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## EDITORIAL

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### ERYSIPELAS IN GENERAL HOSPITALS.

Quite recently the question has been raised in the public press as to the admission of cases of erysipelas into the wards of a general hospital. The subject comes up through a letter of Rev. Canon Ingles, who had tried to secure admission for a person suffering with this disease, and found much difficulty in securing the same.

Erysipelas has been regarded as a surgical disease, but, for good reasons, should not be admitted into a surgical ward. But there are medical wards where the patient have no wounds. We hold that cases of erysipelas may safely be admitted into such.

We would ask the medical profession to recall their cases of erysipelas, with the view of determining in their minds how many instances there were of the disease attacking other members of the family or nurses in attendance. We think the answer would be almost universally in the negative.

We do not hesitate to state that there would be no danger in the admission of such patients into medical wards. The treatment is such as would suit such a ward.

General hospitals may fall into disfavor by laying down rules that place the sick at great disadvantage, and do no good to the institution. A hospital is for the care of the sick, and one cannot well imagine a sick person more in need of proper care than one who is ill with an attack of say facial erysipelas. Care may be carried to the extreme limit of becoming foolish fear.

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### FIRE-PROOF HOSPITALS.

Once more we return to this subject. Quite recently there was a fire in the Aged Women's Home in Toronto, and about \$15,000 worth



of damage was done to the roof. There were 98 aged women in the institution at the time. Many of these were very old and feeble. A strenuous effort was put forth and the entire number removed to some place of safety.

This fire accentuates once more the need for using fire-proof material in the construction of every building in which the aged, the sick, or the insane are to be housed. There must be no trifling with this question. Stringent legislation should be placed in the statute books calling for this type of building from this date onwards.

A fire-proof building may cost more at the time of erection, but they last longer and are so much safer that in the end they prove less costly than buildings that are perishable by fire. Let us act according to knowledge.

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#### CHRISTIAN SCIENCE.

Quite recently a Toronto audience was treated to a lecture upon Christian Science by Bliss Knapp, C.S.B., and the press gave a fair amount of space to what was said. The lecturer was none other than a "member of the Board of Lectureship of the mother church, the First Church, Scientist, in Boston, Mass." We may conclude that what was said was authentic as to the real beliefs of the Christian Science Church on the subject of disease and its treatment.

"It is time that orthodox Christians generally accept this teaching as it relates to temptations of sin, but Christian Science accepts the same teaching as it relates to temptations to sickness. That is to say, we recognize that health is just as much a characteristic or attribute of God as are honesty and goodness, and therefore the individual makes the same mistake who believes that his health is a personal possession as he does who believes that his goodness and honesty are personal possessions. We save our health through the recognition of its divinity—that it is the gift of God—and that God has no more purpose to withdraw it than He would honesty and goodness. Therefore, one's health can no more be destroyed or impaired than can God Himself."

To anyone who is not Eddy mad this is madness pure and simple. No matter how men become honest or dishonest we know that there are such. In like manner we know that there are the sick and the well. But our Christian friends are confounding things that are not alike and then go to work to reason from their false premises. Honesty is a moral quality; disease is a physical condition. It is true that Christian Scientists claim that all disease is only a mental state.



But Christian Scientists grow old and die. They die, too, of consumption, cancer, Bright's disease, during confinement, etc., as do those who are not of their faith. It does seem a most astounding frame of mind for anyone to be in not to be able to recognize that he has a thigh bone and that it may be broken. Erysipelas of the face is a delusion of the mind.

When a Christian Scientist tells us "therefore, one's health can no more be destroyed or impaired than can God Himself," we are on the very verge of the precipice, to fall over which would be to light in an asylum for the insane. We think that the medical profession should pay more attention to the foolish and dangerous teachings of the Christian Scientists. It is not well that these crude views should go unchallenged.

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#### HOSPITAL PATIENTS AND MEDICAL FEES.

From time to time we read of actions instituted by medical practitioners to recover fees for attendance on patients who had received attendance while they were inmates of a hospital and occupied a private ward. In other words were not in any sense pauper patients.

The distinction is not very clear to the lay mind, and here we include with all respect the legal and judicial mind. It has been repeatedly held in court that when a party pays the hospital fees he is clear, unless it was made clear to him that these did not cover his medical and surgical attendance. Those who give their services to hospital patients must protect themselves against imposition by designing patients.

A few days ago Dr. B. E. McKenzie sued a man for \$350 for attendance. Judgment was given against Dr. McKenzie because of the fact that there was a doubt as to whether the patient did not believe that the hospital fees covered all.

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#### DOCTORS IN THE ONTARIO LEGISLATURE.

The medical profession did well in the recent Ontario general elections, and secured eleven seats out of the 106. This means about one doctor in the Legislature for every 340 practitioners. The basis of population for a member is 20,000.



The doctors, with their constituencies, are as follows:—Dr. J. O. Reaume, North Essex; Dr. Charles N. Anderson, South Essex; Dr. David Jamieson, South Grey; Dr. A. W. Nixon, Halton; Dr. A. E. Ross, Kingston; Dr. Elisha Jessop, Lincoln; Dr. R. A. Pyne, East Toronto; Dr. A. E. Vrooman, West Victoria; Dr. H. G. Lackner, North Waterloo; Dr. Forbes Godfrey, and Dr. James McQueen, North Wentworth.

