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WESTERN CANADA MEDICAL JOURNAL

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ORIGINAL COMMUNICATIONS.

*PATIENTS SUITABLE FOR SANATORIUM TREATMENT

BY

R. W. IRVING, M.D.

KAMLOOPS, B.C.

Medical Superintendent Tranquille Sanatorium.

The success of the work of Sanatoriums depends to a very large degree upon the diagnostic work of the attending physician, and in no disease is early diagnosis more difficult and confusing.

THE OBJECTS OF THE SANATORIUM TREATMENT :

(1) The removal of the patient from fresh invasions by the tubercule bacillus from the first implantation, and from all influences leading to the introduction of fresh bacilli from outside.

(2) The establishment in the patient of a process of repair.

(3) The development of the highest powers of natural resistance.

To accomplish such an end the instruments at our disposal are :

(a) Fresh air—continuous.

(b) Free and abundant access to sunlight.

*Read before the British Columbia Medical Association, 1908,

(c) Regulated rest.
(d) Regulated exercise.
(e) Good wholesome food.
(f) Hygienic life.
(g) Medication as indicated.

So long as Sanatorium treatment does not hold out any specific as its cure for the trouble, it seeks to encourage the natural powers of the system to cope with disease. It is then, to a large extent, upon the natural resistance of the system that we look for our basis from which to draw all conclusions as to prognosis.

It must be admitted that we cannot lay down hard and fast rules in the selection of cases, for every case must be the subject of serious study and consideration. Those who are too cautious as well as those who are too hasty will find that they have made many mistakes. Some of the incipient cases and most hopeful rapidly pass downward. This may be due to the unfortunate complication of hemorrhage, pneumonia, pleurisy, extension of tubercular process, or an implantation of a mixed infection. Likewise some of the more advanced and least hopeful cases, in those of good resistance where fibrosis goes on rapidly, become quickly arrested, and are very satisfactory cases with which to be associated.

A case presenting itself for diagnosis of symptoms however slight, of a more or less obscure nature, is always deserving of careful examination to exclude or confirm tuberculosis in its various forms. Since early diagnosis is the secret of success in handling cases of pulmonary involvement, it becomes necessary to investigate all symptoms with care and close application.

The Family History.—This should be gone into carefully to gather the vitality of the ancestors, their tendencies and natural resistance. It is always justifiable to be suspicious of pulmonary trouble more readily developed in those with tubercular history than in those with a perfect history. It cannot, however, bear too much weight in reaching a conclusion for it is surprising how few cases—not more than 30 per cent.—have any definite history of tubercular ancestors, while such a large proportion give a perfect history. It frequently happens that a patient will endeavor to hide from the examining physician many points that to his mind

might suggest a tubercular heredity : The old suggestion of decline in one of middle age, of a long typhoid of some months' standing, of repeated colds, etc., is long exploded, and is at once placed as tubercular. The history however, of parents being very subject to pneumonia of a fatal type is suggestive of poor pulmonary resistance, and in a case with a temperature of 100-102, it might be confused with broncho-pneumonia of a patchy type. The history on both paternal and maternal sides of the house should be carefully investigated.

Personal History.—To gain a full grasp of the resistance the patient possesses, it is necessary to take the history from childhood through puberty to early adult life. The various diseases of the exanthematous type should not be overlooked. In some cases the tubercular infection seems to be primary, and somestimes secondary to the exanthemata. Frankel states "the incidence of tuberculosis of the lung in connection with measles, whooping cough, etc., must be construed as an extension of tubercle already present ; the bacillus being already established in the lung or invading it from the bronchial glands under the softening influence of acute infection." Especially true is this that the persistent cough after measles is often a typical case of incipient tuberculosis.

In such general diseases as typhoid, followed by a persistent temperature with general malaise and some chest signs T. B. is probably a factor to consider. A history of syphilis, diabetes and chronic alcoholism is a very poor prognosis, and in all cases Sanatorium treatment if adopted should be with a view of more or less experimentation.

In patients whose convalescence from other diseases has been unduly prolonged and tedious, it is safe to conclude that the natural powers of repair are rather poor. In those where the history of other diseases reveals tuberculous glands, bones, skin, throat, fistula in ano, etc., with only an apparent arrest of the trouble by surgical means or otherwise, it is quite probable that the lung infection will be of a most persistent and unsatisfactory type.

The habits of life, as to alcohol, tobacco, and venery have a bearing upon the recuperative powers of the system. In the case of a tobacco throat infected with T. B., it becomes a stubborn

case for treatment. Those cases of nicotine excess giving the symptoms of general nerve irritation, rapid heart, optic neuritis, etc., usually prove to be slow in the early part of the treatment. The nervous irritation, together with the restlessness from the change of habit, makes it difficult for the patient to contentedly adopt the "rest treatment."

The History of the Onset of the Tubercular Trouble.—No disease can assume so many different modes of attack. It is one of the most insidious of foes, advancing during darkness and making its attack from many unsuspected quarters. The bacillus may lie dormant for years, to be lighted up in a smouldering form, or as a sharp attack. Turban states "that like the seed on stony ground, the tubercle bacillus can persist in a viable condition in an insusceptible host. We may picture the development of T. B. as occurring at the moment when certain weakening influences, which we recognize as predisposing causes, come into play in the human economy. In one case we may assume that many years elapse between the inception of the bacillus and the breaking down of the prophylactic mechanism ; in the other that the bacillus finds a suitable soil from the moment of its invasion, and T. B. develops at once, it may be in the glands or in the lungs. This conception reconciles the contending views of heredity, foetal infection, and contagion, and affords an explanation of every several theory."

To secure the best results in the treatment of Tuberculosis, the fundamental principle is early diagnosis. Many of the physicians in charge of Sanatoriums claim that 75 per cent. of the incipient cases of T. B. eventually get well under properly regulated life. In this, experience goes to show that they are right. It, therefore, becomes the duty of the attending physician to make the diagnosis early, be positive and decided when dealing with the patient, and insist that all suggestions are carried out. This is no idle task, for at this stage of the trouble the patient and patient's friends refuse to believe that such a condition is possible. Arguments as to family history, the previous physical condition of the patient, the appearance of the patient, are advanced, and frequently another opinion is sought. Should this agree with what they would like to believe, they are only too ready to accept him in future.

The clinical picture of early tuberculosis is an interesting one, and it often happens, symptoms due to other organs occupy the foreground. Two extremes are noted—one class of cases in which long before the appearance of bacilli or elastic fibres in the sputum, a series of symptoms of ill-health will be noted, these not pointing definitely to T. B. The other extreme is that class of cases in which the characteristic signs are all lighted up at once and a fully developed disease appears. In between these comes a large class of cases in which only one or two of the signs are present. In taking into consideration the general condition, attention should be given to blood formation, circulation, digestion, and the nervous system. These patients begin to look pale, or at least show a change of color, are easily tired, both mentally and physically, become easily excited, are irritable, have no appetite, or an actual repugnance to food, bowels become irregular, and there is a progressive loss of weight. A chlorotic condition is usually noted, and in young adults, especially females, it becomes a matter of consideration to decide if it is primary or secondary. Papillion mentions the fact that a chlorotic condition with a low blood pressure is very suggestive of T. B.

The circulation is always more or less disturbed in early tuberculosis. This at first is indicated as an irritable weakness of the heart and of vasomotor system (Turban). The pulse is either persistently rapid or very irregular, rising from 70-80 to 100-120, on the slightest mental or bodily excitement. This condition may be recognized by the patient, or may not. If noted by the patient, he complains of palpitation, shortness of breath, oppression or distress over the upper thorax. Should there be a rise in temperature, the pulse rate is raised higher in proportion. The vaso—motor system becomes very excitable—the patient flushes up when spoken to, complains of a hot head or burning face after food or excitement. They frequently note themselves that they sweat very easily, and during examination the axillary perspiration becomes most marked, dripping in many cases from the elbows. This condition is due to tubercular intoxication, which condition is also responsible for lack of energy and the digestive disturbances. The tachycardia is always a bad prognostic sign, showing a weak antitoxin formation upon the part of the system —an instability. But in taking tachycardia into consideration, it is always well to modify it somewhat by racial temperament.

While pain is not usually regarded as of any particular diagnostic value, unless the involvement is located in the pleura, there are many cases in which the patient complains of a dull boring or stabbing pain in the shoulder, following down the arm, or radiating around the chest. This often leads to a diagnosis of rheumatism, myalgia, intercostal neuralgia.

The expectoration may follow the dry hacking cough of early T. B. only after months or years. The quantity of sputum as well as the character depends upon the degree to which alveoli and tubes are involved.

Haemoptysis in early tuberculosis may be simply streaks and spots of blood, in which case the origin is analogous to that of croupous pneumonia. In many cases these are followed by sputum in which no bacilli are found. In the cases of larger quantities, the sputum is more likely to contain bacilli, and usher in the stages of "open" tuberculosis. In many cases of early T. B. the haemoptysis is a very fortunate occurrence, since it directs the patient's attention to the actual condition of affairs and the absolute need of care.

The presence or absence of bacilli in the sputum has much weight with the general public, and while no examination is complete without a sputum examination as confirmatory evidence, yet the absence of bacilli does not exclude very active tubercular trouble. A negative examination of several specimens taken at the same time is very unreliable. The specimens should be had at intervals, and at least six to ten examinations should be made of such before any positive opinion as to the absence of bacilli can be arrived at.

In making the chest examination, the patient should be placed opposite a bright window, so that the light falls upon both sides evenly. Inspection is never satisfactory with a sidelight. It is needless to say that the thorax should be completely bared. No chest examination can be considered satisfactory when hampered by clothing however light. The sitting posture is usually the more convenient and satisfactory.

Careful inspection of the patient will reveal much that has an important bearing upon the case. Note should be made of the color of lips and mucus membrane to detect the signs of anaemia. It has been frequently noted that a reflex dilatation of the pupil

occurs on the affected side. The character of the skin—if of the clear type with well-marked capillaries and venules, and their prominence. In many cases these are more marked in tubercular than in non-tubercular cases. Particularly are they noted on each side of the manubrium sterni and over the lower ribs on both sides of the ensiform cartilage. They are also found behind in the region of the 7th cervial and upper dorsal vertebrae.

There is often to be noted an enlargement of the thyroid gland in early T. B., which is also likely reflex in its origin.

The shape of the chest, the type of breathing, and its depth also require attention, also any unilateral contraction of the lung leading to an altered relation of thorax and abdomen.

The narrow thorax of great length, narrow width with wide intercostal spaces, prominent clavicles with depressions above and below, a long slender neck, poor muscular development, with a markedly thin layer of fat, serves to outline a typical phthisical chest. Upon deep inspiration a lagging or delayed expansion will give a suggestion as to the area affected. It may at the end of inspiration reach the same degree of expansion as the opposite side, but the lagging is almost a certain sign of involvement of the pleura or lungs. If such a condition of lagging be noted at the apex, it is almost a certain sign of lung involvment, since the pleura over this area is seldom affected. Should the lagging be over the whole side, the case may be one of an extensively involved pleura, or of an extensive lung involvment. Should the case present lagging in the apex of one side and the base of the other, it is probably one of lung involvement in the first location and pleuritic thickening in the other.

