxæmias of pregnancy in the hope of preventing the development of eclampsia; (2) supervision of the general physical and material condition of the patient with the object of diminishing the chances of premature labor; and (3) such instruction during the latter part of pregnancy that the mother will be prepared to suckle her child after it is born. When, however, the subject was taken up by obstetricians, it became apparent that the best results could not be obtained unless the scope of the work were materially widened so as to include everything which is implied by good obstetrics, plus the supervision and instruction derived from nurses and social workers.

Soon after taking up this work, I realized that the recognition and treatment of syphilis early in pregnancy constituted an important and fruitful field for a radical reduction in foetal mortality, and in my presidential address—"Upon the Limitations and Possibilities of Prenatal Care"—before the American Association for the Prevention of Infantile Mortality in 1915, I developed the idea that more lives could be saved along such lines than by any other single method. That address was based upon the critical study of 700 foetal deaths occurring in 10,000 consecutive deliveries in the Obstetrical Service of The Johns Hopkins Hospital, and included not merely the deaths at the time of labor, but also those occurring during the last ten or twelve weeks of pregnancy, as well as those during the two weeks immediately following delivery. Upon analyzing the causes of death, it was found that syphilis was responsible for 26 per cent. of the entire number, and that it caused more deaths than any other single factor, and very many more than the toxæmias of pregnancy, which up to that time had been considered the greatest field for prophylactic effort. Consequently, I concluded that if syphilis could be eliminated from among the causes of foetal death, greater progress in prenatal care would be made than by any other means at present available.

In the 700 cases under consideration the diagnosis was made by the recognition of congenital syphilis in the living child, or from the presence of certain histological changes in the placenta which we had learned to associate with the disease, while in only a relatively small proportion of the cases was it made at autopsy. With the discovery of the Wassermann reaction and the demonstration that the spirochete is the cause of syphilis, our knowledge concerning the disease became greatly widened, so that we were able to diagnosticate it in many mothers and infants in whom it had formerly been overlooked, as well as to demonstrate the syphilitic nature of certain lesions which had previously not been considered as having any relation with that disease.

While preparing my article in 1915, I became convinced that the only way in which the problem could be approached with any hope of effective solution was by determining the Wassermann reaction in every pregnant woman who registered in the Dispensary, and subjecting her to intensive anti-syphilitic treatment whenever it was positive.

This work was begun in April, 1916, and the present paper is based upon the critical study of 302 foetal deaths occurring in 4000 consecutive deliveries between that period and December 31, 1919. In this series every effort was made to elicit a possible history of syphilitic infection and to detect the presence of the clinical signs of the disease; moreover, a Wassermann test was made at the first visit of the patient, and, if a positive result were obtained, she was subjected to proper treatment in the Syphilis Clinic, provided sufficient time was available before delivery. At the conclusion of labor a Wassermann was likewise taken from the foetal blood obtained from the maternal end of the umbilical cord. Every placenta was preserved and examined histologically, and finally, if the child was born dead or died after delivery, every effort was made to obtain an autopsy in order to determine accurately the cause of death, particular attention being given to the recognition of syphilitic lesions and to the demonstration of the presence of spirochetes. Consequently, in each of these 4000 cases we have a careful clinical history of the patient, as well as a record of the maternal Wassermann, of the foetal Wassermann at the time of birth, of the microscopical examination of the placenta, and in case of death of the child a complete autopsy, so that it is apparent that few cases of syphilis could escape recognition. Furthermore, all patients who presented a positive Wassermann were followed up by our social workers, and every effort was made to see that they were appropriately treated. At present we are endeavoring to get back as many patients as possible, who at any time presented signs of syphilis, for the purpose of ascertaining what has happened to them and their

children. Unfortunately, however, this information will not be available for incorporation into this paper, which is based more particularly upon the critical study of the foetal deaths occurring in this series of cases, while the conclusions to be drawn from the Wassermann reaction will be considered in a report to be made to the American Gynecological Society in May.

I think it only fair to preface our study by saying that our material differs from that which may be collected in many other cities by the fact that somewhat more than one-half of our patients were blacks. Thus, in the 4000 cases under consideration, there were 1839 white and 2161 black women, in whom a positive Wassermann reaction was present in 2.48 and 16.29 per cent., respectively. In other words once in every fortieth white, and once in every sixth colored woman. It should, however, be borne in mind that this incidence does not exhaust the possibilities of syphilis, as there were 105 additional women in the series in whom the Wassermann reaction was negative, but in whose histories some mention was made of syphilis. Forty-four of these had presented a positive Wassermann in a previous pregnancy, which had later become negative following efficient treatment, with the result that the present pregnancy ended in the birth of a normal child. On the other hand, in the remaining 61 women, autopsy revealed characteristic lesions and the presence of spirochetes in the foetal tissues, or the live child presented clinical evidence of hereditary syphilis, or the placenta showed characteristic histological lesions.

Of the 302 dead babies 212 came to autopsy. In the former are included not only those dying at the time of labor or during the two weeks immediately following it, but also those dying during pregnancy from the time of viability onward: namely, children weighing between 1500 and 2500 grammes or measuring between 35 and 45 cm. in length. Of the 302 deaths, 99 occurred in white and 203 in black infants, an incidence of 5.4 and 9.4 per cent, respectively; while 157 occurred at the time of labor or during the first two weeks of the puerperium, and 145 were in premature children.

Syphilis was noted in 104 cases, in 89 of which the diagnosis was confirmed by autopsy with the demonstration of spirochetes in the foetal tissues; while in the remainder it was made from the presence of syphilitic lesions in the placenta, associated with a positive Wassermann on the part of the mother. Upon analyzing the causes of death, we obtained the following figures:

	Cases	Percentage
Syphilis	104	34.44
Dystocia	46	15.20
Toxæmia	35	11.55
Prematurity	32	10.59
Cause unknown	26	8.61
Placenta prævia and premature separation	16	5.28
Deformity	11	3.64
Eleven other causes	32	10.69
	<hr/> 302	<hr/> 100.00

Before considering these figures critically, it may be well to say a few words as to how the classification was established, it being understood that the cause of death was determined partly from the autopsy findings and partly from careful study of the clinical history of each case. Thus, in 89 of the 104 syphilitic cases, the cause of death was determined by autopsy, while in the remaining 15 it was based upon clinical findings in the child, or upon the presence of syphilitic lesions in the placenta associated with a positive maternal Wassermann.

Under dystocia are included all deaths resulting from mechanical difficulty or undue delay at the time of labor; as for example, craniotomy, decapitation, birth injuries following operative delivery, prolapse of the cord, undue delay during the second stage incident to disproportion between the size of the child and the pelvis, etc. A certain proportion of such deaths must be attributed to error in judgment on the part of those conducting the delivery, while others were unavoidable. Under the deaths attributed to toxæmia are included not only the children which were born dead during an eclamptic attack, but also the premature live children, which were born spontaneously, or the result of the induction of labor, and could not be raised.

In the category of prematurity, we have included only children whose imperfect state of development appeared to be the sole cause of death. In such cases, no lesions were found at autopsy, and the children appeared to be normal except for their small size. Of course it is possible that a more intensive search for spirochetes might have led to a positive result in a certain number of these cases, particularly when the maternal Wassermann was positive, but, as they were not found, the cause of death was set down as prematurity. Moreover, it should be understood that we have not included in this category premature children born of mothers suffering from toxæmia, placenta prævia or acute infectious diseases, etc., as

under such circumstances death was attributed to the underlying disease, and not to the imperfect development of the child.

Great interest attaches to the 26 cases for which no cause of death could be ascertained. In none of the 14 babies included in this group which came to autopsy could definite lesions be demonstrated; while in the other 12 careful study of the clinical course of labor did not enable us to formulate a satisfactory explanation for the fatal outcome. In several of the autopsy cases, syphilitic lesions could not be demonstrated in the foetal organs nor spirochetes be found, despite the fact that the mothers presented a positive Wassermann or the placenta showed specific changes, so that death could not be attributed to syphilis, no matter what the presumption might be. This group of deaths is of great interest as it affords striking evidence of how little we really know of antenatal pathology, and suggests important possibilities for future research.

It is not necessary to consider in any detail the deaths associated with placenta, as they are clearly the result of the underlying abnormality. Likewise, in the category of deformity, which includes examples of hydroplacenta prævia or with premature separation of the normally implanted cephalus, anencephalus, spina bifida, atresia of the intestinal tract, developmental abnormalities of the heart, etc., the condition originated in the earliest periods of embryonic life, and could not have been prevented by any means at our disposal.

Finally, in the last group are collected 32 deaths, which were attributable to one of eleven different causes, including atelectasis, about which we know nothing, acute infectious diseases of the mother, accidental suffocation, foetal bacteræmia, hæmorrhagic disease, etc. Many of these were clearly unpreventable, while in others our knowledge concerning the underlying cause is so hazy as to make any positive statement inadvisable.