Of these Dr. J. O. Reaume holds the portfolio of Minister of Public Works, and Dr. R. A. Pyne that of Education. These eleven members may be able to do some useful service for the profession should medical legislation come before the House for consideration, as is more than likely.

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#### SIR HENRY BUTLIN AND CANCER.

We hail with delight any new light upon this terrible disease. It would seem as if this has been vouchsafed in the important studies of Sir Henry Butlin. Sir Henry has been a very close student of this disease from the clinical and pathological standpoint, and has had much to do with the work of the Imperial Cancer Research Fund.

In 1905 he advanced the view that cancer was a parasitic affection; but parasitic from within, not from without. He took the view that the new growth was of the nature of a parasite to its host. He now elaborates this view very much more fully, and contends that this is true of all malignant growths.

He contends that the cell of cancer is a protozoa in all respects, that some change has occurred to give the cell an independent existence and that it can continue on reproducing itself independently and indefinitely. It is in this way that one of the phenomena of cancer is to be explained, namely, that the secondary deposits contain the same type of cells as the primary growth.

This cell he has called *unicellula caneri*, and the sub varieties may be named squamous, spheroidal, round, etc. This cell conforms to the laws laid down by Koch for such unicellular organisms. It is constantly associated with the disease, it will produce the disease in a healthy animal, it is found in this second animal, and that it may be separated and studied by itself. This latter condition is the only one that is in the least way doubtful, and now it is asserted by eminent authorities



that this cancer cell has been cultivated apart from the animal in which it originated.

The theory of embryonic rests, chemical stimulation, some external organism living in the cancer cell, are all empty phrases according to Sir Henry. They cannot account for the qualities of the cancer, which he puts thus: "Implant the normal cell and you cannot make it live. Implant the cancer cell and you cannot kill it."

If the cancer cell be a new creature he regards it as being nearest to the protozoa, so near that it is difficult to keep it out of the protozoa. There is difficulty in admitting that the cancer cell is a new created being, but there is no alternative. The facts are plain and cannot be otherwise interpreted.

There are two features that must be borne in mind. One of these is that the cancer cells destroy all other tissues they come in contact with, and the other is that they never revert to any normal form of cell or tissue.

As time goes on the tumor breaks down, ulcerates, and reaches the surface somewhere and becomes infected with various bacteria, and the new formation becomes septic. This accounts for many of the sufferings of the patient.

Investigation has shown that in some way constant irritation induces certain cells to take on this independent form of protozoal life. It looks as if the work that is now being done points to the possibility of a near solution of this disease that has held its secrets so long.

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#### A MARTYR TO SCIENCE.

Those who have lost their health or their life in the search for scientific truth are many, and the world goes on as if it was but little indebted to them, or forgetful of the fact that the comfort of millions has been purchased with the life of these workers.

An instance of this has occurred recently in the case of Dr. F. S. Pepperdene, of London, England. He was one of the early workers in x-ray therapeutics, and did much to perfect the appliances for this system of treatment. He lost one hand by the action of the rays, and is at present suffering with disease in the other.

As the result of this disease he has been forced to take a lengthy rest in the hope that he may recover from the affection. Experience has shown that there is considerable danger to x-ray workers in the production of cancer, blindness, severe burns, and other disorders.



## THE OPIUM TRAFFIC.

That the moral sense of the world is awakening there is abundant evidence in the fact that such good work is being done in the efforts to suppress the opium trade. The nations that have united in this good cause are the United States, Great Britain, China, France, Germany, Italy, Japan, the Netherlands, Persia, Portugal, Russia, and Siam. These dozen countries can do much if they will only continue in the praiseworthy work they have begun.

On the first of December delegates from these twelve nations met at The Hague. These delegates were invested by their respective countries with full powers to act and lay down such rules as may tend to lessen the evils from the sale of the drug. One wholesome indication is that the loss from the opium trade being curtailed is not allowed to way in the deliberations of these delegates.

The production of opium and its sale is to be reduced steadily by a certain ratio each year. In this way by a given year it is agreed that the trade will have become extinct, except such as may be required for proper medicinal purposes.

To this most humanitarian object we extend our sincere sympathy. The amount of disease and suffering that has been caused by the abuse of opium is quite beyond calculation.

But, look, the morn, in russet mantle clad,  
Walks o'er the dew on yon high eastern hill.

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The University of Dalhousie, Halifax, has taken over the control of the Halifax Medical College. The university will in future be responsible for the management and finances of the medical college. There will be a complete reorganization of the medical work of the college, which will be known as the Medical Faculty of Dalhousie University. This change will be of undoubted advantage to the cause of medical education in the Maritime Provinces.

Our esteemed contemporary, the *Western Medical News*, is doing good work by directing attention to the fact that the Commissioner of Health for Saskatchewan has made an important appointment of a person who is not a qualified medical practitioner, contrary to the law of the province.



## ORIGINAL CONTRIBUTIONS.

## IN MEMORIAM OF DR. J. F. W. ROSS.

A Series of Papers Read at the Toronto Academy of Medicine, 5th  
December, 1911.