Example.—Mr. J., aged 42, had first been examined by two leading Toronto physicians for a policy for $10,000 in a large Life Insurance Co., and had been passed. He had a slight cough at the time, but of practically no moment. However, he consulted a throat specialist and little was learned as to his condition. The next day he had a haemorrhage, after which bacilli were found in his sputum, and he was sent to a Sanatorium. His physical condition on admission was excellent. No fever, no increase of pulse, and upon the closest physical examination no adventitious sounds could be found. No evidence of consolidations or congestions, and the only possible sign to be made out was a lag-

ging of the whole right lower base. The physicians who passed him had an opportunity of looking him over very carefully again, and beyond the lagging, found nothing. After six months' care he left the institution, and was engaged in sailing an exciting yacht race when he had another small haemorrhage, and was again examined, when some dry crepitations were noted over the same area. Since then he has remained well. But the chief physical sign was always the lagging over the involved area.

As the disease advances, contractions are likely to be noted over these areas, due to secondary fibrosis. The area becomes flattened, but the expansion in point of time is equal to that of the opposite side. This may go on to such an extent that the whole side becomes flattened, and a narrowing of the intercostal spaces takes place. The degree to which this may go on depends upon the elasticity of the chest wall and the age of the patient. When these contractions involve the left side, pulsation is frequently noted in the intercostal spaces. The normal apex beat may give place to a diffuse systolic shock, extending over two or three intercostal spaces. The heart, not being fixed by pleural or pericardial adhesions, is drawn upward, or outward and upward, and the apex beat may be noted in any situation from the nipple line to the axillary line. Retraction of the lung may allow the pulmonary artery to give pulsation near the sternum in the first left space. While marked contraction of the right lung does occur frequently, the left lung shows this sign more frequently, owing to the ease with which the "lungula" coverlying the heart can be engaged in this phenomena. In cases of some standing, compensatory hypertrophy manifests itself by an enlargement of the side, a widening of the intercostal spaces and an exaggerated expansion.

For percussion diagnosis, various forms of instruments have been invented, but for general work, finger percussion proves most satisfactory. It requires a little practice and perseverance, but when once proficient in the matter, it proves to be the best method, since the tactile sensations assist in cases of slight dulness. The character of the percussion stroke has much to do with the results obtained. In all ordinary percussion it should be light and be carried on during shallow breathing. For the more delicate sounds, the slightest stroke possible that has any acoustic

properties gives the best idea of the area of the consolidation. It is self-evident that heavy percussion produces a greater shock, as well as affecting underlying organs. But in the majority of cases the tendency is to percuss too heavily. The patient should sit erect, and the head be held medium erect, and the examination of the chest should commence above the clavicles and proceed systematically downward until the lower border is reached, taking note of each intercostal space and following a definite comparison of each side at the same spot measured from the median line. There also should be a careful examination made by percussion well up into both axillae.

To percuss the back, the patient's head should be well bent forward, arms folded across the chest, or with the palms of the hands resting upon the shoulders. Thus the scapulas are relaxed, and a considerable space is presented for examination.

In early tuberculosis the change of pitch is more noted upon percussion than the change of intensity. The changes of note in tuberculosis are similar to that of croupous pneumonia, the former requiring months for the change to take place, while the latter takes days. Often in the same case the note will change as the case goes on to recovery, the intensity becoming more marked as the contracting stage proceeds with its consequent increase of connective tissue. Strips of dulness are often overlooked at the lower edge of the lung. These are more frequently noted behind, and may be due to pleural thickening or to exudate.

In auscultation the first symptoms of early tuberculosis is rough breathing. It is distinguished from vesicular breathing in that it appears to be a rapid series of sounds in succession. It is more frequently heard over the apices, clavicles and the spine of the scapula. It is rarely heard over the lower lobes.

Should rough breathing become more exaggerated it gives rise to the form called "cog-wheel" respiration. Most authors claim that this is caused by "valvular swellings of the mucous membrane or an increase in secretions which must be displaced by one side of the air stream." (Sahli).

In following a case of progressive tuberculosis going on to softening there may be heard in the course of weeks, months or years various adventitious sounds depending upon the state of the lung tissue. These are first fine crepitations, then fine rales,

followed by medium, soft rales, and lastly coarse rales. The same sequence can be observed in a pneumonia when the stages are covered in a few days.

To produce the best diagnostic results in early T. B., cough plays an important part. The deep inspiration may give evidence of no trouble which can be made prominent by a cough followed by a deep breath. Some observers go so far as to state that the anterior median borders of the lungs can be satisfactorily examined in this manner only. The cough will frequently bring forth a fusillade of sounds that are practically unnoticed before.

In some cases the sounds make the examination difficult because of the confusion with rales and friction sounds. This happens where the stethoscope does not fit properly to the chest or where much hair is found. Moistening the hair with a soapy solution will overcome the latter difficulty. Due consideration must be given to muscle sounds especially over the trapezius and the fascia of the muscles of the back. The auscultation of voice sounds does not add much to the diagnostic materials, as the case is well advanced before these are recognized. So far as whispering voice is concerned in an early case it adds nothing of diagnostic value. So long as early diagnosis plays such an important part in treatment of pulmonary tuberculosis it will be seen that only the most careful consideration of a doubtful case can prove of service to the patient. To diagnose a case when the patient is already aware of chest trouble or is even suspicious of the same is too late to prove of much permanent value. To diagnose early and to tell the patient the time that it will likely require to produce permanent results will probably meet with a strenuous opposition on his part.

In deciding to send a patient away for Sanatorium treatment, consideration must be given to the distance to be travelled, and to the condition of the patient. Travel in ill-ventilated trains, with the nervous strain and physical exertion entailed in many cases does the patient much harm. Other things being equal, it is always wise to have them take the shortest trip possible. If a long journey is decided upon, it should always be taken in easy stages, avoiding as much as possible night trips in heated cars. Should a patient be just recovering from a haemorrhage, a period of not less than two to three weeks of absolute rest should

elapse before starting upon the journey. Temperature cases of above 100, afternoon or evening elevation, do better to remain in bed at home, or in a general hospital until the temperature shows signs of subsiding, and the patient is well rested. Many cases arrive at a Sanatorium with a moderately low temperature that starts to creep up slowly after the second or third day when reaction sets in. This is largely caused by the strain of the journey, and might be avoided by a few weeks' rest in bed at home before starting. A recent haemorrhage case is much more exposed to tubercular pneumonia by travelling shortly after the accident, than in the course of a few weeks.

After the examination of the patient, and a definite decision is reached in the mind of the attending physician that the case is clearly one of T. B., it becomes his painful duty to inform his patient of the exact condition of affairs. This is rather unpleasant, since to the lay mind such a decision comes as a severe blow. But to be honest and just, it is the first consideration in the mind of the conscientious practitioner. To make light of such a condition is most dangerous for the patient, and will in the course of time cause the patient to criticize most severely the misjudged kindness of the physician. No patient ever forgives a physician who "knew all the time and never told me until it was too late to do anything." It often occurs that the patient, being advised to go to a Sanatorium, is told, "You will be all right in two or three months," and he goes away quite happy. But as time goes on and as the Sanatorium is unable to produce more than, probably an improvement in that time, the patient becomes discouraged. He stands then between two positions, either casting the blame upon the Sanatorium, or upon the attending physician. His position is perfectly just, and from experience in this work, it becomes a well-known fact that in any case, no matter how incipient it may be, no person is able to offer an opinion as to the exact time it may take to produce results. In my own work, I refuse to express an opinion as to the length of time until I have had the case under close observation for some two or three months, and then qualify the opinion by conditions that may keep the patient from making steady and rapid progress.

Again, to tell the patient he may expect three months' treatment, when it will probably require ten months or a year

often gives a great deal of financial and social discomfort that could have been avoided could the patient have had some more adequate idea that the cure comes very slowly and provision must be made for a long period of residence.

Upon this point, Dr. E. S. Bullock, of Silver City, New Mexico, writes : "I am almost daily struck by the fact that my patients upon presenting themselves for treatment, and quite regardless of the stage of the disease, tell me, nearly without exception, that they have been assured that they will get well, and therefore expect a cure at my hands. This shows how a curability fallacy has permeated our profession, for you cannot persuade me that these people have been conscientiously lied to. About the first duty that I have to perform is the very disagreeable one of destroying a comforting illusion and changing the whole point of view in regard to the disease, for I hold that a clear conception upon the part of our patients is almost essential if any good is to be accomplished for them.

To briefly summarize : The cases, then, that lead to results sufficient to allow the patients to return to the ranks of "wage-earners" are :

Adults, of good physique, with no antecedent disease, of good family history, out-door workers, or those engaged in pursuits with hygienic surroundings, good habits, good digestion, with no evidence of involvement of other organs ; a quiet, orderly hopeful disposition, with pluck and perseverance are the best patients. The evidence of involvement being small, even should the onset be acute, the temperature usually gives way satisfactorily to outdoor treatment and rest. Cases of slight laryngeal involvement usually do well by combining the "rest" treatment with patient and constant local applications. A pulse fairly slow, regular and of moderate tension is desirable ; a heart action indicative of a strong muscular wall and nervous control not easily excited by exercise and excitement usually favors a good prognosis. Limited involvement of one apex with good compensation in the other lung favors an encouraging result.

In view of the fact that the fight against tuberculosis is the most active in all the field of medicine from the scientific, social and economic standpoints, I would respectfully beg of the medical men present to guard the patients' interests carefully, to protect the families and the public at the same time by advice and teaching turn the public mind from the tendency to phthisisophobia to the larger and more efficient work of legal regulation of the cases of tuberculosis as found in each and every practice.

*REPORT OF THREE CASES OF CAESARIAN SECTION

BY

W. B. McKECHNIE, M.D.

VANCOUVER, B C.

Mrs. G. age 36, IV para. Height 5' 1". Weight 100 lbs. Had Rachitis when a child in England.

Pelvic measurements—Ext. conj. 18 c.m. Intercristal 26 c.m. Inter spin 23.5 c.m.

First confinement in 1902. Labor very difficult ending with Craniotomy, patient made good recovery.

Second confinement, November 1903. Difficult forceps delivery with dead child.

Third confinement, June 1906. After this pregnancy commenced she consulted me and was told that to have a living child she must either have a section done at full term or have labor induced prematurely. Her friends refused the former. At the middle of eighth month patient entered the hospital and labor was started. After considerable difficulty she was delivered of a living male child which died after thirty-six hours.

In December 1906, she became pregnant again and consulted me during the second month for the purpose of having the uterus emptied. After some persuasion she decided to let pregnancy go to term and submit to a section.

Labor began in the afternoon of August 28th, 1907. Patient was sent to Vancouver General Hospital and immediate operation done.

Operation.—An incision of 17 c.m. in the abdominal wall.