Upon analyzing the figures in the summary given above, it is seen that 89.3 per cent of the deaths are attributable to seven groups of causes, of which syphilis is the most important, as it accounts for 34.44 per cent of the total number, which is almost as high as the mortality for the next three groups combined, as dystocia, toxæmia and prematurity were responsible for 37.34 per cent, or only 3 per cent more than syphilis. Consequently, it is apparent that if it were possible to eradicate syphilis from our material, we should effect as great a reduction in foetal mortality as by doing away with all foetal deaths due to the various accidents at the time of labor, toxæmia, and prematurity combined. This, however, is manifestly out of the question.

As large as these figures seem, they do not entirely represent the ravages of syphilis, since we have already pointed out that it is quite possible that more careful search might have revealed the presence of spirochetes in

the tissues of a considerable fraction of the autopsies in which the cause of death was attributed to prematurity, as well as in a certain number included in the unknown group. Moreover, these figures do not include the cases of congenital syphilis which appeared in babies which were discharged alive, or in whom the disease developed later.

It must be admitted that this unusually large incidence of syphilis can only apply to hospital services with a large black clientele, such as ours, and will not be noted in private practice or in hospitals in communities in which the majority of the inhabitants are white, or in which the colored people are more intelligent than here. Nevertheless, even if we consider only our white patients, syphilis still continues to be a very important cause of foetal death, and this we know by experience can be in great part eliminated. As was indicated above, there were 99 white and 203 black infant deaths in our material, and in them syphilis was the etiological factor in 12.12 and 45.93 per cent. respectively. In other words, one out of every eight of our white babies died from syphilis as compared with every other black baby.

Upon comparing this 12 per cent mortality from syphilis in white infants with the other causes of death, it is seen that it exceeds all other causes except dystocia, and is nearly as great as for that. In other words, while 15.2 per cent of our children died from the various accidents of labor, 12.12 per cent of the white children died from syphilis, so that it is apparent that even in the white race syphilis represents one of the most important causes of foetal death, and is responsible for a greater mortality than toxæmia. Consequently, we should avail ourselves of every method to recognize its existence as early as possible, and then to treat it energetically.

This means that all obstetrical patients should be encouraged to register not later than the third or fourth month of pregnancy, that a routine Wassermann should be made at the first visit, and in case the result is positive, intensive treatment should be started immediately. In the case of the ignorant patient, mere advice to return at stated dates for treatment will not suffice, and it will be necessary for the social worker to follow her to her home and insist upon the necessity of following all directions implicitly. This frequently requires numerous visits, but only in this way can ideal results be obtained. Of course this means the expenditure of a large amount of time on the part of the workers, as well as a considerable financial outlay.

I had hoped to be able to give figures showing a marked contrast between the results obtained in the past when the Wassermann was made only when indicated by the history of the patient and those obtained in the present series in which it constituted a routine procedure. Un-

fortunately, so many elements enter into such a comparison that the tabulations are not convincing, but the following figures will give a graphic idea of what may be accomplished. Of the 4000 women under consideration, 421 presented a positive Wassermann reaction, but unfortunately all of them did not receive ideal treatment. In many instances they registered too late to receive any treatment, while others returned so irregularly that they were imperfectly treated, as for some time we had too few prenatal workers to supervise the patients efficiently, with the result that only a relatively small proportion received ideal treatment. With this in mind we have divided the 421 patients into three groups, namely:

a. No treatment.

b. Inefficient treatment. The patients who received only two or three injections of salvarsan and no after treatment.

c. Satisfactory treatment. The patients received from four to six injections of salvarsan followed by a course of mercurial treatment, with the result that the Wassermann became negative and remained so.

In the three categories there were 157, 103 and 163 patients, respectively, and the results of treatment are graphically shown by the fact that in group *a* 52 per cent of the children were born dead or presented some evidence of syphilis, as compared with 37 per cent in group *b*, and only 7.4 per cent in group *c*. In other words, the evidence at our disposal shows that if syphilis is recognized early in the pregnant woman, and is intensively and appropriately treated, almost ideal results may be obtained so far as the child is concerned. Consequently, there is every reason to hope that in the future syphilis may be practically eradicated as the cause of foetal death in all properly conducted clinics in which the women register prior to the middle of pregnancy.

On the other hand, it must be realized that even with the most perfect mechanism, ideal results will never be obtained, inasmuch as our investigations show that the disease will escape recognition in a certain proportion of pregnant women for the reason that the women frequently exhibit no clinical manifestations and occasionally present a negative Wassermann as well, so that the existence of the disease is not suspected until a macerated child is born and is shown to be syphilitic at autopsy. This, however, should not discourage us, for such occurrences are comparatively rare, and if the course of procedure here outlined is faithfully followed, syphilis can be reduced from the most important cause of foetal death to one of the least frequent.

I hope that you will not think I have been one-sided in presenting the subject as I have, or that my judgment has been warped by our experience in Baltimore. I am well aware that syphilis represents only one

of the causes of foetal death, and that all the others must be taken into consideration in a broad program for the reduction of foetal mortality, but at the present time syphilis appears to offer the most promising field for immediate results. A little thought will make it clear that a considerable proportion of the deaths from dystocia are unavoidable, and until our knowledge concerning the mode of production of eclampsia has become further extended, we must consider that its prophylaxis has almost reached its limit. Likewise, there is no immediate prospect of reducing the mortality from prematurity, as we are almost entirely ignorant concerning the causation of spontaneous premature termination of pregnancy, except when syphilis, toxæmia or gross over-exertion is the underlying factor. Moreover, it must be acknowledged that the foetal death-rate associated with placenta prævia and premature separation of the placenta is susceptible of only very gradual improvement while that due to congenital deformity is at present altogether beyond our control.—*Bulletin Johns Hopkins Hospital*, May, 1920.

PERSONAL AND NEWS ITEMS

Mr. and Mrs. E. C. Whitney, of Ottawa, have given \$100,000 in Victory bonds to the city of Ottawa to be used for the construction of a tuberculosis sanatorium in connection with the City of Ottawa Sanatorium. Mr. Whitney has written to Mayor Fisher to this effect, and includes but one provision, that the city shall be responsible for the upkeep of the institution.

The Belgian Consulate here has been advised that the King of Belgium has appointed Colonel (Dr.) Herbert A. Bruce of Toronto, a Chevalier of the Order of the Crown (Orde de La Couronne), "in recognition of generous services towards Belgium during the war." Col. Bruce was inspector general of Canadian Medical Services in 1916, and afterwards was one of twelve consulting surgeons for the British army.

Dr. J. G. Cunningham has been placed in charge of Industrial Hygiene branch of the Provincial Department of Health.

Charitable bequests of \$500 each were made in the will of the late Alexander Patterson, treasurer of the Masonic Relief Board, to the National Sanitarium and the Hospital for Sick Children.

Dr. John Franklin Campbell, formerly of Toronto, died at his home in Chicago, on July 14. He was a son of the late John Campbell, and is survived by his widow, also a brother, Dr. Colin, and two sisters, Edith and Saroline, of Toronto.

With the opening of the Queen's Medical School in the Fall, a new combined course will be introduced. This course will require seven years. The degree of Bachelor of Arts is to be conferred at the completion of the work of the fifth year of the combined course. For the degree of Doctor of Medicine the student must take, in addition, the fifth and sixth years in the regular course in the medical school. The degrees of B.A. and M.D. may thus be obtained in seven years.

Eight cases of bubonic plague have developed and three victims have died to date at Beaumont, Texas, the State Health Officer announced a few days ago. At Galveston there have been three cases of plague, with two deaths so far, he added. The Health Director declared 20 per cent. of all rats killed at Beaumont were infected with bubonic plague, which he considered a "decidedly heavy rate."

Here is a remarkable illustration of the beneficent effect of lawn bowling on the invalid soldiers. Trooper Hart, of the Davisville Hospital, a victim of shell shock, which seriously interfered with his speech, has been almost completely cured. He was playing against Davey, of Niagara, and in the excitement of the play, his speech suddenly became normal again.

The death occurred a short time ago at Broken Bow, Nebraska, of Mr. Morris who was in his 127th year. He was born at Berren, North Wales, in 1794.

Dr. Alexander Primrose has been chosen as the new Dean of the Faculty of Medicine at the University of Toronto to succeed Dr. C. K. Clarke, who resigned recently. For some time he was professor of clinical surgery at the University, leaving to go overseas with the University Base Hospital with the rank of colonel. From his service with the Base Hospital he was afterward appointed consultant to the Canadian forces in England. His only son, Lieut. H. P. Primrose, a graduate in 1915 from University College, was killed in action in France.

The fourth case of bubonic plague was officially reported at Pensacola, Florida, Henry Hudson, driver for an express company, having caught the disease. Citizens at a mass meeting demanded that the city commission pass an ordinance providing for rat extermination. Mayor Sanders said the ordinance would be enacted as quickly as possible. Word came from the Surgeon-General's office in Washington that unless rats are killed the city would be placed under quarantine.