## THE PRESIDENT'S REMARKS ON THE LATE DR. J. F. W. ROSS.

THE President, Dr. N. A. Powell, said that even before his graduation Dr. Ross became keenly interested in what was being done in our medical societies. Himself a logical reasoner and a clear and forcible speaker, he was at the same time one of the best of listeners. His earlier work was done in the Toronto Medical and the Pathological Societies. Later he was one of the most efficient members of the Clinical Society. On the suggestion of the present speaker and at the request of Dr. Albert Vander Veer, of Albany, he became a member of the American Association of Gynaecologists and Obstetricians, and in the transactions of this society many of his most valuable papers will be found.

When the Ontario Medical Library Association was formed his name appeared as a charter member, and in its work his interest never flagged. By making a large deposit with the library of the surgeon-general's office at Washington he made it possible for any physician in Ontario to obtain the treasures of that vast collection—now numbering 176,000 vols.—at the cost only of transportation of the books desired.

Elected president of the Ontario Medical Association, he set a new example to all of us by showing what a genius for organization could do when coupled with energy and tact such as he possessed.

When the British Medical Association met here he was appointed treasurer, and so well did he manage the financial end of that great meeting that at its close all claims were promptly met, and a thousand dollars remained as a surplus.

Above all these activities, however, must rank what he did in bringing together the four medical societies of our city and in evolving from them the Academy of Medicine.

The way for this movement was prepared by the late Dr. J. E. Graham, of beloved memory, who did more than any man before or since his time to blot out the differences which formerly split the profession in Toronto into cliques and antagonistic organizations. Many had talked of the desirability of union, many also worked to bring it about, but to Dr. Ross was given the admitted leadership which made it an accomplished fact. How strenuous were his exertions and how great



were the difficulties he encountered only two others beside myself will ever know. These others are Dr. Hamilton, hon. secretary at the time of amalgamation, and my co-trustee, Dr. Reeve.

When the new and beautiful home in which you meet to-night was handed over to the academy he said to me: "We have made a good beginning. What we want next is a large auditorium, a membership of 500, and double the number of books which we now have." Had he been spared to us these would have come in the near future.

Can we better show how we honored and loved him than by carrying forward the torch dropped in the tragedy that took him from us.

His untiring zeal in making the trails easier for the feet of those who are to follow us should inspire every fellow to more earnest effort for mutual helpfulness.

Dr. Ross had full records of 1842 abdominal sections. Each one of these was in greater or less degree a fight for a life. By this part of his work alone it may fairly be estimated that he added to the lives of his patients not less than 18,000 years. How much of suffering he relieved only one above can compute.

A private soldier of France fell in his hundredth battle. By Imperial decree his name remains on the muster roll of his regiment, and when it is called a sergeant steps from the ranks and answers, "Dead on the field of honor."

Our comrade belonged to the army whose mission it is to save and not to destroy life. He fell while doing his duty, and no soldier ever left a record more worthy of loving remembrance.

May I be pardoned for giving you in conclusion one personal incident? Once we sat late into the night and talked with naked hearts together. I spoke of the art treasures accumulating in his home. By chance it came out that when we visited distant cities we each went first to the rooms where our friends were operating, and then to the art galleries. By chance also we learned that each of us had for years been specially attracted by the attempts which great artists had made to perfectly portray the Madonna and her child Jesus. I remember saying to him: What is it that holds us so and brings us back again and again to these pictures? The deeper nature of the man came out, it seems to me, in his reply: "It must be the wonderful mingling of emotions—first, the tender love of the woman for her child, and then the awe and reverence of the maiden mother, who knows that she nestles in her arms her Lord and Him who was sent to be the Savior of all mankind."

Only to one whose own home life had been ideal, one who as touch-



ing both mother and wife had been fortunate far beyond the ordinary experience could such an interpretation have come. To both of these he knew his obligation and acknowledged it to his friends in words of manly frankness.

The friend who was with us but yesterday has passed behind the veil, and has solved the mysteries which lie beyond our present life.

He is not lost to us for "Life is ever lord of death, and love can never lose its own." Nor is his influence to become but a memory, for has not Ruskin said with perfect truth, "Every noble life leaves the fibre of it interwoven forever in the work of the world."

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### DR. ROSS AS A SURGEON.

BY J. ALGERNON TEMPLE, M.D., M.R.C.S., ENG., LL.D.

MR. President and Fellows,—I have been requested by the President to say a few words to you about the late Dr. J. F. W. Ross as a surgeon, and though deeply grieved that his unlooked for and much to be lamented death calls for such remarks, yet I feel privileged as an old and intimate friend of his that I have been chosen to pay respect to his memory, for by his death I can truthfully say that I have lost an old and genuine friend and one whom I shall always miss and whose place I shall find great difficulty in filling. It is not necessary to enter into details connected with his early life, as you are all familiar with it.

He graduated from the University of Toronto thirty-three years ago, subsequently going to England, where he took the license of the College of Physicians and Surgeons.

For one year he acted as one of the house physicians at the Toronto General Hospital, and then entered into practice for a few years with his late father, when he determined to take up special work, selecting gynecology and abdominal surgery, to which branch he devoted his whole life, and it is well known to us all how well he succeeded in bringing himself to the very front rank of his profession.

Whatever he undertook to do, whatever task he set himself to do he did with all his might. In order to perfect himself in this special work he went to England and allied himself with the late Mr. Lawson Tait, the then famous abdominal surgeon, and while with him he had every opportunity of seeing the best and most up-to-date work. He also went to Germany and spent some time there studying and working along the same lines of surgery.

On his return to Toronto he continued his special work and to the



end of his life devoted himself with characteristic energy to abdominal surgery.