A slightly shorter vertical incision was made in the anterior uterine wall. The placenta lay directly under the incision. One side of the placena was rapidly separated, the membranes ruptured and the fœtus removed. Afterwards the placenta and mem-

*Read before the British Columbia Medical Association, 1908.

branes. There was no haemorrhage.

The uterine incision was closed with two rows of interrupetd sutures. The first of cat gut, the second of linen. Abdominal wounds closed in usual way. Patient made an uninterrupted recovery and nursed her baby from the second day. The baby weighed 8¼ lbs., and grew well from the first.

Mrs. F., age 43, 2nd para., married 12 years, became pregnant for the first time December 1905, was confined in Winnipeg lying-in-hospital September 4th, 1906. Child was still born, weighed seven and a half pounds. Patient was told that she was not expected to live through the confinement. She was unable to stand for six or seven weeks afterwards. Was unable to walk without crutches for six months. She became pregnant again April 10th, 1907. Had good health throughout her pregnancy. Consulted me December 18th, 1907,. when she gave the above history. Her pelvis gave the following measurements: Ext. conj. 16 c.m. Inter cristal 25 c.m. Inter spinous 23 c.m. Per vaginam the promontory of the sacrum could be easily touched with the finger. The internal conj. being 7 to 7½ c.m. Section was advised to which she readily consented. She entered lying-in-department of the Vancouver General Hospital December 30th.

On Jan. 2nd, 1908, a section was performed. As labor had not commenced some minutes elapsed after the uterus was emptied before contractions began. Haemorrage from the uterine wall was free but easily controlled and readily ceased when contractions began. The child weighed seven and a half pounds. Patient made an uninterrupted recovery and nursed the child from the first. She left the hospital on the 28th day.

The uterine incision was median longitudinal and was closed with two rows of interrupted sutures.

Mrs. F., age 29 years, 3rd para. Highly neurotic. Had one child to first husband. One child to second husband four years ago. This child had Ophthalma Neonatoram.

Patient last menstruated Feb. 27th, 1907. No sign of menstrual flow afterwards. First week in May began to suffer pain in pelvis. No sudden onset. During third week in May the pains became more severe and patient was sent to hospital. The lower part of abdomen was tender to the touch. Owing to neurotic condition of patient a vaginal examination without anaes-

thetic was not satisfactory. She had a temperature of from one to three degrees for several days. The pain gradually lessened and general condition improved. For the four months subsequent to June 15th, she ran a seemingly normal pregnancy except that she complained of the strong foetal movements causing pain. From the middle of the seventh month the discomfort increased and on November 8th she again went to the hospital. During the last five weeks she had to remain in bed most of the time. Up to the end of 9th month the fœtus lay in a transverse position. On date of expectation it changed the breech going down, the occiput lying in the median line above the umbilicus. The abdominal wall being thin the cranial bones could be distinctly felt, the sutures being easily made out. On December 5th, patient said she thought the child was dead as she had felt no movements. since the previous day. On December 9th, the stomach began to refuse food. Anything more than the smallest quantity of liquid being rejected. On December 11th, in consultation with H. H. McIntosh, we decided that pregnancy ought to be terminated. December 15th, patient was taken to operating room. Under anaesthetic the uterus was found to be empty.

Operation—Assisted by Dr. A. L. Kendall. An incision of 15 c.m. showed the fœtus enclosed in its membranes lying in the abdominal cavity. It was brought through the incision the membranes ruptured and the fœtus removed. The placental mass lay in the pelvis enclosed in the folds of the broad ligament. The cord emerged from the side of the mass. The broad ligament was ligated in sections below the mass and the whole thing removed. The ovarian artery was enlarged to the size of a small goose quill. The uterus was the size of a three months pregnancy. A small gauze drain was left in the wound and removed on the third day with no discharge whatever. Patient made an uninterrupted recovery. The fœtus weighed 9 lbs. 6 oz. Male. Fully developed. The cuticule was exfoliating.

In this case the ovum with its membranes had become gradually extruded from the side of the tube or from the broad ligament. This had likely taken place during patients illness in May.

BLOOD PRESSURE

BY

T. PROCTOR HALL, M.A., Ph.D., M.D.

VANCOUVER, B.C.

Measurement of blood pressure which a few years ago was an experiment belonging only to the physiological laboratory is rapidly taking its place as an every-day aid to diagnosis. In all conditions involving disordered circulation such measurement is indispensable if serious mistakes are to be avoided. The not uncommon spectacle of a patient with high blood pressure taking large doses of digitalis or other heart tonics is one that has no longer any excuse for existence. Measuring the blood pressure is in many cases as imperative as taking the temperature in typhoid fever.

Blood pressure is usually measured in the brachial artery on a level with the heart. This pressure is continually varying. The maximum pressure, the crest of the pulse wave, is the easiest to measure and is clinically the most important. Its cause is the muscular force of the left ventricle in systole, opposed by the tension of the arterial coats and the resistance of the smaller arteries and capillaries, and modified by the volume of blood relative to the arterial capacity.

The process of measurement is simple. The apparatus consists of a broad rubber bag reaching round the arm, on the outside of which is an inelastic band ; a manometer connected with the armlet by a rubber tube ; and a double-valve hand bulb for inflating the armlet with air. As the air pressure is gradually increased the pulsation at the wrist becomes suddenly fainter and soon disappears. The pressure is read at the moment of disappearance, at which point the air pressure on the outside of the arm just balances the maximum pressure of the blood in the artery.

Several precautions are necessary to secure accurate results. The width of the armlet is important. If it is too narrow the air pressure, owing to the tension of the muscular and other tissues,

is greater than the pressure on the artery and the reading is too high. A width of ten centimeters is advised. For arms of moderate size seven or eight centimeters is ample, but the greater width has no disadvantages. The armlet must fit the arm loosely and the muscles must be relaxed. The exact position of the armlet, the presence or absence of light clothing, and the position of the patient, make no appreciable difference in the accuracy of the result ; though the position of the patient may affect the blood pressure itself.

There are very great differences in the blood pressure of different persons. It is generally assumed that the normal pressure is 110 to 125mm. mercury in women and 120 to 180mm. in men. It is true that these are average pressures, but it does not follow that they are normal. My own observations (made with a modified Riva Rocci apparatus, the armlet 75mm. wide) extending over several years, during which measuring the blood pressure has been part of the routine of every office examination, leads me to the conclusion that the normal systolic blood pressure of men and women of all ages from ten years upward is one hundred and twenty millimeters of mercury, or 163 centimeters of water. This conclusion is based on the following facts :—

(1) Every perfectly healthy individual examined, from 7 years of age to 70, had a blood pressure within one or two millimeters of 120.

(2) Every person whose blood pressure varied materially from 120 showed some other abnormality sufficient to account for the variation.

(3) When health was completely restored, if not before, the blood pressure became 120. There were some apparent exceptions to (1). A man whose blood pressure was found to be 155, with no further examination, and who claimed at the time to be perfectly well, consulted me two weeks later for chronic dyspepsia. Another, a physician claiming perfect health, whose blood pressure was 145, was (I afterwards found) a frequent sufferer from rheumatism.

Abnormal blood pressure indicating serious disorder is often found along with normal temperature. In general a variation of 15mm. from the normal pressure is as serious as a variation of one degree F. from normal temperature.

Blood pressure in young children is less than in adults and is very variable. Normal pressure in adults is not easily varied, that is to say, under ordinary conditons it remains constant. Abnormal pressures are much less constant, varying from the mean for slight causes.

The lowest blood pressure found is zero, as during a faint when the wrist pulse is imperceptible. The lowest continuing pressures that I have found or read of were about 60mm., and in all of those cases death followed within a few days. The highest pressure I have measured was 280mm., in an old disabled sea captain. Others have reported 350mm. and over 60mm. pressure, half the normal, is dangerously low ; 240mm., double the normal is dangerously high. Sclerosis of the brachial artery will give an apparently high pressure. Under ordinary conditions there is no difference in the pressures in the two arms.

In a large number of cases high pressure is a result of vaso-constriction. The three common causes of vaso-constriction are : (1) Mental strain or worry ; (2) Reflex nerve irritation ; (3) Auto-toxicosis. Arteriosclerosis and sclerotic conditions of the liver and kidneys are more often concomitant results than causes of high pressure. In valvular lesions of the heart, compensatory hypertrophy is probably a direct cause of the high blood pressure which is then necessary for efficient circulation.

Blood pressure, like temperature, calls for direct treatment only when dangerously high or dangerously low. It is a valuable index of existing conditions. When other abnormal conditions are corrected abnormal blood pressure rapidly becomes normal ; but while its causes remain active it is impossible to secure more than a temporary correction of abnormal pressure.

Low blood pressure may result from hemorrhage, malnutrition, exhaustion, toxicosis, or any depressing agent. In such cases it is usually assumed that the heart is weak. But more often the fault is relaxation of the arteries or veins or both, from defective enervation.

Little information regarding the effects of medicines upon blood pressure can be gleaned from medical literature. For temporaray reduction of high pressure I have found the following useful :—Moral agents (Faith, in some one or something, it matters not what so long as it results in mental and psychic rest) ;

Vibratory massage of the spinal muscles ; High frequency electric currents ; Nitrites, pilocarpin, veratrin, gelsemin, lobelin.

Low blood pressure is increased by, improved nutrition ; Mental resolution ; Pleasurable emotions ; Deep breathing ; Low frequency alternating currents ; Strychnin, digitalin, strophantin, adnephrin, cactin,* atropin, ergot, etc. The useful therapeutic dose of any of these agents may be so small that it would produce no measurable effect upon a normal person. **

The foregoing remarks apply to maximum or systolic blood Diastolic pressure has exactly the same causes except that resistance of the aortic valves replaces the muscular force of the left ventricle. Assuming the integrity of the valves, the difference between these two pressures, taken in connection with the pulse rate, is a valuable measure of heart power. Diastolic pressure is measured by the same apparatus. As the air pressure is slowly increased a sudden decrease may be noted in the pulse volume, and at the same time the manometer column makes maximum movements with each pulsation. This pressure is approximately diastolic.

* For a full discussion of the properties of Cactin see the American Journal of Clinical Medicine for August, 1908, pages 1043-1056.

** Disregard of this principle has led some careful observers to wrong conclusions. Strychnin in moderate doses of 1-100 to 1-20 grain is a powerful corrector of subnormal pressure, but the same dose has little effect on pressures that are normal or supernormal.