Dr. Claude R. Woods, son of Mrs. F. H. Clifford, 11 John Street, Brockville, and his wife, well-known residents of Delhi, N.Y., were instantly killed, and their guest, Miss Louise Stanford, Tenafly, N.J., was seriously injured on July 6, when the automobile in which they were

riding was struck by a Delaware and Hudson Railway passenger train at a grade crossing near Unadilla, N.Y., 18 miles south-west of Utica.

A suspected victim of bubonic plague died recently in Tampico, according to despatches received the other day from that city by several of the Mexico City newspapers.

Every effort is being made by the Government to combat the bubonic plague at Vera Cruz. Orders have been issued making sanitary authorities there the supreme power in the city, dominating even military officers. Twenty-five cases, most of which have proved fatal, have been reported since the outbreak.

Dr. W. J. Johnston wishes to announce the removal of his office from 154 Carlton St. to 29 Wellesley St., Toronto, where he will confine his practice to the treatment of genito-urinary conditions, especially venereal diseases, having recently completed three years special work in military general hospitals.

Mayor Eden of Kitchener, has been notified by the Military Hospitals Commission that the city will be expected to take over the Freeport Military Hospital by December 1st next. The institution was fitted up early in the war as a tuberculosis hospital by the city, but during the second year of the war it was turned over to the Government authorities for the accommodation of tubercular patients returning from the war. The accommodation was considerably increased, and during the last year, between 50 and 60 returned men have been accommodated. It is proposed by the Military Commission to remove the soldiers to some of the larger and permanent hospitals in the province. Mayor Eden is of the opinion that after the institution is taken over by the city, it should be turned into an Isolation Hospital for the County. Since the Government took it over, about \$70,000 has been expended in improvements.

Following are the officers elected recently by the Canadian Public Health Association: President, Dr. Amyot, deputy minister of public health department, Ottawa; Secretary, Dr. H. D. Defries, Toronto; Treasurer, Dr. Fred Adams, Winnipeg.

Masses of peony blossoms, pink and white roses, with here and there bowls of white daisies, decorated the auditorium of the West End Y.M.C.A. The building was packed to the doors with guests for the third annual graduation exercises of the Women's College Hospital. Owing to the unsettled weather it was impossible to hold these commencement exercises on the lawn of the Nurses' residence, 149 Rusholme Road, as had been originally intended. The diplomas were presented to the

seven graduating nurses by Lady Eaton, the address being given by Dr. B. P. Watson, who is one of the consulting staff of the hospital.

There is some talk at the Toronto City Hall of selecting a site for the new isolation hospital may be located somewhere along Danforth Avenue.

The officers elected for the Toronto Branch of the Canadian National Council for Mental Hygiene are: Hon. President, Prof. P. Sandiford; President, Canon Plumtre; Vice-Presidents, Rev. Father Minnehan and Dr. Margaret Paaterson; Secretary, Dr. Eric Clarke; Treasurer, Dr. T. R. Robinson; Sites Committee, Mrs. J. B. Laidlaw; Policy, Dr. E. A. Bott; Membership, Mrs. A. M. Huestis; Publicity, Miss L. Brookling; Laws, Mr. W. D. Gwynne; Finance, Mrs. W. B. Meikle. Judge Mott, Dr. G. Anderson and Miss Mann were elected members of the General Committee.

The voters of Galt defeated, a short time ago, the by-law to raise \$30,000 for the purpose of enlarging the hospital and creating a nurses' home.

At a recent meeting of the Simcoe County Council it was decided to have the public schools medically inspected.

A deputation from North York waited upon York County Council recently, urging that the Pickering College, which has been a military hospital, remain as a hospital under civilian control. The matter is to come up again. It was estimated that \$40,000 would equip the building as a hospital.

An action was brought against Drs. Lapp and Wilkins in the Cooberg Assizes for \$10,000 for negligence in setting a fracture. Mr. Justice Logie dismissed the action without costs.

OBITUARY

C. DAY CLARK, M.D.

Dr. C. Day Clark, F.R.C.P.S., died at the Private Pavilion, General Hospital, Toronto, on July 15th, following an operation. The deceased, who was born in Odessa, Ont., 57 years ago, had been prominent in fraternal circles for many years, having been physician for the Independent Order of Foresters for the last two decades. He was a graduate of Queen's University, Kingston, and following the completion of his course there studied for three years in England. Upon returning to Canada he had a private practice until he accepted office with the Foresters. He was also a member of the Masonic Order. He is

survived by his widow and one son, Norman. The funeral service was held at his late residence, 121 Bernard Avenue, and interment took place at Kingston.

J. T. S. HALLIDAY, M.D.

The remains of the late Dr. J. T. S. Halliday, of Peterboro, were laid to rest in Little Lake Cemetery, on July 6th, following a public service at St. John's Church and a private service held at his late residence. The pall bearers were all fellow practitioners, Dr. G. S. Cameron, Dr. F. C. Neil, Dr. D. Carmichael, Dr. A. Moir, Dr. A. W. McPherson and Dr. N. D. Buchanan.

R. M. MASON, M.D.

Dr. R. M. Mason, ex-M.P.P., of North Victoria, died at his home in Fenelon Falls on July 5th. Although suffering for some time past, he was able to walk down town on July 2nd. The late R. M. Mason was born in Adjala Township, Simcoe County, and practised at Mono Mills; but for twenty-five years had been a resident of Fenelon Falls. He occupied various positions of trust, including membership on school board, town council and county council, was a Mason, Oddfellow and Orangeman. He represented North Victoria for the Conservatives for eight years, being defeated at the last provincial election in the U.F.O. landslide by Rev. Edgar Watson of Fenelon Falls.

JAMES McDERMOTT, M.D.

The entire community of Sunderland turned out to pay its last respects to the late Dr. James McDermott, who had passed away after a short illness. Dr. McDermott was born in the Township of Tecumseh, in the County of Simcoe, in 1845. A son of the late Neil McDermott, one of the pioneer residents of the county, Dr. McDermott graduated in medicine in the year 1870, and immediately began the practice of his profession at Sunderland, until his death, he continued to attend to his arduous profession even up to the Sunday morning, which was the beginning of his last illness. He leaves to mourn his loss, besides his widow, three children, Mrs. R. J. Carson, Orillia, Mrs. E. Blanchard, Brantford, four grandchildren and one brother, Mr. William McDermott, of Beeton.

MAJOR-GENERAL W. S. GORGAS, M.D.

British appreciation of the services rendered humanity by the late Major-General William C. Gorgas, former surgeon-general of the United

States army, was evidenced by unusual honors paid Friday, July 9th, when funeral services for the deceased general was held in St. Paul's. The arrangements were at first under the auspices of the Royal Society of Medicine, but were taken over by the government, under supervision of the Health Minister, Dr. Christopher Addison.

General J. C. Steele had charge of the military escort, consisting of the 2nd Grenadiers and staff, three squadrons and of the 2nd Life Guards, the 3rd battalion of the Coldstream Guards, the 1st battalion of the Irish Guards, and the Coldstream Guards' bands. The 2nd Life Guards' Band was stationed in the Cathedral. The King was represented by Sir John Goodwin, his surgeon, and a number of British and other military and naval officers and diplomatic representatives attended the services.

BOOK REVIEWS

HUMAN PHYSIOLOGY

The Principals of Human Physiology by Ernest H. Starling, C.M.G., F.R.S. M.D., Sc. D., F.R.C.P., Jodrell Professor of Physiology in University College, London. The Chapter on the Sense Organs, revised and rewritten by H. Hartridge, M.A., M.D., Cantab. Third Edition with 597 illustrations, 10 in color. Philadelphia: Lea and Fibiger, 70-710 Sansam Street, 1920; Price, in cloth, \$7.50.

In upwards of thirteen hundred pages, the authors, and especially Prof. Starling, tells the story of the physiology of man. The first edition appeared in 1912, and now we have before us the third edition. This is a full and complete statement of what is known regarding human physiology by an outstanding authority. Professor Starling has left nothing undone to make this an unusually valuable work. His reputation as a writer and investigator on this subject of medical science is well known. In addition to his vast knowledge upon all physiological questions, the author possesses a specially clear and lucid style of exposition, a very valuable asset in the preparation of such a book. We can state that every organ and function of the body receive due attention; and the matter throughout is reliable and exhaustive. The illustrations are numerous and of superior merit. They assist greatly in bringing out the meaning of the author. The publishers have produced a beautiful volume and are entitled to a full measure of praise. The paper is of a very fine grade, the typography is clear, and the binding is such as to make the volume a very attractive one in every way. For anyone to be able to say, "I have studied Starling's Physiology" is proof that he has read one of the latest and best books on physiology.