It was about this time—that is after his return from England—that our professional intimacy sprang up, and it continued unbroken up to the time of his death. He was appointed to the gynecological staff of the General Hospital by the Toronto School of Medicine, while I was acting in the same capacity for Trinity Medical College.

Almost daily we met in the wards of the hospital assisting one another in operations and consultations, and it was during these frequent meetings that I learned his worth and the accuracy of his opinion.

As a diagnostician he was most reliable and accurate. He never gave a hasty opinion; he was always sure of his grounds before he spoke his mind. In an obscure case he would spend a long time taking into account every little detail of the history, all past and present symptoms, carefully weighing the most minute point, searching every part of the body that might aid him to form a proper opinion, and when once he had made up his mind he would adhere firmly to the conclusion arrived at. He never expressed a doubtful opinion; he was always positive, and it was a very uncommon thing to find him wrong. I learned the worth of and always admired his diagnostic powers. He was kind, gentle and generous to a fault; the pecuniary side of a case never entered into his mind; he gave the same attention and skill to the poorest patient as to those in better circumstances; he never refused me his aid and advice in any case or at any hour of the day or night. No social engagement did he ever allow to interfere with his professional work—it was duty first and pleasure after.

As a writer he contributed very many excellent articles to the medical press. As an operator he was neat, brilliant, quick and very thorough. I never saw a case leave his hands unless it had been well done, in fact, could not have been better done, and I can say this from personal observation of very many cases. As a teacher he was capable and painstaking. He never begrudged his time to impart knowledge to the student, as many who have passed through his hands can testify. The young undergraduate of to-day will miss in him an up-to-date and competent instructor and one whose place will be difficult to fill.

In conclusion all I can say is I deeply deplore his death. He was an honorable, upright man and an accomplished surgeon. His death is a great loss to the profession of Canada and to this academy in which he took such a deep interest. The same fortitude of character which was so strongly marked in his life did not forsake him in his last hours when he obeyed the summons of his Creator.



## DR. ROSS AS A MAN.

BY JOHN L. DAVISON, TORONTO.

MR. President and Gentlemen,—I esteem myself particularly happy in having been asked by you, sir, to make some remarks upon our late much lamented Dr. Ross as a man. After Dr. Temple's kindly address on Dr. Ross' characteristics as a member of the profession, my task should be easy, but I find a difficulty, not in lack of material, but in the very *embarrass des richesses*, which the subject offers me.

For many years it was my good fortune to be very intimately connected with Dr. Ross in a social way, and I felt and still feel that I knew him thoroughly. To say that to know him was to love him may sound like a platitude of platitudes, but in this case it is a simple statement of fact.

Perhaps no calamity has occurred in my lifetime which so shocked me, and this to a great extent, because of the, humanly speaking, needlessness of the catastrophe. Nature's laws are, however, inexorable. The law of gravity is not more certain than the law of accidents. What to our finite minds looks purely accidental is as much a part of the law, the great one and eternal law, as is the rolling of the suns in their course. We are forced to look upon nature as supreme. The race progresses, the onward march of evolution is never stayed, but the individual is a vanishing quantity. Human distinction, matters not; the scientist and the yokel, the prince and the peasant are all equal under this universal law of nature. As has been well said by someone, "So careful of the type she seems, so careless of the single life."

*"Pallida mors aequo pulsat pede pauperum tabernas Regumque turres."*

Such considerations may bring us comfort when we reflect in our calm moments about our own taking off, but to the crushed hearts of loving relatives and friends, they bring little solace.

The versatility of Dr. Ross' character makes it impossible to speak of him under all the phases of his active and useful life, and I shall very briefly attempt only a few. First allow me to give those of you who never were his companions in the wilds, some idea of his character in the field of sport. He was an ardent lover of the rifle, the gun, and the rod. There is no place in the world, so far as I know, where one gets so close to a man, where one finds out what kind of timber he is made of so well as on the trail, in the canoe, and around the camp fire. It is pleasant to think of the many glorious hours and days we spent together on the blue waters of the lakes of Algonquin Park and of



the Georgian Bay. His was a soul which thoroughly enjoyed primitive life. He had the ability to get close to the earth, and to nature in her wildest or in her most silent moods. The crashing storm in the forest, the whitening waves of the wind-swept lake, the foaming rapid seen from a canoe, or the silent breathing of the woods on a summer's day, all filled with the deepest joy.

He was one of those fortunate individuals who was able to take all the good, all the sweetness out of a sojourn in the woods. He sometimes loved to woo nature alone. I have known him to go away in a canoe, with a book of poems, or a philosophical treatise, and spend the long May day drinking in the glories of the woods, the waters and the flowers.

He was a close observer of wild animal nature, as must be everyone who is a good sportsman. His skill as an angler was very considerable. His knowledge of the game made him the Nestor of the party and he was generally at the head of the list as to game of all kinds. I would like to enlarge upon this side of his character, but time will not permit. Suffice it to say that some of the most delightful memories which life holds for me are connected with holidays spent in the wilds with Jim Ross. This much I must add, for it was characteristic of the man, that whatever work was forward he took the "butt end" as we say in the woods, his was the heaviest pack, his the most tricky canoe, his the longest trail. To those who have experienced life with a camping party, this will mean much; to those unfortunate ones who have never enjoyed a good rest, away from civilization, where some of the amenities are left behind, and the superfluities of comfort which we all enjoy at home, are not, those whom the great Walton describes as "other respectable folk," I may say that his was the major share of the toil and trouble, cheerfully undertaken, and I know thoroughly enjoyed in the doing. His happy song at night by the fire, while not that of a Caruso, was "a lusty note and strong." I know that he is now in the happy hunting grounds; certainly he takes with him more than the average man's knowledge of how to act wherever the trail may lead.