EDITORIAL

The Possible Great Influence of Country Doctors

The general lack of interest which the average country practitioners appear to take all over the world in professional matters is probably due to the fact that they find great difficulty in arranging to attend the various Provincial and Dominion gatherings and so have little chance of discussing the measures brought up with their medical brethren. The lack of this interest is greatly to be deplored. One thing is certain that when a countryman in any profession does take a lively interest in the welfare of his calling and shows it by attendance, etc., at the meetings, he very rapidly comes to the front. The country doctor, through force of circumstances, to be successful must be self reliant, decisive and observing—qualities which make for leadership. It is, in truth, impossible to exaggerate the part the country practitioner can play in building up a better professional spirit in the West. Their being so far apart from one another and feeling their number so small has helped them to ignore their power as a strong factor in determining the standard of their profession. This is a wrong way to judge. How often have we to acknowledge the immense power in political life of a vigorous enthusiastic minority. Even in our own profession, we can think of the influence that has been wielded by those who hailed from the country *when they did stir* themselves. In the history of nations whence have most of the great leaders arisen ? It is thought by many that the life of the country—given ability—tends to give a man a saner and more broad minded view. We have in cities men in power who seem distinguished by neither great narrowness nor the opposite but in the country it is noticeable that those controlling affairs are either large minded progressive men or provincial nonentities. Let us hope that the medical gatherings of 1909 will be remarkable for the large attendance of men from the country alive to their power who will see that no measure is passed by their council or association unless they have fully considered it and for which their opinion is recorded. May there be manifested

this year a strong professional spirit—that spirit which causes a man to place as first consideration the good of his profession and second his own—the result of which is the welfare of both.

The desire for a United Medical West is gradually growing in force, and the least that can be said is, that the medical profession, in this, is only keeping pace with the times. On all sides a distinctly *Western spirit* is being felt, which is encouraging for to-day we have two roads before us—that of *provincialism intensified*—because held to by nothing but material reasons—or union and broad mindedness which means that for the welfare of the profession in every sense it is desirable that the provinces be united under one Council and Licensing Board and one Western Association (for discussion among the general profession of important Western matters). This association would in no way endanger Dominion unity. There is no more reason for supposing that than imagining Canadian patriotism would be a danger to Imperial. The one rests on the other. At least we should be strong enough then not to have the unedyfying spectacle of the decision of the Medical Council being set aside by the courts of law. *Western* union we need—not merely Provincial and Dominion. Every day makes it more clear that the requirements of the West are not by any means always identical with those of the East.

Absurdity of Boundary Lines

We read in the report of the C. of P. and S. Manitoba that a letter was received from a doctor complaining of medical men from Sask. coming into Manitoba and practising without a license. No wonder—The public marvels! However, if we have such laws, *let them be enforced.* Few laws and *stringently* enforced is a good rule in professional as well as business life, or the whole thing is a farce. B. C. is said to fear that were interprovincial registration passed there would be a rush of men into their province. We know, however, that generally the physician who moves much is the one to suffer. But after all, why should there not be exchange in our profession as well as in the church and law? Our clergy and lawyers are constantly going East and to the Coast and men from these parts coming to their posts.

From the higher point of view the coming of a new man

from one province into another, if he be well up in his work, should be a matter of rejoicing. It is the community which loses such a man that should do the mourning, and of the other sort—the failure—we need have no fear. Many, who for protective, selfish interests are putting up barriers surely forget the time when they entered the province on reciprocal terms. There are those, again, who stand out against retroactive legislation because fearing men of many years experience might move into their district and enter into competition with them. This is improbable —most have little desire to move. This is proved by the fact that many to whom this would apply say they do not mind if the measure is not retroactive and they are willing to sink self-interest in that of the profession.

Meetings

The Manitoba Medical Association meets June 22nd and 23rd at Brandon.

The Sask. Medical Association meets the first week of July at Saskatoon and the Alberta Medical Association meets at Calgary, August 18th, 19th and 20th.

The Canadian Medical meets at Winnipeg, August 23rd, 24th and 25th.

The B.C. Interior Medical sometime in September, and B.C. at Seattle in conjunction with the three Western States of U.S., July 22nd and 23rd.

In our correspondance column we publish a letter from a subscriber *re* a new hospital. We are glad to get facts. It is impossible for us to know the inner workings. If any statement is wrong we shall be glad to hear. It proves the necessity of the strictest investigation into the running of hospitals.

CORRESPONDENCE

To the Editor of the Western Canada Medical Journal.

Sir:—In your April number the announcement is made under "Medical News" that "The hospital at Nokomis, Sask., will be opened May 1st." This information is given, no doubt, for the benefit of physicians in the vicinity of Nokomis. The announcement as it appears is somewhat misleading in that it conveys the impression that we have a public hospital here. Perhaps it would be of advantage to physicians in the vicinity to know exactly how things stand with regard to the "hospital." This institution was opened last summer and was the cause of a great deal of inconvenience to physicians in this locality, and of expense to the town, owing to misunderstanding as to the management. The "hospital" is purely a private concern owned and operated by two women from Chicago, Mrs. Buck and Mrs. Hesse, neither of whom are graduate nurses. These parties came to Nokomis last spring with the intention of opening a hospital. The first move in that direction was to make a canvass of the town for public subscriptions. They were successful in raising a sum in the neighborhood of five hundred dollars. The impression was given to the subscribers that the institution would be public, or at least that a public ward would be opened in connection with it. The building was proceeded with and in due time the corner stone was laid at a public gathering. When the institution was opened the public were somewhat surprised to learn that the cheapest bed in the "public" ward was Ten Dollars per week, drugs, dressings, washing and medical attendance extra. The cheapest "private" ward was Twenty-five Dollars per week, others Forty and Fifty Dollars per week, with no conveniences of any kind. It so happened that a number of physicians hearing that there was a hospital at Nokomis forwarded patients to this institution under the impression that it was public. The consequence was that these patients were either turned away or the town authorities were asked to pay their expenses. On one occasion a local clergyman was asked to pay for one of these patients because he had found the party very ill and removed him to the "hospital." Two cases in particular came under my own personal observation—the one, a poor homesteader, suffering with appendicitis and requiring immediate operation, was brought to me by a physician from a point some forty miles distant. We removed the man to the hospital intending to operate there. We were "held up" at the door and informed that our patient could not be admitted unless he could guarantee payment at the rate of Fifty Dollars per week!! We were compelled to remove this man to one of the local hotels and operate there. The other patient, a case of my own, was charged Forty Dollars per week for the use of a tent! Surely it is a misnomer to term such an institution a hospital when we think of the correct meaning of the term. It is simply a financial undertaking, the same as any mercantile business.

These "ladies" have made it impossible for local physicians to send patients to them owing to the manner in which they were treated. Now, the parties are holding a "big stick" over our heads in the form

of a threat that if we will not send them patients they will bring in "opposition" in the form of a physician from Chicago or some other point.

In conclusion I may say that the institution was closed during the winter months owing to lack of funds (and patients). The "ladies" returned to Chicago for the winter, now like the swallows, have reappeared and are preparing for the "spring rush," hence the announcement in your April issue.

Yours faithfully,

B. A. SANDWITH.

Nokomis, Sask., April 27, 1909.

ANSWERS TO CORRESPONDENTS

Enquirer: In British Columbia a medical man can obtain registration on the strength of qualifications from Great Britain and Ireland if registered in Great Britain or Ireland previous to June 30, 1887, otherwise he must undergo an examination and pay registration fee of not more than $100. In Manitoba British qualifications are accepted and a fee of $75 required. In Alberta an examination must be passed, the fee for which is $50 in addition to the registration fee of $50. In Saskatchewan at present registration is in abeyance till the formation of a College of Physicians and Surgeons.

PROCEEDINGS OF THE WINNIPEG CLINICAL SOCIETY

The Winnipeg Clinical Society met, Tuesday, April 6th. Owing to the absence of the president, Dr. Hunter took the chair. The minutes of the previous meeting were read by the secretary, Dr. Munroe, and approved.

Dr. W. S. McDonald: I have met with some five cases of athletes running races, and in view of the fact that foot races are so popular these days I thought it would be interesting to show these cases and ascertain what advice should be given by us to these men, and show what relation the heart in these cases would bear to life insurance. In this case the apex beat is displaced downward and to the left; not diffused; he has a strong pulse. 65; the heart's action not excited at all. He has a systolic murmur at apex, best heard to the left of the nipple and from there to the base of the heart on the right side. I desire to have a diagnosis tonight, am inclined to think he has not an organic valvular disease. At any rate his conpensation appears to be first-rate. He had left sided pleurisy five years ago, and it was thought to have been tubercular; I cannot find any evidence of pulmonary tuberculosis. I believe there is an impairment of the vocal fremitus on the lower part of the left lung. Five years ago he was told he was exercising too much. He has done considerable footracing and bicycle racing; done 15 miles across-country running. The heart is enlarged.

Dr. Gilmore showed a microscopic slide of Vincent's Angina, showing the spirillum and the bacillus.

Dr. Trick showed a case of Bronchiectasis History: This man was born in England; came to Canada six years ago, age 53, mother died at 88, father at 87, no particular cause. One brother in good health; one brother killed in an accident; no sisters; 5 children healthy and two died in infancy. Typhoid in 1905; two weeks in hospital and three weeks after leaving hospital he was working. He had pleuretic effusion in 1892. The doctor took away 3½ pints of fluid. Since having typhoid he has had a cough. I saw him a year ago and he had considerable bronchitis, but he didn't quit work until this month. He is a carpenter in the C..P. R. hotel and station; there is considerable dust there. I saw him about a month ago, he had acute bronchitis and I sent him to St. Boniface hospital; considerable secretion formed on left side and on lying on his right side comes up in great quantities or almost chunks. It looks a greyish color and purulent. No tubercular bacilli in it. Some clubbing of the fingers. Trouble dates from when he had typhoid in 1905. He attributes the pleuretic effusion to having a blow on the shoulder. Two examinations of fluid for tubercle bacilli. When he was in hospital temperature varied from 101 to normal. Sometimes had temperature in the morning; time of temperature varied.

Dr. Milroy: On examination I find the left side fallen in—contracted. Expansion on deep expiration, on the left side his side does not expand as the right side does. There is some dullness; on purcussion the vocal resonance on ausculation the left side sound is masked. I didn't get localized sounds except a little below the axilla in front of the median axilliary line. I could not find any evidence of

cavity or the cavernous breathing you get where there is marked bronchiectasis. I think there is a much thickened pleura on that side, and from the conditions present there is no doubt there was a pleurisy with effusion. The effusion has disappeared, and there is collapse of the lung, but whether there is tuberculosis there, I am not prepared to say. From the want of evidence it is pretty hard to say whether there is tuberculosis present; where you cannot get the tubercular bacilli after frequent searching, but I think if the doctor will continue searching I believe he will locate the T. B. There is loss of flesh, I understand. The man should be improving and the loss of flesh should have ceased and the chances are there should be an improvement, but I understand there is still a general failure and loss of flesh. I think that you would find if we could see into the thorax that there is a considerable thickened pleura and I am inclined to think there is tuberculosis there, and perhaps the pleura may be the portion of the lung that may be particularly affected.