DERMATOLOGY

A text book of Dermatology by J. Darier, Physician to the Hospital Saint-Louis, member of the Academy of Medicine, Paris, France; Honorary Member of the American Dermatological Association, etc. Authorized translation from the second French edition, edited with notes, by S. Pollitzer, New York, ex-President of the American Dermatological Association, Corresponding member of the French Society of Dermatology Syphilography, etc. Illustrated with 204 engravings and 4 colored plates. Lea and Febiger, Philadelphia and New York, 1920; Price, in cloth, \$8.50.

Dr. Darier has long been known as an authority on diseases of the skin. This edition brings one's knowledge of these diseases well up to date. The translation has been very well done by Dr. Pollitzer. The author avoids any attempt at a classification of skin diseases, and proceeds at once to take up the various skin diseases. The book is written with the object of making the study of Dermatology as simple and useful as possible. The illustrations are well selected and well executed. They *do* illustrate. In carefully looking into the contents of this volume we arrive at the conclusion that it is a very helpful one, and one that can be recommended to the medical profession. Anyone who studies its pages and becomes familiar with the illustrations will experience but little difficulty in the diagnosis of skin diseases. The author gives a carefully thought out line of treatment for all cases. The book is a handsome one, and will prove a most useful addition to any medical library.

DISEASES OF INTESTINAL TRACT

Diseases of the Intestines and Lower Alimentary Tract by Anthony Bassler, M.D., Professor of Gastro-enterology, Fordham University Medical College and New York Polyclinic Medical School and Hospital, etc. Illustrated with 184 text engravings and 62 full-page half-tone plates, with over 70 figures, some in colors. Philadelphia: F. A. Davis Company, Publishers, English Depot, Stanley Phillips, London, 1920: Price, \$7.00 net.

Every medical practitioner will admit that diseases of the intestines and lower alimentary tract are very common, and very troublesome. They are difficult of diagnosis and often very resistant to treatment. Naturally one turns to a work on the diseases of these organs with considerable interest, hoping to find new light to guide him in the management of his patients suffering from intestinal maladies. In the first place we note that the ground is very fully covered, and that no subject is omitted that should find a place. In the next place we note with pleasure the great care that is given to the making of a diagnosis of the many affections discussed. During recent years much progress has been made in this regard, and the most modern methods are here set forth. The treatment is sound and rational, and will yield the best results obtainable if properly

followed out. The mechanical features of the book are all that one could desire. The paper, press work, and binding go to make up an attractive volume. We can very cordially recommend this work to our readers.

PATHOGENIC MICROORGANISMS

Pathogenic Microorganisms, a practical manual for Students, Physicians, and Health Officers, by William Hallock Park, M.D., Professor of Bacteriology and Hygiene, University and Bellevue Hospital Medical College, and Director of the Bureau of Laboratories of the Department of Health, New York City; and Anna Wessels Williams, M.D., Assistant Director of the Bureau of Laboratories of the Department of Health; Consulting Pathologist to the New York Infirmary for Women and Children; assisted by Charles Krumwiede, Jr., M.D., Assistant Director of the Bureau of Laboratories; Assistant Professor of Bacteriology and Hygiene in the University and Bellevue Hospital and Medical College, New York City. Seventh edition, enlarged and thoroughly revised, with 214 engravings and 9 full-page plates. Lea and Febiger, Philadelphia and New York, 1920; Price, in cloth, \$6.00.

This book needs no introduction now, as it has become a well-known and familiar friend. The subject matter of this book is well arranged, and in such form as to be readily available for reference. The joint authors of the present edition are specialists of high standing, and well qualified to lay before the medical profession the latest views and best methods on bacteriology. The work throughout is of highly practical character, and of the utmost value as an aid to the clinician in the working out of a correct diagnosis. There are few medical books that can be recommended with more genuine confidence and pleasure than this one. Everything about it tends to render it an indispensable companion to all who are called upon to consider the relationship of bacteria to disease, and how to detect their presence. i

GENITO-URINARY DISEASES

Transactions of the American Association of Genito-Urinary Surgeons, Thirty-first annual meeting held at Hotel Dennis, Atlantic City, N.J., June 16th and 17th, 1919. Vol XII. Published for the Association by Williams and Wilkins Company, Baltimore, Maryland.

This volume of the transactions of American Genito-Urinary Surgeons is up to the standard of former annual reports, which is high praise. The papers cover a wide range of subjects, and are from the hands of eminent specialists. Such transactions are placing within the reach of the medical profession the best that is to be had, and are excellent guides for all to follow. We hope this volume may have many readers, as mankind will gain thereby.

DIAGNOSIS OF DISEASES

Symptoms in the Diagnosis of Disease by Robart Amory Hare, M.D., B.Sc., Professor of Therapeutics and Diagnosis in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital; one-time Clinical Professor of Diseases of Children in the University of Pennsylvania, etc. Eighth edition, thoroughly revised. Illustrated with 195 engravings and plates. Lea and Febizer, Philadelphia and New York, 1920. Price, \$6.00.

There are few more useful or readable medical books on the market than Prof. Hare's *Diagnosis of Disease*. It is not too lengthy and it is very accurate and scientific. The various regions and organs of the body are taken up one by one, and the symptomatology of disease affecting each examined and explained. This work is now in its eighth edition, a fact which should be a guarantee of its worth, and that it has been appreciated by a steadily growing number of readers. We have, in the past, had the pleasure of reviewing this book, and the words of praise then spoken can now be repeated with the feeling that each edition adds something new and useful. The author is a keen student of medical literature, and has enjoyed great opportunities for clinical observation! and this taken with a very lucid style renders his studies on *Diagnosis of Disease* of special merit. We also commend the publishers share in the make-up of the book. Nothing has been omitted to make the work a thoroughly useful one.

OCULAR THERAPEUTICS

By Dr. Georges Robert, formerly assistant in the National Clinic, and Scholar of the Pasteur Institute. Masson and Co., Library of the Academy of Medicine, 120 Boulevard, Saint Germain, Paris, 1920; Price, 6 Francs.

Here we have a small but useful manual on ocular therapeutics. The book contains much useful information on the treatment of eye diseases. Throughout its pages there are many formulas for prescriptions for the various conditions discussed. This is a great help, especially to younger practitioners, who are anxious to know what older and experienced members of the profession would suggest. This little book meets a want, and meets it very well.

CLINICAL PATHOLOGY

A Laboratory Syllabus of Clinical Pathology by Charles E. Simon, B.A., M.D., Professor of Clinical Pathology in the School of Medicine and the College of Physicians and Surgeons of the University of Maryland, Baltimore, Md. Lea and Febiger, Philadelphia and New York, 1919; Price, \$2.00.

This is a practical guide to the best methods to employ in the laboratory in the making of examinations of stomach contents, the blood, the urine, spinal fluid, etc. The directions for the carrying out of the technique are very minutely given, and so clearly stated that there need be no

confusion on the part of the student. The book is bound with a blank page for notes with each page of text. In this small volume the laboratory worker will find a first class guide.

DIABETIC MANUAL

A Diabetic Manual for the mutual use of Doctor and Patient, by Elliott P. Joslin, M.D., Assistant Professor of Medicine, Harvard Medical School; Consulting Physician, Boston City Hospital; Collaborator of the Nutrition Laboratory of the Carnegie Institution of Washington, in Boston; formerly Lieutenant Colonel, M.C., U.S. Army. Illustrated, second edition, thoroughly revised. Lea and Fibiger, Philadelphia and New York, 1919; Price, \$1.75.

Dr. Joslin is so well known as an authority on diabètes that his work is accepted without question. The present edition of his small book on diabetes gives the fullest instructions on the feeding and management of this class of patients. All that need be said is to urge that every physician secure a copy and study it carefully.

ONTARIO MEDICAL ASSOCIATION

REPORT OF COMMITTEE ON MENTAL HYGIENE.

Mr. President and Members:

Judging from my own experience in general practice I feel that it is quite as necessary for the average practitioner to be familiar with the manifestations of mental diseases as it is necessary for him to be familiar with infectious diseases. He will have as many of one class to manage as of the other and the careful management of the mental class of cases will produce as much happiness and prevent as much misery as will the careful management of the exanthemata. One feels, of course, that any effective campaign to widen a practitioner's knowledge should have as a basis the clinical observation of numbers of cases properly classified and intelligently presented. It is questionable whether adequate provision is being made for the clinical instruction of Undergraduates throughout the Province. No doubt, eventually, the National Committee for Mental Hygiene may stimulate an interest in this subject, particularly among laymen, but the need for awakening the public conscience is not quite so great as the need for awakening the sense of responsibility in the minds of those charged with the instruction of future medical practitioners.