I am not a success as a business man myself, and so I am no judge of business capacity, but those who are capable of forming a correct estimate, have always told me that he was gifted with a capacity for accomplishment. His ample fortune—ample for a professional man—won by his own efforts, will bear witness to his powers in this direction. He was always known as a square dealer, one who could never stoop to the trickery of baser business methods, but who was out in the open



in fair competition. This combination, with his professional ability, is rare, and is certainly a mark of more than ordinary versatility.

There is something in the makeup of a man, outside of his knowledge, his generosity or his kindness. I refer to that which is expressed by that over-worked word, "personality." In Dr. Ross this was strong. Everyone knew just where he was; there was no shilly-shallying, no uncertainty. He always stood for what was good, honorable, manly, straightforward. His honesty was of a virile type—no thought of personal gain or distinction could ever swerve him from the straight and narrow path.

There was something heroic in the last act of his life which he himself directed. You have, no doubt, all heard of his electing to remain, bruised, fainting, and in dire distress by the bleak, wintry roadside, while his chauffeur, who he supposed was in worse state than himself, was sent on to a place of refuge. Relations of acts not a whit more worthy have come down to us through the storied centuries as examples of the height of unselfishness to which truly noble minds may rise. The officer who gave half his cloak to the wounded soldier, Sir Philip Sydney, who gave first of his bottle of water to a stricken comrade, were not more truly great in these acts than was Dr. Ross in this, as I have said, his last self-directed act. Such nobility of character should not be forgotten, and I trust the archives of our academy may keep the memory of this, among other remembrances, always green.

I wish to speak a few words, very modestly, of his family life. My knowledge of this is not gathered from experience of Dr. Ross with his wife and children; but the occasion never passed without his showing both by act and word that he was indeed a wise, affectionate and loving husband and father. The relationship between the doctor and his sons was a revelation; it was beautiful and uplifting. They were friends, chums and good fellows together. With this part of his family life I have had some experience, and I can only say that it was delightful to be in company with father and sons in the woods—no stronger word can be said. For, to persons of middle life, the presence of boys is often oppressive, and especially if the father be of the company. His tender love for his wife was to him too sacred a thing to be manifest, except to those who knew his inmost heart.

His capacity for work was phenomenal, and his strong sense of duty ever before him. No thought of personal convenience, no thought of present pleasure or enjoyment, ever I believe, weighed as a grain in the balance, in delaying for a moment that which he believed should



be done. I was always struck with the thoroughness with which he did everything he undertook, and his impatience with imperfect performance in others. His whole life work shows to what extent his thoroughness, promptness and readiness made him eminent in his profession and in the community. "If the power to do work is not talent, it is the best possible substitute for it."

He had, as all sensible, hard-worked men have, his fads. Pyle says, and I think very wisely, that, "fads constitute a mental anti-toxin to the poison generated by cerebral over-activity." His wholesome, bright and cheery nature bore witness the beneficent action of this mental anti-toxin, for cerebral over-activity, was a part of his working-day life.

I would like to speak of him as a friend, of his kindness of nature, of his thoughtfulness for those not so fortunately circumstanced in life as himself, of his well-known generosity, his manliness, of his qualities as a fair-minded, out in the open opponent, of his loyalty to his friends, but time will not permit. Bacon has said, "He that dies in an earnest pursuit is like one that is wounded in hot blood; who, for the time, scarce feels the hurt; and therefore a mind fixed and bent upon somewhat that is good, doth avert the dolours of death. But, above all, believe it, the sweetest canticle is Nunc dimittis when a man hath obtained worthy ends and expectations. Death hath this also, that it openeth the gate to good fame, and extinguisheth envy. *Extinctus amabitur idem.*"

Well, he is gone. If it be vouchsafed to us by nature to know our friends on the other shore, as is believed by so many of our faith, then I humbly trust that when my turn comes to go out alone into the darkness, when the grim ferryman approaches that other shore, I may see the face of my dear old friend there to welcome me, as I know and feel he would welcome me, and hundreds of others whose hearts are in his keeping.

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### DR. ROSS AS A PRACTITIONER.

BY ALLEN BAINES, M.D., TORONTO.

**T**O-NIGHT it is my sad privilege to try to give a life portrait of my late dear friend, James Ross, to endeavor to tell you what he was as a man.

First, looking back over the vale of the years, unblurred by the mists of time, I see him again as a youth, and I find how truly he verified the poet's assertion that "the boy is father of the man"; for this



fair, stalwart, blue-eyed lad, full of courage and full of vitality, was then already possessed of that immense energy which, revealing itself alike in work or play and dominating all his movements, became, later, the keynote, as you all know, of his life.