Dr. Stewart: It is not very satisfactory to make a hurried examination but what I got would agree with what Dr. Milroy has said. I got cavernous breathing in the left axilla, and agree that the pleura must be thickened on the left side. I got very distinct dullness throughout the whole extent of the lung behind on the left side, and the dullness is very marked below and I thought the right apex was dull also, but couldn't be sure, as circumstances were not such as favored a thorough examination. There could be scarcely any doubt that tuberculosis is at the basis of the trouble. I understand that two examinations of sputum have been made. I should think that examinations of the sputum should go on in a case of this sort until 15, 16 or 20 had been made, but I should be inclined to make the diagnosis in spite of the negative findsnould be inclined to make the diagnosis in spite of the negative findings. I think it a very gross error to wait for positive sputum findings before making diagnosis as to tuberculosis and it keeps a great many cases hanging until the late stages when they should have been treated in the early stages. It looks very much to me like a clear case of tuberculosis. I would look for a cavity just below the clavicle.

Dr. Rorke: The only thing that appears to me would be the question to be settled is whether the tug of the retracting scar formation of the pleura would be sufficient to dilate the bronchi to cause the cavity formation without the cavity of tuberculosis. With the amount of dulness present you don't get very much vocal fremitus, there must be a greatly thickened pleura that has the effect of dilating the lung. Would that be sufficient to give these cavities the ability to give forth these great quantities of sputum and whether that is not a sclerosing and not a breaking down?

Dr. Milroy: I think that the condition we find there is no doubt a lot of pleural adhesion and pleural thickening, and a fibroid condition there. My own experience would show that there is sufficient adhesions and pulling to produce the distinct bronchiectasis. I could not make a cavity on auscultation, but I should think from the condition of the pleura and the amount of pleural adhesion, would be quite sufficient to account for the symptoms of bronchiectasis, apart altogether from the breaking down of the lung as a result of tubercular lesion. If that was the condition alone, without any tubercular basis, I think there would be the amount of failing that there is at the present time. The adhesions are quite sufficient to account for all the symptoms as given by Dr. Trick of Bronchiectasis. I remember a case two years ago which was diagnosed as a case of tuberculosis. I had made a number of

examinations of sputum; it was empyema and patient was operated on and the fluid removed and the patient recovered and the evidence of the cavity disappeared. When the patient was admitted to the hospital there was all the evidences of the cavity and several doctors made the diagnosis of tuberculosis although we had no evidence of the tubercular bacilli in the sputum

Dr. Mackenzie: I have not examined the present case but I might cite a case of what I considered was true bronchiectasis: A young woman, 27, called me to see her for profuse haemoptysis. After considerable trouble I succeeded in getting that checked. She gave me the history after recovering, that 19 years previously she commenced having a cough, which followed the whooping cough and the cough gradually became worse and she commenced coughing up immense quantities of fluid. Diagnosis was made tuberculosis and treated for tuberculosis for years, but never lost any weight. She remained with the treatment for tuberculosis for a number of years, taking creosote and codliver oil and finally discarded it, and during all this time for 12 or 15 years she put up about a pint of this material in the 24 hours. At the time I saw her and subsequently to this hemorrhage, she would put up about an average of a cupful before retiring. Before retiring this was her regular practice of stooping over and putting up this cupful of pus before going to sleep. She had been doing this five years. During the next three years I saw her with marked hemoptysis. She would put up fluid very freely and I thought the last hemorhrage she would die; however she recovered and I looked up the literature on the subject and found in bronchiecteal abcess, it is advised in sever cases to cut down and drain. I had her prepared for operation but with a view of confirming my anatomical position I had her put under the X-ray. The next day I asked her how she felt and she said she had felt fine and I said to keep right on going to see Dr. Bond, and she has made a considerable progress.

Dr. Bond: We had no difficulty in bringing out in the radiograph the exact position of the trouble and Dr. Mackenzie asked me what I would do in a case of that sort. I said I would use the X-ray, andhad I known he was likely to have turned the case over to me I would not have said so. However he very kindly insisted, with the result that after giving a few treatments the pus formation was checked and finally stopped altogether and the patient is today quite well and apparently in perfect health.

Dr. Mackenzie: In this case there was absolutely no emaciation; she is splendidly formed, plump woman, and had never lost any weight, although putting up this material for 19 years. She had had repeated tests made for tuberculosis but negative results were obtained. Why should this woman, who, for such a large number of years, had been putting up the large quantity of material and as the cavity kept getting smaller, have increased haemoptysis?

Dr. Hunter: What would be suggested as to the treatment of Dr. Trick's case?

Dr. Stewart: The treatment should be the same no matter what the diagnosis is and it should be that of acute tuberculosis, while the patient has temperature he should be in bed, practically outside, in fresh air night and day, and sleep out of doors, and one of the most important things would be control of the patient as regards rest; insist that he be not allowed to walk down town or here or there at will so long as his temperature remains elevated. I think he should be fed

liberally with the ordinary diets, and some additions made to that, such as milk and eggs. These are just the ordinary treatment. As far as the slight abnormality in this case I have no treatment to suggest at all.

Dr. Trick gave a report on the case of gangrene of the big toe shown a month ago before the society. "After he was here the gangrene went slowly up the toe and a week ago last Wednesday it was so painful that even with morphine he couldn't sleep, so we amputated the toe and the second day after the amputation there were red streaks up the front of the leg and considerable swelling, this continued getting worse and we decided to amputate the leg at the middle of the thigh last Wednesday, a week afterwards. When the leg was amputated the popliteal artery was completely blocked for about an inch and a half above the place of amputation and above that the popiteal was pulsating well, and ligature put around the artery and the amputation was of an anterior and posterior flap and a couple of pieces of gauze put in for drainage and it healed up by first intention, and he is sitting up in bed and feeling very good.

Dr. Lehmann: It is generally in the popliteal artery that thrombosis takes place. The disappointing part is that frequently the other artery is in a bad condition as one will often have to amputate the other as well, because the condition that produces the artheroma on one side produces the artheroma on the other side, and it is well to bear that in mind of the patient is considerably disappointed if he finds his other leg is going the same way as the first.

Dr. Trick: There was history of pain down the front of the leg from one year ago. The gangrene has been coming on since last January.

Dr. Milroy gave results of the use of serum on a case af acne. Dr. Leeming took part in the discussion. It will be printed next month.

GENERAL MEDICAL NEWS

Graduates of University of Manitoba and License List for Manitoba and British Columbia.

M.D.

C. H. Bastin ; F. C. Bell, B.A. ; P. G. Bell, B.A. ; J. E. Bloomer ; E. S. Bolton ; M. C. Bridgman ; E. E. Bryans ; E. E. Bugg ; J. S. Clark, B.A. ; W. A. Cooper ; W. D. Dixon ; C. C. Everson ; E. Grant ; W. E. Guest ; M. Hjaltason ; D. R. Houston ; G. R. L. Ireland ; H. T. Irvine ; H. W. Lewis ; W. N. Maines ; A. E. Medd ; A. E. McGavin ; D. F. McIntyre ; J. D. McQueen ; J. A. McTavish ; H. E. Montgomery ; J. P. Palsson ; N. J. Paul ; W. W. Pirt ; C. Rice ; P. C. Robertson ; W. Ross ; A. J. Swan ; E. J. Washington ; D. V. S. Winkler ; V. W. Wright.

C.M.

W. A. Cooper ; C. C. Everson ; A. E. McGavin ; J. D. McQueen ; C. Rice ; W. Ross.

Silver medal—P. G. Bell, B.A.

Bronze medal—D. F. McIntyre.

O'Donnell gold medal in obstetrics—W. Ross.

Hutchison gold medal (aggregate of the full course)—D. F. McIntyre.

FOR LICENSE.

M. E. Douglass, 2 ; F. O. Gilbert, 2 ; W. H. Lambert, 2 ; J. G. B. Lynch, 2 ; R. G. Snyder, 1B.

J. A. Belanger passed class 2 in ophthalmology and otology.

Out of the thirty candidates who sat during the current week at the medical examination for entrance as practicioners in British Columbia, held in the Provincial Government buildings, twenty-three were successful. The names of the new B. C. doctors follow : J. R. Atkinson, H. W. Coapes, K. E. Crompton, G.

H. Dart, G. B. Braeseke, J. W. Ford, W. J. Furse, R. C. Hill, B. A. Martin, R. S. McArthur, C. S. McKee, G. E. McKenzie, J. L. McLellan, R. D. Panton, S. Paulin, W. H. Rennie, D. R. Shewan, J. S. Shurie, R. C. Symmes, W. P. Walker, W. C. Walsh, J. A. Wilson and C. H. Workington.

The examining doctors were : Drs. McKechnie, Tunstall and Proctor, of Vancouver ; Dr. Sutherland, of Revelstoke ; Dr. Walker, of New Westminster, and Drs. Jones and Fagan, of Victoria.

The president and vice-president of the B.C. College of Physicians and Surgeons, were appointed at a meeting held in the Provincial Government buildings last night—Dr. W. H. Sutherland, of Revelstoke, being president, and Dr. McKechnie, of Vancouver, vice-president.

MEDICAL NEWS

On Thursday evening, May 14, Dr. Thornton, M.P.P., delivered an inspiring address to the graduating class of Manitoba Medical College. It is proposed to make such an address an annual event. Among other matters, Dr. Thornton touched on the question of registration and pointed out as an instance of the absurd conditions existing that men with national and even international reputation, if they attempted to give advice while in Winnipeg were liable to be hauled before a Manitoba Magistrate. He said, however, he was quite in sympathy with the Roddick Act.

F. C. Bell read the valedictory address of the graduating class to the professors.

The Vancouver Medical Association organized a Milk Commission which recently held its first meeting. The members of the Commision are Dr. W. D. Brydone-Jack, M. H. O.; Dr. Underhill, Dr. O. Weld; Dr. C. S. McKee, (Secretary). The dairymen are willing to co-operate with the Commission. The idea is that the Commission shall inspect the premises of the dairymen, examine the milk supply bacteriologically and chemically and grade the dairies accordingly. The dairymen will be granted certificates of classification which should be of great

help to the buyers of milk. This is the result of Dr. Kendall's paper.

The following are the names of the successful graduates of Queen's University from Western Canada :—Degree of M.D. and C.M., H. E. Chatham, Stettler, Alta. ; J. C. Schillabeen, Regina, Sask.

Edmonton held a Mammoth Hospital Fair, the beginning of this month.

The Anaesthetics Bill which is before the House of Commons provides for the administration of anaesthetics by only legally qualified medical practitioners and also that after Jan. 1, 1911, no person may be registered under the Medical Acts unless he has received theoretical and practical instruction in the administration of anaesthetics.

The asylum at Ponoka is to be rushed ahead this year as it is urgently needed.

The directors of the Moose Jaw General Hospital consider there is urgent need for an isolation hospital and are willing to present a site if the city will build.

The report from the finance committee of the Jubilee Hospital, Vancouver, shows that the treatment of an exceptionally large number of free patients has put the hospital behind financially.

W. M. Lancaster of Weyburn, Sask,, has been successful in the M.D. C.M. examination, London, Ont.

The time for giving out patent medicine stamps has been extended to May 15th, to accommodate small drug stores.

The M.H.O. of Vancouver reported that one out of every eight deaths reported for the month were due to Tuberculosis.