With respect to the graduate body, it seems possible to reach them partly by general meetings of special associations, such as the Medico-Psychological, partly by the inclusion in the programmes of existing associations, of papers and discussions dealing with mental diseases and also in an appreciable measure by the distribution of well prepared

articles in the Hospital Bulletin. The meetings of a special association are unlikely to have much value unless there is a good attendance. In my opinion, therefore, it would be wise either to have a section of the Ontario Medical Association dealing with this subject or to have the annual meetings of the Association coincide in time and place with the Ontario Medical Association. Of these two alternatives I would prefer the former. To carry such a plan through would require a good deal of time and thought by interested people. One important factor in this connection, and one which applies to the publication of the Bulletin, is the need for medical officers to undertake special studies and record their findings. All medical officers do not possess this ability and few have the opportunity because of the demands made upon their time by the routine work involved in care and treatment.

Now that the war is over it is to be hoped that the Legislative Assembly of the Province of Ontario will make liberal provision for the expansion in numbers of Ontario Hospital physicians and for a remuneration so proportioned to the economic trend of the times that conscientious, thinking graduates will be attracted to the service."

Your Committee have (by permission of the writer) placed this quotation from a letter addressed to Dr. Harvey Clare, one of the members of this Committee, by Lieut.-Col. C. S. McVicar, O.C. of the Dominion Orthopaedic Hospital, Toronto, at the head of this report, because it is an admirable statement of the present situation and contains valuable suggestions, which the Committee desire to recommend to the members of the Ontario Medical Association for attention and necessary action.

The foundations of proper Mental Hygiene must be laid very early. The healthy little baby who is allowed and encouraged to sleep at least twenty-two hours out of the twenty-four, who is nursed by the mother at regular intervals and not oftener than every four hours, whose day passes quietly by—as regularly and quietly as the earth turns round on its axis, has made a good beginning. With a happy, loving, serene, sensible mother, who has good self-control and is not easily upset, and understands the profession of motherhood and home-making, the development of the baby's mind proceeds favorably. The baby should be allowed to amuse and discover himself and all his fingers and toes and other permanent equipment. But he should not be left alone too much, nor ever frightened, and especially not kept awake at night, even to please father or the rich uncle.

The growing child should never be excited, or overwhelmed by the powers of a grown-up person. Plenty of sleep is essential to the building of a good nervous system.

Children should be left to struggle with their own little difficulties. They like to try things as much as we do, and that is Nature's way to make them strong in mind and body.

Above all, children should learn self-control. To tumble down and be encouraged, not to be frightened but to treat the fall as a joke, adds to the happiness of a child. They should know that their parents possess self-control and are equal to the difficulties of life and that they want their children to be as happy as they themselves are in these possessions. Moods and tempers and passions can usually be averted. It takes two to make a quarrel, and usually temper and passions are really quarrels between parents and children. Obedience and self-control are habits which every child must learn for himself.

Kipling has a good study of Mental Hygiene, beginning:

"If you can keep your head when all around you
Are losing theirs and blaming it on you"

and ending:

"If you can fill the unforgiving minute
With sixty seconds' worth of distance won,
Yours is the Earth and everything that's in it,
And, what is more, you'll be a man, my son."

The homicidal insanity of King Saul, subject to fits of depression, never able to learn how to obey, is a great contrast to the heroism of Job, who met the terrible disaster of life like a man, and said:

"Naked came I out of my mother's womb, and naked shall I return thither. The Lord gave and the Lord has taken away, blessed be the name of the Lord."

The mental and spiritual strength of the British people is a great asset in war and peace. We must strive to send it on unimpaired to the younger generation.

The first principle of Mental Hygiene then is the formation of good mental habits and a fine character and personality in childhood. A normal nervous system is one that is equal to the difficulties of life.

The late Charles Mercier once stated that the causes of all mental disorders are two—heredity and stress. Here then we have two further principles of Mental Hygiene.

The importance of proper parenthood cannot be over-estimated. The right to life and happiness is one thing and the right to parenthood is another.

If a mentally defective man or woman is to all intents and purposes only nine or ten years old, is he or she to be allowed to pollute the stream of national life by bringing into the world mentally-defective children?

If the heredity of a man or woman shows hereditary insanity, is he or she to be allowed to bring into the world children who are to bear the terrible brand and burden of mental disease?

Every effort should and must be made to educate public opinion, amend the marriage laws, and impress on all citizens the fact that it is wrong to permit children to be brought into the world when it is known that they cannot have a fair chance on account of the dreadful handicap of hereditary mental defect or mental disease. Every individual case must be judged on its merits and by the best medical expert advice. Not all insanity is hereditary.

Secondly, Stress: "The slings and arrows of outrageous fortune," as Shakespeare calls them—shocks and insults that the nervous system of man was never meant to bear, especially when repeated and long-continued, are undoubtedly offences against mental hygiene. The stress may be of the cell or of the psyche.

Recent experiments by Professor Waller, which show that certain speech where emotion is involved actually produces metabolic changes in the cells, while other speech does not produce such changes, are interesting as showing that perhaps stress of mental emotion may produce insanity as surely as certain toxic conditions do.

Psychologists seem to fall broadly into two classes—the idealists who look upon the nervous system as the instrument of spirit, and the biologists who "subject the intellect to mechanistic forces."

Whichever we believe, there can be no divergence of opinion that once we have discovered which way madness lies we had better make a right-about-turn away from it. It is well known that solitary confinement, or long continued life at lonely outposts with no companionship, or enforced idleness, or deprivation of human rights, whether of the head or the heart, or starvation of natural desires all have an unhygienic effect upon the mind.

There are certain things that are known as the necessities of life, meaning air, water, food, clothing and shelter. There are certain necessities of the life of the mind and no human being should be deprived of these.

The publication in January, 1920, of the report of Mr. Justice Hodgins on Mental Defect and Mental Defectiveness in Ontario, affords the profession and the public an opportunity to study profitably an excellent account of the conditions of this very grave problem of Mental Hygiene in this Province and how it should be remedied and that NOW. The report contains the latest expert information and your Committee earnestly recommends any member of the Ontario Medical Association who

may not have seen a copy of this report to write at once to the Honourable the Provincial Secretary, Parliament Buildings, Toronto, asking for a copy, so that he may possess himself of the valuable information contained in this report.

Further, your Committee believe that the provision of better facilities for the treatment of incipient mental disease is a great national duty and would draw attention to the communication on this subject from British experts in Mental Disease, which appeared in the London *Times* of February 6th, 1920, and also to the leading article in the same issue of that paper. Under date of February 21, 1920, *The Hospital* states as follows: "Treatment of Incipient Mental Disease."

"A GREAT NATIONAL DUTY.

"To urge reform in our methods of dealing with early mental disorder would seem to labor the obvious. The most elementary thinker must long have realized the hopelessness of our system. Unfortunates who fail to conform to the common mental type have hitherto been left to struggle alone at the mercy of chance surroundings. Even though the sufferer desires advice and treatment, he has had nowhere to turn for expert guidance—unless he would risk the stigma of 'insanity' or 'lunacy.' By the time he has qualified for admission to the recognized institutions his case has usually become too desperate for hope of cure. Before the War this policy, representing uneducated public opinion countenanced by governments devoid of scientific outlook, was distinctly cruel and uneconomical; it was also suicidal and therefore there is now a chance of focusing public opinion upon it.

THE REVISION RECOMMENDED.

The Medico-Physiological Association of Great Britain and Ireland has recommended revision of our methods of treating incipient mental disease and the provision of opportunity for study and research. The early symptoms of disorder long before certification is possible, at a time when the need for well-considered treatment is obviously urgent, as it is only then likely to be successful. On the other hand facilities for skilled treatment at this early stage have been deplorably few.

For this state of affairs an ignorant public is to blame for stigmatizing the mentally afflicted in whatsoever category or degree, as almost culpably beyond the plea—an opinion which has been regretably supported by the official attitude.

A short Amending Bill to the Lunacy Act would provide for treatment in the early or curable stages of mental disorder without certification, by embodying the reforms most urgently needed. The proposals

outlined by the sub-committee of the Medico-Psychological Association, are, in brief, as follows: "The provision of clinics—the so-called psychiatric clinics—in large centres of population, and especially in connection with the general hospitals and where schools of medicine exist; the extension of the system of voluntary admission (which now obtains in respect of licensed houses and registered hospitals for the insane), so that patients whether of the private or rate aided class may place themselves for treatment in county borough mental hospitals; or further provision for the private patient class, so that with the approval of the Board of Control, such may be received without certification (but with the cognizance of the central authority) into homes privately owned or supported wholly or partly by voluntarily contributions, and also into existing public and private hospitals ('licensed houses'); also received, with the sanction of the board, as single patients, without certification, provided that a medical practitioner gives a written recommendation, stating that suitable treatment can be obtained in the proposed house.

"Of the above proposals, that concerned with the establishment of clinics in psychiatry—with in-patient and out-patient departments—as integral parts of the general hospital system is the most important; and in the operation of these clinics lies our main hope of avoiding the never-ending extensions to existing asylums."

MEANS ALREADY AT HAND.