In the days of early and of later manhood, still we associated with him, as one of his essential characteristics, this eager enthusiasm which spurred others on and endeared him to his fellows. It showed itself in his play on the lacrosse field, in his drill on the grounds of the Queen's Own, it gave zest to his favourite sports of yachting and fishing, riding and shooting, but how much more did it avail him in all his splendid surgical work. One might liken him to one of the swift boats that he loved, breasting storm and overcoming obstacles by the force of its impulse, yet governed in all its movement by direct obedience to the Touch of the Man at the Helm—that Man at the Helm to Whom the true man ever submits himself.

He never lost sight of a sense of duty and a reverence for discipline. These were the balancing powers of his life, which, himself obeying, he, as a leader, never failed to require in others.

Some men there are whose life work seems to extinguish in them all desire for the less practical side of life. With him this was not so: Side by side with his passionate love for that profession in which he was so brilliant a light, there was in him a true love for things artistic and literary. It was a true love—neither a superficial adoption of art phrases nor a feigned but unfelt admiration. That could not be, for his honest, ardent soul scorned all pretence. Books of the best kind were the friends of his leisure hours, and the names upon his well-filled shelves showed that he took especial pleasure in works on travel, history and biography. Gifted with keen artistic sense and judgment, he had gathered around him a very fine collection of paintings. Every moment of travel was a joy to him: men and manners, customs and scenery, all were impressed upon his keen and observant mind, and much was reproduced for others in his beautiful views, for he was an adept in photography. When he came home it was an intense pleasure to follow him in his able and vivid descriptions which gave life to his photographs, and many charming evenings have been thus spent in his company, nor was his pleasure as entertainer one whit less than ours as listeners, for his noble and expansive nature enriched itself in making others the sharers of its own sunshine and happiness. Nor did it stay there, but, descending into earth's darker spots of woe and sickness, it never lost a chance of allaying misery nor of lifting the cup of hope and cheer to the weary lips of the suffering. No night was too dark,



no way was too rough, no journey too long, no house was too poor for the entry of this kind and skilful friend of man. Truly can it be sung of him that he

“Wrung from his soul its applicative strength,  
And bent to the cord the strong bow of his ken,  
And, bringing his life to the level of others,  
Held the cup he had filled to their uses at length.”

He was “a man among men,” and “his life was a pledge of the ease of another’s.” Each of us will remember instances hitherto untold of his kindness—untold because his manner was to do good deeds by stealth and in quietness and not for praise of men.

Among many that I know, one alone shall be related: At about two o’clock one morning a practitioner in the east end of the city telephoned, asking him if he would come out to try and save the life of a dying woman, the wife of a poor labourer who could pay nothing. Payment was the last thought in our friend’s mind. A woman, wife and mother lay dying, so, being such as he was, of course he did not hesitate a moment. “Get good lights,” he answered, “and plenty of hot water, and I will come as soon as possible.” Arriving there with instruments and dressings kept ready for emergency, he found the surroundings utterly unfit for operation, so, lifting the patient and wrapping her poor blanket around her, he took her to his cab and held her all the way in his arms, which were numb with sustained effort when they arrived at the hospital. At once he operated, and to-day that woman lives, a happy, grateful wife and mother.

I am sure that many of us in this room could cap the story with others of the same kind. Such deeds as these were not bright spots here and there in his career. They formed a large part of his life and they were an index to his beautiful nature and to his conception of himself with all that he had, riches, mental power and manual skill, as a steward of God, dedicated to the service and help of his brother man. This conception was the motive power, forbidding him to allow any social engagement or pleasure to interfere with work, whether undertaken for remuneration or for love.

Our admiration and affection so exceed our powers of its expression that all our words seem inadequate, and behind them lie those deeper thoughts which can hardly be clothed in language, because friendship, so sacred and so intimate, seems to hinder our speech. We know we have felt his great loyalty of soul, which could neither find nor allow others to find flaws in those that he loved. A loyalty too



strong to be hedged by any time-serving diplomacy—too strong and too honest. He was the upright son of an upright gentleman, of whom men said, to quote the words of the late Dr. Hodder about him, "I like that man, he is so honest." With the loyalty was coupled an unbounded desire to do the best, to give the best of himself, his goods, his hospitality to those thus bound to him by friendship's ties. With reluctance I finish my poor tribute to one of the brightest and the kindest and the most gifted spirits whom it has been my privilege to claim in affection. Unspoiled by wealth, but using it for further stewardship, unhardened by contact with the world, this true, brave soul passed out, as he had lived, in the exercise of his high profession, his last act being one of a deep unselfishness that proclaimed him a follower of that Saviour to whom he has gone.

I have not dared to speak of him as husband and father. We who have seen him in his home life know how beautiful it was in both capacities, what love and companionship was rendered by each to him and by him to each. Therefore, we can partly gauge the agonising grief of these days of separation for that dear wife and those sons and daughters. Let all we say to-night, however imperfect, be an expression of love for his memory and deep and heartfelt sympathy for his nearest and dearest in their distress.

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A FEW NOTES REFERRING TO THE CONTRIBUTIONS TO  
MEDICAL LITERATURE AND THE WRITINGS OF THE  
LATE DR. JAMES F. W. ROSS, TORONTO.

BY FREDERICK W. MARLOW, F.R.C.S., TORONTO.

**D**URING the brief time that one has had in the preparation for this meeting of a few notes referring to the contributions to medical literature and the writings of the late Dr. James F. W. Ross, of Toronto, one has been able only to make a hurried review of the numerous papers written by him on subjects in which he was particularly interested.