Those interested in the demonstration of the open air treatment of Tuberculosis should read the articles appearing in the *Metropolitan Magazine,* beginning April number.

Dr. Arthur, of Vegreville, Alta., announces the donation of $1,000 from eastern friends for the establishment of a Nurses Home in connection with the Presbyterian Hospital of which he is medical superintendent.

Saskatoon has been chosen as the site for the Saskatchewan University.

The Legislative Council of Quebec has rejected the Bill to incorporate the Christian Science Church of Westmount on the ground that the sect represents a belief which it is not desirable to encourage in a Christian Province and the Baptist Ministers of Portland, Oregon, have asked the physicians to co-operate with them in conducting a campaign against Christian Science.

Quebec has extended the course of study requisite for license to five years.

Dr. Fagan has reported that he found the health of Prince Rupert City good and a water supply sufficient for 50,000. The city is under the control of the G.T.P.

Dr. Mackid read a paper on venereal diseases to the Calgary Moral and Sanitary League. The officers of this society are *Hon. Pres.*, Justice Stuart ; *Pres.*, Dr. McEachern ; *1st Vice-Pres.*, Dr. Lafferty ; *2nd Vice-Pres.*, Rev. J. A. Clarke ; *3rd Vice-Pres.*, T. Underwood ; *Secretary*, Dr. W. T Lincoln ; *Treasurer*, Dr. W. E. Graham ; *Committee*, Drs. M. A. Scott, R. J. Hutchings, G. A. Anderson.

There is an iteresting article on the "Health of Teachers" in *School Hygiene* for May.

The plans for the Ninette, Man., Sanatorium have been adopted and work is to be hurried forward.

L. W. Luellen of Boston has invented a neat contrivance whereby you touch a button and receive a new little paper and paraffin cup full of ice-cooled water. The New York Health authorities have already adopted it for use in schools and municipal hospitals.

By its sanitary regulations New York has reduced its yearly death rate from 25 per 1000 to 18.

The Children Charter which has recently been passed by general consent of the British people provides for :

1 Infant life protection.
2 Prevention of cruelty to Children and young persons.

3 Juvenile smoking.
4 Reformatory and Industrial Schools.
5 Juvenile offenders, etc. A "child" is anyone under 14.

This act is said to foreshadow a newer and nobler age in legislation.

In Britain objections to the compulsory notification of tuberculosis are disappearing. The people are beginning to see the value of it—the advantage to the community and to the patient who now recognizes that by this means additional help is obtained to combat it.

Among the distinguished physicians who will take part in the proceedings of the Canadian Medical Association meeting in August are Dr. Bell of Montreal who will give the address on Surgery; Professor Adami of McGill College who will give the address on Medecine and Professor Starling who will also give an address. The President is Dr. Blanchard of Winnipeg. Professor Roddick will also be present and will discuss the question of Dominion Registration and Interprovincial Reciprocity.

The Prince Albert medical men have formed a Medical Association. The officers are :—

President, Dr. A. David ; *Vice-Pres.,* Dr. P. Shelley ; *Secretary,* Dr. T. W. Fowmey , *Treasurer,* Dr. A. B. Hopkins.

The *Lancet-Clinic* has had some interesting articles on "the Evolution of Fees".

PERSONALS

Dr. Snyder, formerly of Radisson, Sask., has started practice at Lille, Alta.

Dr. Senkler, Vancouver, has returned from his visit East.

Dr. Baldwin, one of the oldtimers in the Edmonton district and who for years held the post of Medical Officer to the North West Mounted Police is revisiting Edmonton.

Dr. E. F. Taylor, from England, is visiting at Ulster, Alta.

Dr. and Mrs. Hogle, of Nanaimo, have been visiting Vancouver.

Dr. Arthur, of Field, is visiting Vancouver.

Dr. and Mrs. Pirie have returned to Calgary from their trip to the coast.

Dr. Tanche's residence, Silver Lake, was destroyed by fire lately and his family had a narrow escape.

Dr. Turner, of Fort Sask., has recovered from his recent illness.

Dr. Prowse, Winnipeg, has returned from his visit to England.

Dr. McLean, President of the Winnipeg Medical Association, has returned from London where he has been specially studying the surgery of the Nervous System at Queen's Square Hospital.

Dr. Matthews, of Edmonton, has gone to Edinburgh, Scotland, for the purpose of taking up hospital work. He intends spending two years in postgraduate studies.

We are glad to hear that Dr. F. S. Pope, M.R.S.C. (Eng.) of Calgary, after about two years in California, is now completely restored to health and has returned to Calgary and resumed his practice.

Dr. Bigelow who has been taking a postgraduate course at Chicago has returned to Brandon.

Dr. W. M. Pirt has joined his brother in practice at Carman.

Dr. and Mrs. Gunn, of Kenora, have been visiting Dauphin.

BORN

BRYDONE-JACK.—April 16th, Vancouver, the wife of Dr. F. W. Brydone-Jack of a son.

MARRIED

PIRIE-WALSH.—At Calgary, Dr. George R. Pirie to Miss Greta Walsh, daughter of W. A. Walsh, K.C., Calgary.

SPECIAL CORRESPONDENCE

Discussion on Registration in the Four Western Provinces.

The question of the four Western Provinces uniting together and adopting some scheme of registration that would raise the standard of qualification and would permit any applicant complying with the conditions thereof, to practice his profession in any one of these Provinces, is one that ought to appeal very strongly to every member of our profession truly and sincerely interested in the uplifting and maintaining of a higher standard. To bring about such a result is worthy of the best effort of every one of us.

The efforts of Dr. Roddick and those associated with him, to secure an Act regulating medical registration over the whole Dominion, brought the subject of a more extended form of registration than now exists very prominently before the profession, and it was discussed very freely and favorably in the public press, medical journals, and medical societies. As you know, Dr. Roddick succeeded in securing the passage of an Act by the Federal Parliament providing for Dominion registration, the Act to become law as soon as the Legislature of each Province in the Dominion passed legislation accepting the provisions of the Rod dick Bill.

It was hoped that every Province would at the first opportunity pass the necessary legislation, and no difficulty was anticipated until action was taken by the Council of the College of Physicians and Surgeons of the Province of Quebec, expressing disapproval of the Roddick Act, and memoralizing the legislature to refuse the necessary legislation, and regrettedly the request of the Medical Council was acceded to, and the legislation was refused, although a large and influential body of the Profession in the Province was in favor of the Act. The result of this action by the Legislature of Quebec leaves the Roddick bill a dead letter on the Dominion Statutes. But while the Roddick Act failed to materialize, the educational campaign carried on for a number

of years by Dr. Roddick and his co-workers to harmonize and unify the various elements necessary to secure the passage of his Act by the Dominion Parliament, has borne good fruit, and we find today an amount of interest and agitation in a number of the Provinces that is rapidly spreading and will sooner or later extend over the whole Dominion, and result in some general standard being adopted in all the Provinces, that will permit men qualifying under it to practice their profession in any province in the Dominion, as well as securing for such licentiates the advantages and privileges of a British graduate.

There is no doubt that the public regard it as an anomaly, and find it difficult to appreciate and understand why a licentiate of one Province should not be competent and qualified to practice in another province without undergoing examination, and regard such a condition of affairs as a reflection on the medical profession, and would welcome with great favor any change that would ensure such a result.

A large and increasing number of the leaders of our profession feel very strongly, that the good seed sown by the Roddick agitation should not be allowed to lie fallow, and that the Provinces, or as many of them as can unite together, should take steps to adopt a uniform standard for registration, and use every effort to induce others to join until every Province in the Dominion is within the circle.

Great hopes and great things are expected from our Western Provinces in every department of life and work; the East is looking to the West for progress and advancement. Let our profession in the West show that we appreciate the possibilities and responsibilities of the opportunity that is open to us, and rise to the full expectations of our brethren in the East, and have four Western Provinces lead the way, and form a federation for the purpose of registration, and adopt such a standard of qualification within such federation as would admit us to reciprocity not only with any province in the Dominion, but with any part of the Empire, if we so wished it.

Those of us who take an active interest in the welfare and standing of our profession in the West, believe that the time and opportunity is propitious and at hand when we should lead in this movement, and show our brethern in the East that we are truly

and sincerely possessed of that spirit and progress which permeates western life, and are willing to sacrifice any seeming local and provincial advantage which at present divide us, and join together in such a movement as heretofore referred to.

Before offering any suggestions as to the means to adopt to secure our object I will first refer to the conditions now governing registration in the four Western Provinces, and give you my reasons for believing a change in our system is advisable and called for.

Each Western Province now controls the right to license within itself, and demands an examination from every applicant for registration with one exception, viz.: British licentiates of standing before the year 1887, the latter securing this privilege on account of a decision of the Supreme Court of British Columbia. The other provinces accepted the decision.

After over twenty years experience as a member of the Council of the College of Physicians and Surgeons of the N.W.T. and of the examining board, I am satisfied that preparing and marking examination papers is not a gift, but an art that can only be acquired by large experience and the possession of scientific and practical knowledge, that is not always available in some of our Western Provinces, and that an examination even when most carefully conducted under our present regulations is not satisfactory, and does not ensure that even a large majority of the candidates who are admitted, possess the knowledge and qualifications that they ought to.

There are some crucial points that must be kept before us, and upon which much difference of opinion exists, and upon which some agreement must be reached before any change can be made, viz.:

1st. Shall we make any change from our present situation?

2nd. If so, shall each Province retain the power, which it now holds, to license within its own boundaries?

Before replying at length to the above points, I would beg to remind you, that no great advance or forward movement has ever been secured without unity of action, self-sacrifice, and compromise, on the part of those most deeply interested in the success of such a movement: and I appeal to that spirit of progress and advancement which is so characteristic of Western life,

and further to that spirit of self-sacrifice which is the inheritance of all true medical men who appreciate the full responsibility of their calling, and that it is a duty incumbent upon them, at all times and on all occasions, to raise their hand and voice and make every effort within their power, to secure and maintain such efficiency and standing in the members of their profession, as will enable them to be of the greatest service to their fellowmen. And if we are to accomplish such a result, we must be prepared to sacrifice personal ends and personal opinions, and compromise on the points of difference between us, for what is in the best interests of the profession generally.

I will now take up the crucial points referred to and discuss them.

1st. Shall we make any change from our present situation?

I think we should make an effort to do so for the following reasons: The number of men entering on the study of medicine is increasing from year to year, notwithstanding that the length of the course is being extended in a number of schools, and sooner or later will be adopted by all medical schools of good standing. The active competition between schools does not tend to foster the exaction of the highest efficiency from their graduates. And as the number of graduates is increasing to a greater extent than the population requiring their services, producing overcrowding of the ranks of the profession, which has a deteriorating influence in many ways and should be guarded against if possible. The raising of our standard will be the means of preventing inferior men securing registration, and the license to practice within the federation. It will supply men of higher professional attainments and efficiency, and ensure greater public confidence in the members of our profession.