Several clinics of this nature were already in existence before the War and have done excellent work in the direction of treatment, teaching and research. Indirectly the War has been instrumental in establishing others; but they have been insufficient to cope with its added burden. Incidentally, the war has served to make it clear, even to the most unscientific observer, that mental disorder is not entirely due to inherent defect or to "weakness of will"—and one cannot over emphasize the importance of the public attitude in this matter. During the war, moreover, soldiers were received and treated in mental hospitals without orders or certificates for at least nine months before being sent to an asylum. This procedure had such tremendous advantages as to demonstrate incontrovertibly the desirability of applying a similar system to civil life.

Though the reforms outlined have been repeatedly urged and presumably recognized by the government there is no tangible evidence that any step has been taken to put them into practice. Truly, as the *Times* leader states, "a point has been reached where legislation falls behind scientific understanding." Legislation always will fall behind; but we may at least expect of our legislators to keep in sight.

We would add one note of warning: "Scientific understanding"

should be represented by those alone who are qualified to express its judgments. Nowadays the number of psychological amateurs within and without the medical professional, is legion. At a time when a united front is essential their fruitless controversies over and over again confuse the issue.

Your Committee would call attention to the good work done by the Provincial Association for the Care and Training of Mental Defectives, and of the Canadian National Committee on Mental Hygiene, and also to the organization of the Medico-Psychological Association of Ontario, and would commend these three organizations to the favorable consideration and support of the Medical Association.

Finally, your Committee would draw attention to the great importance of the Education of Public Opinion about the work of Mental Hospitals.

The time is at hand for a great advance in the care and treatment of patients suffering from mental diseases. Public opinion demands it, the medical profession have long felt that such an advance is not only possible and desirable but imperative if any adequate consideration is given to the matter from the standpoint of the best interests of the patient, the public and the profession.

If this advance is to take place the first step is to take the public into our confidence and tell them what is needed, and why. Before we do this we must reform our own ranks and look to our own weapons for the campaign of education. We must be fully persuaded in our minds. If we are to arouse enthusiasm in others, we must possess it ourselves, and if we are to show others the way we must first make the new road ourselves.

First of all, then, what can be done to raise the status of our Mental Hospitals in the estimation of the community? Let us take as an illustration the Nursing Department. A great deal has been done in the past to improve the status and work of this Department. The course of study, the examinations, the award of certificates to the successful candidates, the payment of probationers and nurses, all established some years ago, were great steps in advance and a corresponding advantage has been gained by the Mental Hospitals.

Among the Nursing Sisters who went overseas on the strength of No. 16 Canadian General Ontario Military Hospital at Orpington we are told that none did better work than the nurses from the Training Schools of the Ontario Mental Hospitals. Of course, the credit of that good work is not all to be given to the Training Schools any more than the glory of mighty deeds of valour and endurance of our heroes in the Can-

adian Expeditionary Force is to be given to the Department of Militia and Defence. Personality and patriotism were the soul of these deeds and that good work, though without training, knowledge and discipline the deed and the work could not have been done.

The duty of the hour is now to reorganize the curriculum of the Training Schools and bring it up to date, to put into force a real scheme of affiliation with the General Hospitals, to improve the staff of Lecturers and Teachers and bring the examination work up to a better standard, pay more attention to it, take more trouble with it, and generally make the results more satisfactory. None of these things can be done until we place at the head of the Training Schools for Nurses in the Mental Hospitals of Ontario as Superintendents of such Training Schools, those who are real leaders in the nursing profession, in whom the pupil nurses can have confidence and to whom they can look up, those who can make the young nurses feel happy in their work and confident that they are learning more every day and that their work really counts. The demobilization of the Matrons and Nursing Sisters from overseas, now almost accomplished, affords a remarkable opportunity for finding women who could take charge of such work and who are capable of organizing and carrying out the work of a Training School to which any nurse might be proud to belong, and whose names would be a guarantee to the public and to the authorities, as well as to the probationer, that any application sent to such a Superintendent of Nurses would be carefully considered and, if accepted, would guarantee to the young nurse adequate professional preparation, comfortable and suitable living arrangements and a reasonable prospect of success and usefulness in her nursing career.

Secondly: the medical student should get some chance to understand the fascinating interest and wonderful opportunities awaiting the general practitioner who has some real knowledge of nervous and mental disease. The average medical student fights shy of this part of his work. He thinks "an asylum" (as he generally calls it, but should never be allowed to call it) a most unpleasant place to go to. He does not know how *reasonable* those who are supposed to have "lost their reason" are, if we can only get their point of view. He does not know that the mighty tree of mental disease has sprung often enough from the tiny seed of some bad mental habit or peculiarity, very much like his own bad mental habits or peculiarities, which has been allowed to grow and grow till the bad habit is master. He never guesses that the most brilliant results in modern medicine so far may likely be surpassed in his own time by the triumphs yet to be won in the field of mental disease. Psychiatrists should never be satisfied until their lectures are the most popular and interesting of the whole Medical Course. In this connection

the following is quoted from the report of Dr. Ernest W. Jones, Inspector-General of the Insane, Melbourne, Victoria, Australia:

"Such training should be given by means of a unit in each of the larger teaching hospitals, which should include an out-patient clinic, as well as wards for the treatment of early cases of mental disorders, to be conducted by experienced specialists, who should be appointed as members of the ordinary hospital medical staff. These wards are not to be confounded with the refractory and isolation wards commonly in use in each large general hospital, but they are to be wards wherein the border-line cases, i.e., hysteria, neurasthenia and psychasthenia, are to be admitted and treated alongside mild and quiet and recent cases of genuine mental disorder. Such departments, called Psychiatric Clinics, are to be found in other countries, and the work done in them has proved to be of the very highest importance and value to the community. They become the centre in teaching in neurology and psychiatry, of post-graduate work, and of research in these subjects, and by their aid the knowledge and treatment of insanity is brought from the back of beyond into everyday association with the treatment of bodily disorders. In the correct elucidation of the cases coming to him in this clinic, the alienist physician has the assistance of the surgeon, the gynaecologist, the pathologist, and all the usual specialists at present to be found on the staff of a large hospital, and it follows that in turn his advice is sought by the other specialists."

In the third place we should probably have "Out-door Clinics" for patients who are "nervous" as people call it, and whether these are begun at our Mental Hospitals or our General Hospitals, or whether the two co-operate and have one "Out-door Clinic" at the General Hospital, which would be the best of all, there is no doubt that in any case these "Out-door Clinics" would do a great deal to educate public opinion.

In the fourth place, "After-Care" or "Family Care" is essential. It is the social re-establishment of former mental patients who have really recovered and are not a danger to themselves or anyone else,—(A recent tragedy in New York City is a stern warning against the crime of discharging patients who have not safely recovered, and, most of all, without any further supervision or skilled care). In suitable cases the re-establishment of cured patients in the community is the best of all means of educating the public as to our work and incidentally it saves money.

The Mental After-Care Association of England now cares for 1,074 patients. The Annual Meeting of the Mental After-Care Association was held on March 10th at the Clothworkers' Hall, E. C., under the Presidency of the Master of the Company, Mr. Walter Mews, who emphasized the

importance of the task of finding suitable work for poor persons convalescent or recovered after treatment in institutions for the insane. The report, read by Dr. Percy Smith, showed considerable increase in the number of "Cottage Homes", and efforts are made to provide those capable of employment with situations within their scope under sympathetic employers; in many cases it is necessary to extend, sometimes for years, kindly supervision and advice with a view of preventing relapse.

Your Committee respectfully submits this inadequate Report on a most important subject, hoping that it may stimulate discussion and necessary action.

HELEN MacMURCHY

REPORT OF THE COMMITTEE ON THE VENEREAL PROBLEM.

Mr. President and Members:—

Your Committee request that the following resolution be presented at the Annual Meeting.

"Be it resolved that this Association put itself on record as endorsing the action of the Provincial Board of Health in its appreciation of the seriousness of Venereal Diseases, and in its programme in combating and treating these diseases. This said programme includes:

1. Establishment of clinics for the diagnosis and treatment in various centres.
2. General education of the public through the distribution of literature and the active co-operation of the Canadian National Council for Combating Venereal Diseases, which constitutes the voluntary part of the Government's plan throughout Canada.
3. Furthermore, the Association pledges itself to co-operate to the fullest extent in order that this programme may be effectively carried out."

Provided such resolution is carried, your Committee further request that the necessary steps be taken in order to place this resolution in the hands of the proper authorities.

CHAS. H. HAIR.

REPORT OF THE COMMITTEE ON THE RETURNED SOLDIER PROBLEM.

Mr. President and Members:

Your Committee desires to submit the following report:

That whereas certain regulations have been adopted by the Department of the Soldiers' Civil Re-Establishment in regard to the treatment of returned soldiers, the following resolution be approved of by the

Ontario Medical Association and transmitted to the authorities of the Department concerned:

"That the regulations of the Department of the Soldiers' Civil Re-Establishment dealing with men for one year after discharge be strictly adhered to, with reference to free medical treatment, as failure to do this may result in an injustice to regular medical practitioners throughout the Province, and further, that discharged men be notified by the Government when the period for free treatment has ceased."