His earlier contributions date back to a little more than twenty years ago, and there are several of comparatively recent date. Altogether there are some seventy papers, and while a very few of these are merely case reports setting forth some particular feature of interest and importance, the vast majority are compilations and deductions from personal experiences setting forth in a clear manner the various de-



velopments and stages of progress in the science of gynaecology and of abdominal surgery during the past twenty years. In fact, it is doubtful if one could appreciate the progress of these sciences more clearly in any way than by a careful perusal and study of these papers.

Careful preparation, and the avoidance of introducing useless material, together with a candid, plain-spoken, and good literary style, are amply demonstrated, and when one considers the large number of his contributions, one can form but an inadequate idea of the work entailed in their preparation and what this must have meant to a man so busily occupied at all times and under all circumstances.

During the decade preceding the last it was in the American Association of Obstetricians and Gynaecologists that the surgical procedures of the pelvis and abdomen were actively discussed by many of the most noted surgeons that America has produced, and out of their deliberations arose many valuable suggestions. The late Dr. Ross was an active member of the association, being its president in the year 1897, and it was at the meetings of this association in various cities of the United States and in Toronto as well that many of his most valuable papers were read and discussed. As a result of this and from the intrinsic value of his work and contributions to medical literature at a time when gynaecology and abdominal surgery were making such rapid, onward strides, he attained such recognition on the American Continent as has been gained by but few American surgeons and probably by no other Canadian surgeon.

That he was a pioneer in his work there is much evidence. His papers on "Ectopic Gestation," written in 1892 and 1893, show that he was in the front rank in the successful recognition and treatment of this important disease, and those papers, together with others written at various later intervals, embody as much useful information as can be found elsewhere concerning it.

His papers dealing with the surgical treatment of fibro-myomatous or other tumours of the uterus demonstrate very clearly the stages through which the operation of hysterectomy has passed in reaching its present state of comparative surgical perfection. His description of the earlier operations in which the stump of the uterus was snared and treated extraperitoneally would almost make anyone of the younger generation rejoice in the fact that he had not begun his surgical career until the operation was transformed and that method banished forever. Dr. Ross was one of the earliest surgeons to suggest and to successfully adopt a method of ligating the tissues around the cervix uteri between the abdomen and vagina so as to permit of the entire removal of the



uterus and complete closing of the abdominal wound. This was in 1891, and a year later before the Ontario Medical Association he said, "I will never do another abdominal hysterectomy with an extra-abdominal pedicle as long as I live if I can operate by this other method. I feel that this operation will be the one generally adopted before another five years are over. I can heartily recommend it."

Early and late papers have pointed out the most rational methods of procedure in cases in which abdominal tumours are complicated by pregnancy.

Not a few papers have been devoted to the subject of the treatment of pelvic inflammations and these point out very clearly the type of case demanding surgical treatment, and the methods to be adopted, and describe the palliative measures to be diligently pursued in others.

Other valuable contributions embody such subjects as Caesarean section, appendicitis, peritonitis, intestinal obstruction, alimentary anastomosis, cholecystitis and gangrene of the gall bladder, gall stones, pyelonephritis during pregnancy, and peritoneal tuberculosis.

One paper demanding special mention was read at Richmond in 1896. This was a time when the now deservedly defunct operations of ventral suspension and fixation of the uterus were much in vogue for the treatment of real or imaginary flexions. The title of the paper was "Unnecessary and unnatural fixation of the uterus and its results." Dr. Ross invaded the American camp, practically single-handed, and denounced such procedures in the strongest possible manner. He said, "I venture to predict that the operation will be almost unheard of at the termination of another decade, owing to the fact that it is physiologically and anatomically unsound." The present dishonourable status of these procedures proves his prediction was correct.

Dr. Ross was ever wont to deprecate the performance of unnecessary and unjustifiable operations, and this is well shown in the paper just mentioned and also in others in which he condemned many years ago the too frequent removal of tubes and ovaries that were not the seat of gross pathological changes or of the patients' ills.

In recalling the fact that only a few years ago the use of the elastic ligature as a method of performing the operation of gastro-enterostomy was strongly advocated, it is interesting to note that at least eighteen years ago this method was tried in a similar procedure and failed and was discarded just the same as it failed and was discarded more recently. In 1893, owing to the persistence of a biliary fistula following a cholecystotomy in a case of obstruction of the common bile duct by a small malignant growth giving rise to severe cholaemia, Dr. Ross at-



tempted to produce a fistula between the gall bladder and the duodenum by the application of an elastic ligature. More than a month later the patient died from repeated haemorrhages, and on examination it was found that the elastic ligature had disappeared and had left a firm adhesion between the gall bladder and duodenum, but no fistula. Dr. Ross' case was the thirteenth of cholecystenterostomy reported in the literature. In one other the elastic ligature had been tried and failed, the majority of the successful cases having been done by direct suturing. In his remarks on the case Dr. Ross said, "As to the methods of producing anastomosis, I will in future resort to direct incision and direct suture." Later on, with others, he tried the Murphy button and other mechanical devices, but soon returned to his previous determination to employ direct suturing in all cases of alimentary anastomosis.

A careful perusal of his writings will show beyond the shadow of a doubt that Dr. Ross had early attained a firm recognition of the principles underlying the science of gynaecology and of abdominal surgery and was rewarded with unbounded success in their practice.