For these reasons I think we are justified in placing our requirements for registration as high as any Province in the Dominion, both as to length of study for degree and the standard of our examination for registration.

By adopting such requirements we will not only secure well equipped and well qualified men, but on account of the great and increasing field which our Western Provinces offer as opening for the schools in the East, we will exert a direct and compelling influence on them, to lengthen and strengthen their course of

training to secure the highest efficiency possible, as no school in Canada can afford to be excluded from our Western Provinces ; and we would be in such a position as to entitle us to be received into reciprocal union if we do so desire it not only with any province in the Dominion but with any part of the Empire ; and as I have already said, I do not think our present system of examination will ever secure for us such a position as referred to above, or the standing we are seeking. To carry out the suggestion as to a longer course of study, we should provide that all students beginning the study of medicine after the change, shall take a five years' course for their degree to entitle them to write at our examination.

2nd. Shall each Province retain the power which it now holds, to license within its boundary ?

I am strongly of the opinion that it should not, as it would be in a position to perpetuate conditions which it is our great aim and object to overcome and remove, and if we wish to carry out such a movement successfully and raise our standard, I do not think it requires any further argument than I have already urged on the first point, to prove the wisdom of withdrawing this power and authority.

As you know the Roddick Act did not take away this power possessed by the different Provinces, and while I know it was impossible to secure the passage of the Dominion Registration Act without this concession, on account of the existence of Medical Schools in many of the Provinces, I always thought it was the weak point in the Act. Such condition as to schools does not exist to such an extent here as would stand in the way of this power being withdrawn from the Provinces, and for this reason the time is opportune to come together.

A question while not necessarily involved in any scheme for federation, will obviously suggest itself to the minds of many, and I do not think any discussion would be complete without reference to it, viz.: the question as to whether if such a scheme should be adopted, any privileges should be extended to licentiates registered in any of the affected Provinces at the time of the coming into force of such scheme, to register in any of the Provinces of the Federation without examination. The Roddick Act provided that all licentiates who were licensed and in practice

in any part of the Dominion for six years previous to the date of the coming into force of the Act were eligible for registration without examination and also that all less than six years were eligible for registration at the completion of the six years. I fail to see any justice in this latter provision, or in the admission at first of only a time limited number of licentiates. I cannot see why a licentiate of six years standing should be admitted and one of six years, less a day, should be excluded. I could appreciate the stand that all should be included. I do not myself hold any stronger convictions on this point, and would be willing to accept any solution of this question if it should prove a stumbling one that we could agree on rather than have our movement fail to materialize.

Before proceeding to discuss the various schemes that suggest themselves to me as practicable and workable, providing for a union of the four Western Provinces, with one examination as the avenue to registration in any one of them, I wish to refer to another question which will occur to many, but I also wish to make it very clear that it is a distinct and separate issue from the general scheme of federation—the question is that of "Reciprocity" between the four Western Provinces, without any change in the requirements for registration.

AS TO RECIPROCITY

I am not in favor of reciprocity between the four Western Provinces under the present registration requirements for the following reasons: It would not raise the standard of qualification. Alberta and Saskatchewan only ask for a four years' course of study. If adopted it could only prevail on the present basis for a short time, when a change would have to be made, as Manitoba and British Columbia have a provision in their law that on and after a certain date in the near future a candidate to be entitled to write for registration must have taken a five years' course for his degree. As soon as this date arrived the Alberta and Saskatchewan Medical Acts, which now call for a four years' course of study, would have to be changed to conform with those of Manitoba and British Columbia. Further I have already expresed myself at great length under a previous heading as to my opinion of the unsatisfactory character of the present system of examination for registration. That it does not ensure such

qualification and efficiency in our licentiates as we should require of them. Further we could not look forward or hope to secure reciprocal privileges for our licentiates from sister Provinces or other parts of the Empire with a higher standard of examination, even if we so desired it.

"SCHEME FOR FEDERATION."

That the four Western Provinces, Manitoba, Saskatchewan, Alberta and British Columbia join together and form a Federation that shall have power and authority through a "Federated Board," to provide and regulate the conditions which every person, wishing to register in any of the Provinces in the Federation, must comply with before being entitled to register.

There are several schemes by which this Federated Board may be constituted, and under each scheme will be defined, the power and authority which each Board shall have:—

I will now discuss these various schemes.

Scheme Number 1.

That the Medical Council of each Province in the Federation shall elect two of its members for the life of the Council to constitute with an equal representation from each one of the federated Provinces a "Federation Board."

The duties of the Board in this scheme which I set out hereafter in detail and which is carried out by the officials of the present councils within the Federation, and which I am satisfied is practical and workable and will secure the standard which we are aiming for, would have to be embodied in an Amendment to the present Medical Act of each Province containing the provisions hereinafter set out :

1. Five members shall be a quorum for the transaction of business.

2. The Federation Board shall meet once a year in each Province in rotation, the date and order to be fixed from time to time by the Board, and may hold a special meeting at any time and place at the call of the Chairman.

3. The Federation Board at its first meeting shall organize by the appointment of a chairman and secretary, who shall hold office until his successor is appointed, and shall make such rules and regulations for the conduct of its business as it may see fit.

4. The Federation Board shall appoint from time to time a

board of examiners for the yearly examination hereinafter provided for, with the subject allotted to each, and any vacancy occuring in the examining board between meetings of the Federation Board, shall be filled by the chairman of the Federation Board, naming some one for the vacancy, and shall immediately advise the secretary of the Board of such appointment which shall be confirmed by the Board at its first meeting thereafter.

5. The Federation Board shall prescribe the subjects for such examination and the marks required for a pass in both written and oral examinations.

6. The Federation Board shall prescribe the qualifications to entitle the candidates to write at such examination.

7. The Federation Board shall fix the date the Province and place in each Province where such examination shall be held from year to year, but in no case shall it be held where there is not a large thoroughly equipped hospital.

8. The Federation Board shall have power and authority in case any candidate fails to pass in all subjects, to prescribe the conditions of re-examination of such candidate as to whether he shall take all or only a portion of the examination again.

9. No supplementary examination shall be given.

10. The Federation Board shall have power and authority to fix the examination fee.

11. There shall be an examination held once a year in each Province in rotation for registration to any of the federated Provinces.

12. Every applicant for registration as above must pass this examination or comply with such other requirements as the Registration Board may impose.

13. The examination shall be written and oral.

14. The Federation Board shall have power and authority from time to time to prescribe the conditions upon which any Province of the Dominion shall be allowed to enter into reciprocal relations with us for registration purposes.

15. Expenses in connection with the meetings of the Registration Board and examinations shall be borne equally by the Provinces in the Federation.

The Secretary of the Federation Board.

16. The Secretary of the Federation Board shall as soon as

possible after any meeting of the Board at which examiners are appointed, notify such examiners of their appointment and the subject alloted to each of them, and that they will be expected to prepare a paper whenever requested to do so by the registrar of the Medical Council of the Province where the examinations are to be held, and will be expected to attend the examination and take part with the Registrar in conducting the examination, and that each examiner will be expected to conduct the oral examination on his own subject.

17. The Secretary of the Federation Board shall as soon as possible after the early or other meeting of the Board, forward to the Registrar of the Medical Council of each Province in the Federation a copy of all proceedings of the Federation Board and shall notify each Registrar as above of the filling of any vacancy in the examining board as heretofore provided for.

18. The Secretary of the Federation Board shall forward a certified statement of the expenses of each meeting of the Board, to the Registrar of the Medical Council of the Province where the next examination is to be held.

19. The Registrar as aforesaid to whom the Secretary of the Federation Board is directed to forward a statement of the expenses of each meeting, shall on receipt of such statement, pay such expenses and collect from the other Provinces in the Federation their share of the same.

20. The Registrar as aforesaid shall make all arrangements to carry on the examination and shall take charge of and conduct the same assisted at all times by at least two members of the examining board.

21. The Registrar as aforesaid shall at least one month before the date of the examination notify each member of the examining board that he must forward his examination paper to him to reach him at least two weeks before the date of the examination, and must attend at the examination and assist the registrar in conducting the same.

22. The Registrar as aforesaid shall collect all candidates' papers and distribute them to the examiners, who shall mark them and return them to such Registrar, with a report of their markings, including the marks of the oral examinations. The report of the examiners shall be final and not subject to revision.

23. The Registrar as aforesaid shall prepare a report of the result of the examination and forward it to the Secretary of the Federation Board, who shall issue a certificate to the successful candidates stating that they had passed the examination, and that on presentation of their certificate to the Registrar of the Medical Council of any of the Provinces in the Federation, and the payment of the registration fee for that Province they would be entitled to register therein. The Registrar as aforesaid holding the examination shall pay the expenses in connection with examination out of the examination fees received by him for such examination, and distribute the balance equally between the Provinces in the Federation, with a certified statement of the amount received and paid out.

24. Members of the Board shall receive $10.00 per day and travelling and other necessary expenses incurred in connection with attendance of meetings of the Board.

25. Members of the examining Board shall receive $10.00 for the preparation of each examination paper, and $10.00 per day and travelling and other expenses incurred in connection with attendance at the examination.

26. While I may have overlooked some minor details, I am satisfied that the foregoing scheme is a practicable and workable one and will give satisfactory results. It does not create any new and additional administrative body outside and independent of the present Medical Councils.

27. The Federation Board does not interfere with the existence or duties of the Medical Councils in each Province, only in so far as to power given the Federation Board to prescribe the requirements for registration is concerned, and certain details in connection with the examination.

28. Each Medical Council maintains its own Medical Register, admits to registration all applicants entitled to register in the Province under the new regulations, and carries on all the duties conferred on it by the Medical Act of each Province, except as set out in the preceding paragraph, and would, as now, have control of all monies received for examination.

29. The scheme provides an examination Board of unquestionably high character, the members of the Board may be selected from any part of the four Provinces, and with such a

wide field for selection a board of the highest efficency can be assured.

30. With up-to-date and thoroughly equipped hospitals in every Province furnishing abundant material for oral and clinical examination by thoroughly competent examiners, the results of such an examination should be highly satisfactory and open the gate to reciprocity with any part of the Empire, if so we desire it.

31. The constitution of the Federation Board ensures, that the members of it will always be men well acquainted and interested in all matters in their own Province, and can be relied upon to deal with the duties assigned to them with a full knowledge of all the conditions affecting their actions.

32. The duties of the Secretary of the Board will be very light and I am sure that any member of the Board who may be chosen to that position will be pleased to perform them.

In this scheme in making provision for the constitution of the Federated Board and providing its powers, it is necessary to insert in the Amendment to the statute in detail the powers to be given the Board and everything in connection with the examination as the Board is empowered by statute to utilize an officer of the present medical council, viz.: the Registrar, for very important duties in connection therewith which is the merit of this scheme, and whom the Board has no control over and otherwise could not make use of, were I to follow the same procedure in providing for the powers of the Board as I have done in Schemes Nos. 2 and 3 hereafter, viz., by a general clause (and efficiently so) giving the Board power and authority to provide requirements for registration and examinations and carry them out as it can do so within its own officials.