Of course it is understood that this resolution is not in any way applicable to continued treatment for men suffering from a definite war disability, but is applicable to ailments arising after a discharged man has entered civil life, such ailments being in no particular attributable to war service.

It has been brought to the attention of this Committee that Canadian Army Medical Officers having served in the Imperial forces and later having returned to the service of the C. E. F. have had deducted from their war service gratuity an amount equivalent to all bonuses received from the Imperial Army. Your Committee feels that in adjusting such gratuities the difference in rates of pay in the two services, the absence of Separation Allowance in the Imperial Service, etc., should be taken into consideration, and that Canadian Army Medical men whose service was not entirely with the Canadian Forces should receive the same treatment as would have been accorded them had their services been entirely in the Canadian Expeditionary Forces. Your Committee further desires to point out that during the past year the emoluments of Army Medical Corps Officers serving in Canada have been considerably higher than those for similar services being rendered in England, and desires to raise the point why the increased rate of pay should not be applicable to the officers serving abroad.

All of which is respectfully submitted.

G. STANLEY RYERSON.

REPORT OF COMMITTEE, ON THE LIQUOR PROBLEM.

Mr. President and Members:

The Province of Ontario in 1916 enacted as a war-time measure the Ontario Temperance Act. Since then it has been perpetuated by an overwhelming majority.

In reality the people declared for the abolition of alcoholic liquor as a beverage and accepted the Act as a means to that end. Our concern, therefore, is not with the purpose behind the law, for that is apparently

fixed, but with the Act itself. Is it the most effective law that can be devised to carry out the heavy burden which it entails on them.

As the Ontario Temperance Act stands at present it says in effect to physicians:—

In order that the law may be properly observed, we place on you the responsibility without remuneration, of being the custodians of large quantities of liquor. You must discriminate between those of your friends and patients who need and those who simply want it. Of course if you take the path of least resistance you will be the gainer financially. If you do your full duty you will make enemies and lose patronage. While we have put you in this difficult position, we do not entirely trust you, and therefore we require that you shall treat lightly your professional vows and disclose the nature of the trouble from which your patient is suffering, when you prescribe liquor.

Your Committee believe that a law which demands such a service from one section of the community is faulty in principle. But is there any other way by which people may obtain liquor for medicinal purposes without defeating the object behind the Act? Your Committee have not been able to answer this question definitely, but ask that the members of the Ontario Medical Association during the next few months, consider carefully the feasibility of placing the responsibility of liquor ordering upon the people themselves. To put the question in more practical form: Would it be advisable to strike out the portions of the Act relating to the sale of liquor by vendors on medical prescriptions (Sec. 51, subsections a, b, c), and to substitute the following:

1. Any adult may obtain a quantity of liquor not exceeding one quart from a vendor not oftener than once a year, on making an affidavit that it will be used only for medicinal purposes, and that no other member of his or her family residing under the same roof, has procured liquor from a vendor during the preceding year.

2. In order to provide for those cases in which a larger quantity of liquor is required in any one year, the Board of Commissioners shall employ regularly an appointed medical officer to make personal investigation in such cases and issue orders if he sees fit.

In the meantime your committee recommend that the Government be asked to make the following changes in the Act:

1. Elimination of the statement on the prescription form as to the nature of the patient's disease.

2. The making it obligatory for all Druggists to carry in stock whiskey and brandy in original six-ounce packages.

G. S. YOUNG.

MISCELLANEOUS

LICENTIATES OF ONTARIO COLLEGE OF PHYSICIANS AND SURGEONS

The list of those who passed the examinations of the College of Physicians and Surgeons in June, 1920, is as follows: John P. Anderson, Wilsonville; Cyril Douglas Archer, Kingston; Harold Grover Armstrong, Brussels; Harold Edward Baker, Elmvale; Gordon L. Bell, 110 Spencer Avenue, Toronto; Nathan J. Bicknell, 103 Rose Avenue, Toronto; James Gordon Boyes, London; H. Stanley Brown, Cornwall; Gordon Campbell Cameron, 65 Hilton Avenue, Toronto; Walter Bethune Carruthers, Sarnia; Earl Bingham Clouse, 384 Bloor Street West, Toronto; William David Stanley Cross, Gravenhurst; William Allan Dafoe, Madoc; Charles Scott Dickson, Niagara Falls, Ont.; William Beattie Dickson, Niagara Falls, Ont.; John Franklin Docherty, Seaforth; Thomas Fraser Draper, Kingston; George Hardy Eagles, Owen Sound; George Harold Ettinger, Kingston; Harold Ferguson, Uxbridge; Charles Wolseley Ferrill, Cobden; Charles Patrick Fitzpatrick, Napanee; William Fulton Gillespie, Edmonton, Alta.; Omer Grenville Hague, 158 Borden Street, Toronto; Robert Carr Hall, Toronto General Hospital; H. William Hendry, 86 Amelia Street, Toronto; William Ernest Henry, Markdale; Walter Piper Hogarth, Fort William; Percy Lyle Irvine, Drayton; George Stanley Jeffrey, Caledonia; William Ealing Johnston, 162 Pearson Ave., Toronto; Faustina A. Kelly, Sudbury; Roy Clifton Kingswood, London; George Lionel Dent Kennedy, Ottawa; William Daniel Lanspeary, Windsor; Stanley Francis Leavine, Elgin; Joseph Albert LeMay, Ottawa; Henry Lipsett, 258 Simcoe Street, Toronto; Harold Smith Little, Ridgetown; Frank Percival Lloyd, 34 Tennis Crescent, Toronto; Frederick Alexander Logan, Niagara Falls; Edward Ignatius Loughlin, London; Duncan Marrison Masson, 112 St. Vincent Street, Toronto; Wallace Russell Matthews, London; Janet Rodger McClure, 32 Kendal Avenue, Toronto; Bernard William A. McDougall, London; Peter Douglas McIntosh, 16 Walker Avenue, Toronto; Alexander Lynn McKay, 13 Prince Arthur Avenue, Toronto; John Grant MacLeod, Dunvegan; Elford John Nelson, Guelph; Harold Ira Palmer, Brantford; Arthur Podnos, 119 Grange Avenue, Toronto; William Gayner Powell, Stratford; Melville Anderson Platt, London; DeWillet Stanley Puffer, 49 Grenadier Road, Toronto; Loudon Corsan Reid, Toronto General Hospital; Roland Pitman Reynolds, London; Fred Rittinger, Kitchener; Frederick Charles Robbins, 56 Tranby Street, Toronto; James Winfield Rush, 55 Dupont Street, Toronto; Norman Hodgins Russell, 26 Kendal Avenue, Toronto; Eugene Harold Shannon, 649 Bathurst Street, Toronto; Percy Lawson

Smith, St. Lawrence State Hospital, Ogdensburg, N.Y.; Ervin Lockwood Stone, Kingston; Clifford Etheridge Taylor, Cobalt; Henry D. Taylor, 51 Redwood Avenue, Toronto; W. Earle Throop, Frankville; William C. Tweedie, Rockland; George Theodore Urquhart, West Owen Sound; Lloyd Egerton Verity, Brantford; Wilfrid Parsons Warner, St. Thomas; William Edwin Weekes, Wardsville; Howard Henry Willis, 153 Pacific Avenue, Toronto; David Bruce Wilson, 12 Webster Avenue, Toronto; Percival Thomas Henry Wythe, Hamilton; George Todd Zumstein, St. Catharines; Winfield Holmes Miller, Batavia, N.Y.; Malcolm J. Gibson, Hamilton.

LICENTIATES OF THE MEDICAL COUNCIL OF CANADA

Dr. R. W. Powell, Ottawa, registrar, and Dr. R. Ferguson, London, chairman of the board of examiners of the Medical Council of Canada, announce that the following candidates—44 in number, arranged alphabetically—have successfully passed the examinations held in June in Toronto, Winnipeg and Vancouver, and will be registered on the Canada Medical Register. This gives the qualification for license in every province of Canada:

A. E. Alden, Shawinigan Falls, Que.; D. Black, Victoria, B.C.; D. F. Busted Rochester, Minn.; W. N. Campbell, Calgary, Alta.; G. D. Chown, Dubuc, Sask.; G. B. Cross, St. John's Nfld.; W. A. Dafoe, Madoc, Ont.; C. S. Dickson and W. B. Dickson, Niagara Falls, Ont.; W. A. Dobson, Vancouver; F. J. Donnelly, St. John, N.B.; M. S. Driver, Vancouver; C. M. Eaton, Truro, N.S.; F. D. Facey, Millet, Alta.; K. C. Forsyth, Ottawa; A. F. Gillis, Merritt, B. C.; J. E. Harvey, Kelowna, B.C.; G. L. Hodgins and W. E. Johnston, Toronto; G. D. Little, Montreal; G. Lowry, Carp, Ont.; E. Lozinsky, Montreal; F. L. Letts, Glanworth, Ont.; W. M. Keys, Toronto; A. C. MacMillan, Avonmore, Ont.; Dorothy Miller, Scotland; L. A. Miller, Edmonton; W. Morrish, Sceptre, Sask.; R. C. McCullough, Vancouver; A. L. McDonald, Sylvan Lake, Alta.; P. D. McIntosh, Toronto; J. R. W. Nicholson, Winnipeg; G. Upham, Miocene, B.C.; W. F. N. Rodin, Winnipeg; K. F. Rogers, Toronto; E. E. Rogers, Vancouver; P. H. Salmond, Regina, Sask.; L. E. Saurriol, Lancaster, Ont.; Marger Stauffer, Winnipeg; A. Upham, Minocene, B.C.; W. P. Warner, St. Thomas, Ont.; J. A. West, England; C. F. Wright, Smooth Rock Falls, Ont.; E. R. Ziegler, Vancouver, B. C.