Scheme Number Two.

That the Medical Council of each Province shall elect two of its members to hold office for the life of the Council, to constitute with an equal representation from each one of the Federated Provinces, the "THE FEDERATION BOARD" with full power and authority to organize and conduct its business as it sees fit, to prescribe the requirements for registration to any of the federated Provinces, to provide for, regulate, and carry on through its own officials and appointees all examinations which

they may hold for registration to any of the federated Provinces, to fix and collect all fees for such examinations, to manage and control its own finances and funds, and shall issue a certifiacte to any person requesting it who has complied with and fulfilled all the conditions for registration which the Board may call for, and directed to the registrar of the College of Physicians and Surgeons of the Province in which registration is sought, this certificate shall be authority for such registrar to register the person on payment of the registration fee of such Province.

While provisions for the constitution of the Board in this scheme are the same as in No. 1, the power and authority vested in the Board in scheme No. 2, is much greater, it is given full and unrestricted control over the requirements for registration and over all examinations which it may hold, and the conduct of the same; fixes and collects its own examination fees and administers its own funds independant of any control or direction of any Medical Council or Statute but does not interfere with the existence or duties of any Medical Council in any other particular other than empowered as above.

Scheme Number Three.

That two members of the profession be elected by the profession in each Province, who, with an equal representation from each one of the Federated Provinces elected in the same manner, shall constitute the Federation Board, with the same power and authority as specified in scheme No. 2. Scheme No. 3, differs from No. 1, both in the manner of constituting the Board and in the large and independent powers conferred on it. It differs from No. 2, only in the manner of constituting the Federation Board, all other powers conferred on the Board in schemes 2 and 3 are the same, including the right to create an independent fund from examination fees. Further, scheme No. 3 involves the election of a second elective Medical body in each Province. Many will question the necessity, wisdom or real occasion of the election of such a second independent Medical body when equally good material is always available in the present Medical Councils, who are elected by the popular vote of the profession.

The subject is one of very great importance and interest to the profession, and as the matter has been discussed and referred to at some length in the Medical Journal in the West, it has

become a live question of engrossing interest, which no doubt the different Provincial associations and Medical Councils will take up at their annual meetings.

If any agreement is to be reached, delegates should be appointed as has been already suggested by the bodies above referred to attend the different meetings.

If this programme is carried out it will at once be apparent whether an arrangement is possible and if so, the scheme that will be acceptable for the proposed Federation.

If the stage of unanimity is reached as to the scheme it will be an easy matter to complete it.

A delegate or two could be appointed from each Medical Council to meet together at some central point, and with proper legal assistance prepare the amendments necessary to be made to the Medical Acts of each Province to put the scheme into force.

I trust I will be pardoned for going into the matter at such length and detail, and I thought it important enough to do so, with a view of interesting the profession and throwing as much light on the subject as I possibly could.

J. D. LAFFERTY,
Calgary, Alta.

EXTRACTS

If there be one significant phase to the activity of the medical profession to-day, it may be said to be its incessant and insatiable activity to learn the causes of diseases and death, to the sole end that disease may be prevented. Yet the public is too often doubtful and sceptical of our veracity and our motives when we attempt to demonstrate that such is actually the case, and this because in daily practice, each busy with his own cares and responsibilities we become isolated, or too often public attention is attracted to our minute differences and not to our grand agreements and we fail to present A UNITED FRONT to the public in this most important work in which we are engaged..—"Preventive Medecine", from "The Maritime News."—March, Dr. Walker's paper.

"The super-medical man will not fail to be a broadly consistent Christian.. .. .. .. far removed from fanaticism, "faith doctor" or a "praying healer".. .. .. 'Tis true, 'tis pity, and pity 'tis 'tis true" that there are not more Christian doctors then we should have more scientific christianity and less "Christian Science" so-called.—*Medical Brief*. May.

CANADIAN MEDICAL ASSOCIATION

For the forty-second annual meeting of the Canadian Medical Association in Winnipeg on the 23rd, 24th and 25th of August, 1909, transportation arrangements have been completed. For delegates, their wives and their daughters, (no others) from points east of Port Arthur the rate will be single fare plus twenty-five cents, for round trip tickets, provided fifty or more are present holding Standard Convention Certificates. These tickets will be on sale from August 14th to 21st, final return limit from Winnipeg, September 25th. If Lake Ontario route is used, payment of the following arbitraries must be paid to the pursers of the Richelieu lines : During August, Toronto to Montreal, $8.00 ; from Kingston to Montreal, $4.50. During September, from Toronto to Montreal, $6.65 ; from Kingston to Montreal, $3.50. Upper Lakes : Going, $3.50 additional ; returning, $8.50 additional. Side trips from Winnipeg one fare for the round trip, August 25th to September 24th inclusive. Alaska-Yukon-Pacific rates will apply for side trips to Pacific Coast points. Side trips to interior points in British Columbia will be announced in the annual circular issued in June or July 1st. Local convention plan arrangements will prevail for the West as far west as Laggan, and Coleman, Alberta. Lowest one way first class fare from British Columbla ; date of sale of tickets beginning August 16th to 19th inclusive, with final return limit September 25th. Anyone can find out the single first-class fare to Winnipeg by enquiring of their station agents.

SOCIETY MEETINGS

Manitoba Provincial Medical at Brandon June 22 and 23.

Sask. Medical, July 1st week.

B.C. Interior Medical, July.

Alberta Medical, 18th, 19th, and 28th August.

Canadian Medical, August 23 t o 25.

British Society, August 25 to Sept. 1st

NOTICE

ODD-NUMBERED SECTIONS

As already publicly announced, odd numbered sections remaining vacant and undisposed of will become available for homestead entry on the coming into force of the Dominion Lands Act on Sept. 1, next.

As the records of only the even numbered sections have hitherto been kept in the books of the various land agencies in the western provinces and the time having been very limited since the passing of the act within which to transfer the records of all odd numbered sections from the head office at Ottawa to the local offices, it is possible that the transfer of records in some cases may not have been absolutely completed by the 1st September. In any case where the record of any quarter section has not been transferred, application will be accepted but will have to be forwarded to head office to be dealt with.

As it has been found impossible as yet to furnish sub-agencies with copies of the records of the odd numbered sections and in view of the large probable demand for entries, all applicants for entry upon odd numbered sections are strongly advised to make their applications in person at the office of the Dominion Lands Agent and not through a Sub Land Agent. Applications for even numbered sections may be dealt with through the Sub-Land Agent as before if desired.

J. W. GREENWAY,

Commissioner of Dominion Lands,
Winnipeg, August 22, 1908.

Synopsis of Canadian North-West Homestead Regulations

Any even numbered section of Dominion lands in Manitoba, Saskatchewan and Alberta, excepting 8 and 26, not reserved, may be homesteaded by any person who is the sole head of a family, or any male over 18 years of age, to the extent of one-quarter section of 160 acres more or less.

Application for entry must be made in person by the applicant at a Dominion Lands Agency or Sub-Agency for the district in which the land is situate. Entry by proxy, may, however be made at an Agency on certain conditions by the father, mother, son, daughter, brother or sister of an intending homesteader.

DUTIES:

(1) At least six months' residence upon and cultivation of the land in each year for three years.

(2) A homesteader may, if he desires, perform the required residence duties by living on farming land owned solely by him, not less than eighty (80) acres in extent, in the vicinity of his homestead. Joint ownership will not meet this requirement.

(3) A homesteader intending to perform his residence duties in accordance with the above while living with parents or on farming land owned by himself must notify the Agent for the district of such intention.

Six months' notice in writing must be given to the Commissioner of Dominion Lands at Ottawa, of intention to apply for patent

W. W. CORY,

Deputy of the Minister of the Interior.

N.B.—Unauthorized publication of this advertisement will not be paid for.

IF WE could coin a word so comprehensive as to cover all the qualifications and superior properties of KASAGRA it would be synonymous with the word "Sterling" for the standard of excellence established and the uniform quality maintained has made

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The Sterling Cascara Preparation

Kasagra in small doses of from five to fifteen minims, well diluted, can be depended upon to give satisfactory results and tonic laxative effects not to be had from any other aromatic cascara preparation offered to the profession.

Sample on request.

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5-09

PROBABLY at no season of the year than during the months of April and May do you have so many neurasthenic cases to treat. Those Physicians who have given Dike's Digestive Glycerophosphates a thorough trial in their practise, have found it the most serviceable for neurasthenic patients and run down nervous conditions, nervous dyspepsia, etc.

The Active Digestants in Dike's Digestive Glycerophosphates, are a decided factor in assisting the thorough assimilation of the Glycerophosphates and are a valuable therapeutic agent as well.

If you havn't tried Dike's Digestive Glycerophosphates we would like to send you a sample.

Your druggist will supply you at $3.00 per winchester or $5.00 per gallon.

FREDERICK STEARNS & COMPANY

WINDSOR, ONT. DETROIT, MICHIGAN

Real Emergency Agents

PARKE, DAVIS & CO.'S HYPODERMATIC TABLETS

MEET EVERY REQUIREMENT.

They are freely soluble. They are *hand-molded*, not compressed. They dissolve completely in lukewarm water in a very few seconds. *Test them for solubility.*

They are active. Every agent entering into their composition is rigidly tested. *Their therapeutic activity is beyond question.*

They are of uniform strength. The content of each tablet is accurately determined, the medicament being uniformly subdivided by our method. *The dose is invariable.*

They are stable. They are molded by a process which insures firmness. *They do not crumble in shipping or handling.*

PARKE, DAVIS & CO.'S HYPODERMATIC TABLETS are real emergency agents. Prompt, efficient action follows their administration. There is never any delay, never any uncertainty. *Specify them when ordering.*

Supplied in tubes of 25—not 20, as are tablets of other manufacture; 25 per cent more medication for the same price.

Home-Made Buttermilk

EASILY PREPARED WITH LACTONE (BUTTERMILK TABLETS).

Professor Metchnikoff, the eminent bacteriologist, sub-director of the Pasteur Institute of Paris, in his book "The Prolongation of Life," shows that premature senility is probably due to putrefactive decomposition of waste material in the colon, with the absorption of toxins which cause arterio-sclerosis and other senile changes. He recommends the use of cultures of lactic-acid bacteria as a preventive of the putrefactive process, the most suitable vehicle for their ingestion being buttermilk.

Good dairymen's buttermilk is hard to obtain; but pure, fresh buttermilk from LACTONE (buttermilk tablets) may be had every day in the year, right in one's own home.

LACTONE is a selected culture of lactic-acid bacteria, in tablet form. One tablet will convert a quart of fresh milk into buttermilk in 24 to 36 hours—buttermilk of most delicious flavor and possessing the full nutritive value of sweet milk—a refreshing beverage, an excellent food for invalids, convalescents and children.

Buttermilk from LACTONE is used and prescribed by many physicians. We suggest that you give it a trial.

LACTONE (buttermilk Tablets)—Bottles of 25. Full directions with each package.

PARKE, DAVIS & COMPANY

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