ONTARIO HEALTH FIGURES

During the month of June Ontario was swept by a severe epidemic of measles, according to the figures issued by the Provincial Health Department. Only in one month in the last twenty years has there been a

greater number of cases of measles reported. That was in March, 1916. The number of cases reported for June was 3,613. However, while the number of cases was great, the number of deaths from the disease was less than in the month of May. The deaths in June numbered 22, while in May there were 46 deaths.

Smallpox is again on the increase according to the figures. In June there were 349 cases reported, as against 290 in May and 305 in April. No deaths occurred in June from this disease. Diphtheria and scarlet fever both show an increase.

Cases and deaths of communicable diseases reported by local Boards of Health for the month of June, 1920, follow:

	Cases	Deaths
Smallpox	349	0
Scarlet fever	371	12
Diphtheria	342	45
Measles	3,613	22
Whooping Cough	151	15
Typhoid fever	31	12
Tuberculosis	220	184
Infantile Paralysis	2	1
Cerebro-Spinal Meningitis	9
Influenza	39	29
Influenzal Pneumonia	10
Acute Primary Pneumonia	260
	5,118	599

Venereal Diseases reported by Medical Officers of Health for June: Syphilis, 1869; gonorrhoea, 183; chancroid, 4. Total, 356. There were three deaths from syphilis.

HEALTH CONDITIONS ABROAD

Dr. Royal S. Copeland, president of the Board of Health of New York City, has returned from the International Health Conference in Brussels, impressed with the grave view the European health outlook presents to the world.

"There is typhus in Poland, cholera in the Balkans, smallpox in Italy and plague in the Mediterranean ports," he said. "Now there is to be a Moslem pilgrimage to Mecca and Medina in the middle of July, which will constitute a new peril as a possible cholera and plague carrier. The only effective international health authority in Europe is the British, which has an international branch under a most capable chief.

TORONTO'S HEALTH

The June report issued by the medical health officer shows that measles are very prevalent in the city. Following is a comparative statement:

	June, 1920.	May, 1920.	June, 1919.
Diphtheria	142	151	105
Scarlet fever	108	130	111
Typhoid	8	1	4
Measles	1188	1040	8
Smallpox	29	27	1
Tuberculosis	37	71	63
Chickenpox	100	63	127
Whooping cough	39	27	54
Mumps	77	177	113
Diphtheria carriers	57	37	14

Pneumonia is much less prevalent. There were 10 cases of pneumonia reported in May and 38 cases in the month just closed.

CARE OF THE FEEBLE-MINDED IN WESTERN CANADA

Speaking of the work done on the recent survey carried out by the Canadian National Council for Mental Hygiene in Western Canada, Dr. C. K. Clarke, at the annual meeting of the Toronto branch of the Ontario Association for the Feeble-minded, held in the board room of the Toronto General Hospital, lauded the West for the advances it had made in providing for the care and education of the feeble-minded. Dr. Clarke spoke of investigations made in all the Western provinces but referred especially to the educational work being done in British Columbia and Saskatchewan. Reports of the past year's activities of the Toronto Branch were read and adopted and officers were elected for the coming year.

In referring to British Columbia, Dr. Clarke mentioned the special classes for defective children in Vancouver where they already have fifteen established. He dwelt at length on the institution known as the Boys' Village, where children who are unable to attend the ordinary schools are to be sent to be educated. On a site of 1,300 acres beautiful wooded and with every facility for educational purposes, building is being pushed rapidly ahead and several units will be occupied soon. Living quarters are so arranged as to provide accommodation for fifty children in each unit and meals are served at a central dining hall. There are also administrative buildings and amusement centres in addition to a gymnasium. The Village does its own dairying and has one of the finest herds of dairy cattle on the continent.

A new model school which is to serve as a model for all the schools in the Province of Saskatchewan has been erected at Aurora, Sask. The school is equipped with modern sanitary and heating apparatus. The doctor also mentioned the establishment of several psychopathic hospitals, including two in Winnipeg.

MEDICAL FACULTY, TORONTO

The following appointments to the Faculty of Medicine and Connaught Antitoxin Laboratories of the Toronto University were handed out by the Bursar recently. About one hundred more appointments are to be made to other faculties. They will be announced later.

Clinicians—Drs. R. G. Armour, G. F. Boyer, W. R. Campbell, A. W. Canfield, A. H. Caulfield, F. A. Clarkson, H. K. Detweiler, J. H. Elliott, A. A. Fletcher, A. M. Goulding, N. Gwyn, B. Hannah, G. W. Howland, H. S. Hutchinson, R. Jamieson, N. M. Keith, J. D. Loudon, D. McGillivray, A. J. Mackenzie, A. G. McPhedran, J. H. McPhedran, F. S. Minns, E. A. Morgan, L. Murray, W. Ogden, J. A. Oille, T. J. Page, H. C. Parsons, G. Pirie, F. W. Rolph, C. Sheard, jr., D. K. Smith, G. E. Smith, H. Spohn, G. S. Strathy, E. J. Trow and G. S. Young.

Dr. G. W. Lougheed, demonstrator clinical microscopy; Dr. A. B. Moffatt, assistant clinical microscopy.

Pediatrics—Miss A. Courtney, chemist; Miss I. MacLachan, assistant chemist, and Miss G. Boyd, research fellow.

Connaught Antitoxin Laboratories—Dr. R. D. Defries, associate director in charge of antitoxin division; Dr. A. H. W. Caulfield, part-time research associate; Miss L. Hanna, research assistant.

HYGIENE OF THE FEET

Owing to the demands of modern civilization, and to the fact that it is nearly always covered in a leather casing, the human foot has been rendered weak and delicate. In an interesting paper upon the subject, published in the *Lancet* Dr. F. Johnson compares the foot of the desert-dwelling Arab with that of a city artisan, very much to the detriment of the latter.

The free and easy movements of all the joints of the foot, unimpeded by any stiff covering, together with the influence of light and air, account for the perfect shape and physiological efficiency of the Arab's foot. His circulation is so good that he hardly feels the cold of the mountain-side.

The evils of the high heel and the pointed shoe, in the case of women, are not confined to the feet, but influence the whole system through the disinclination to take sufficient exercise that naturally follows.

CORPS ORDERS

BY MAJOR-GENERAL G. LA F. FOSTER, C.B., ACTING DIRECTOR-GENERAL OF
MEDICAL SERVICES

226 Special Order Ottawa, Ont June 28, 1920

Major-General J. T. Fotheringham, C.M.G., upon retiring from the duties of Director-General of Medical Services, desires to take leave of all Officers, Nursing Sisters and other Ranks of the Medical Services, both those who are still serving and those who have been demobilized but who have at any time served under him.

He is deeply sensible of the constant loyalty and high efficiency of the Service as a whole, both Overseas and in Canada; and of his indebtedness as Officer Administering the Service in Canada to the personnel as a whole.

The memories of the Great War, with its priceless opportunities for serving King and Empire and Native Land, will remain an inalienable asset to us all, and particularly the good-will shown by the Service and the Profession generally, to those who have been carrying the heavy burdens of responsibility for policy and administration, both at this Headquarters and in the Districts.

R. E. SNELL,
Colonel, A.D.M.S. for a D.M.S.

PROHIBITION THAT DOES NOT PROHIBIT.

A few weeks since the report went out that the alcoholic ward at Bellevue Hospital was to be closed for lack of patients, that the Municipal Lodging House was practically vacant, and that the number of "alcoholics" in the city hospitals has been diminished to one-fifth or one-third their former number. Bird S. Coler, Commissioner of Public Welfare, now asserts that the wards are not only not empty, but that the number of patients is increasing and that many of these persons are in a serious condition owing to the fact that they are getting much worse liquor than when the traffic was regulated. He threatens to send out inspectors if there is no better enforcement of the prohibition within the next thirty days. It is notorious that any one wanting a drink of whiskey in that city can get it without difficulty if he has the price; but a sick person who may need alcohol to save his life is allowed only one pint in the course of ten days, or an ounce and a half a day.