That he was charitable, fair, and possessed of due regard for others is well known. Speaking of the doctor's ideals in practice he said, "Charity should be written in letters of gold on the brow of every doctor, and what he gives in charity will come back to him a thousandfold in the heartfelt gratitude of suffering humanity. His heart should be full of love, and light, and sunshine, and uplifted with the nobleness of his calling."

In his presidential address to the American Association of Obstetricians and Gynaecologists in 1897, he said, "The young should be encouraged and guided by their seniors. All of us must have some pleasant reflection as we look back upon the action of some of the older men in our profession. We may perhaps have some unpleasant reflections, because, unfortunately, some of the older men are unable to tolerate the advance of youths amongst us. It ought to be pleasant for any of us, when our hands shake with age and our eyes are dimmed as a consequence of senile changes to be able to point to one of the younger men and say: "This is one of my pupils. See what he has done. He is a credit to all who have been connected with him." And the younger men should never fail to retain a certain amount of fatherly respect and reverence for those to whom they owe so much. Opinions of others demand respect; it is sometimes difficult to understand their meaning, because we put our own interpretation upon that meaning."

Some of his closing words in the first presidential address to this Academy of Medicine were these: "Peace, gentle peace is pleasant; but



there are "wagging tongues in every parish," and doctors are estranged from one another for life owing to a lack of mutual understanding. New ideas seem to beget ruthless criticism. While we exhort the members of our profession to dwell together in peace, we do not ask them to sacrifice principles for the sake of peace. Our academy, we hope, will promote harmony. Having reached the half-century mark, and having fought many fights, I am convinced that infinitely more good may be accomplished by the ways and means of peace. Let the means adopted to attain our ends be manly and above board, so that the practice of our profession may indeed be an honourable calling.

Bickering is said to originate with the older men. Be this as it may, it would be the ideal part of the younger men in all quarrels to keep their own counsel in the interests of peace. Envy has been called the shadow of success, and detraction the echo of its voice; but envy, so common to the human race, might wisely be buried in the deepest recesses of the heart and be known to none but its unfortunate possessor. Fellowship should actually mean what it implies; a spirit of comradeship should prevail, and if we cannot become close friends we can at least remain loyal comrades."

417 Bloor Street West, Toronto.

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### THE OUT-PATIENT CLINIC; ITS AIMS AND POSSIBILITIES.

BY C. N. B. CAMAC, M.D., NEW YORK CITY.

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1. The Dispensary and the Practitioner.
2. Dispensary Abuse.
3. Investigating, Visiting Nurse and Social Service Work.
4. Donations, Bequests and Volunteer Workers.
5. The Scope of the Dispensary Work.
6. The Medical Staff.
7. The Clinical Laboratory.
8. Medical Meetings.
9. Medical Records.
10. Medical Report.
11. Teaching.
12. Directors' Meetings.
13. The Building.
14. Cost of Maintenance.
15. The Ontario Educational System and Toronto's Position in Medical Education.
16. Summary and Conclusion.



Some months ago I received from the Managers of the new Toronto General Hospital and the Fellows of the Toronto Academy of Medicine an invitation to present to them an address upon the subject of the Out-Patient Clinics of New York. In my reply to this invitation I pointed out that, while I had taken a great interest in this subject, visiting and studying many such clinics, my actual experience was too limited to enable me to aid, by an address, the work of organization. It was, however, indicated by the Managers that they were seeking information from many sources, and as plans were maturing they would be glad to hear from a New York source. It seemed then that if I were to record some of the mistakes made in the management of a dispensary in New York City, and to point out the lessons learned therefrom, it might be of service.

In the effort to upbuild and expand your hospitals and university you have shown that your plans are so broad and so deep that they have already assumed proportions of international importance. In this scheme of development you are endeavoring to meet not only the educational demands of the Dominion, but also the immediate needs of a large and growing local population. One of the most important of these local needs is the Out-Patient Clinic.

#### 1. THE DISPENSARY AND THE PRACTITIONER.

The proposition to establish a hospital rarely meets with opposition, while a like proposition with regard to a dispensary almost uniformly is received into a community with disfavor. So important is this to the citizen and the profession that it will be well to trace its origin and causes.

Prior to the establishment of dispensaries (1,700 about), every physician cared for a large number of patients who could not pay. Those not treated by a legalized physician were drugged by grocers, peppers and apothecaries—and for these services a small fee was charged. The sale of something of no value nets for a time more than 100 per cent. *financially*, though morally the calculations differ. With such unrestricted practices affairs reached a shocking state. What finally brought the whole subject to public attention was an act in the reign of James I., entitled “Freemen of the Mystery of Grocers and Apothecaries of London,” *whereby these tradesmen might perform phlebotomy*.

In the year 1617 the adulteration of drugs, incompetency and scandal became so broadcast that the College of Physicians succeeded, by a new grant, in bringing the apothecaries under the college control. Though a step in the right direction this led to the most absurd situations. Mead and other physicians met the apothecaries at a coffee house



in the morning and evening and without seeing the patients, gave advice and prescriptions, a procedure which forcibly suggests the modern "absent treatment." We dare not, however, be too censorious, for it is only a few years ago that our own dispensaries did about the same, with this difference—an ignorant patient described his ailments, and, without an examination, a prescription covering the chief complaint was given.

Thus the London physician was entirely dependent upon the apothecary for his practice as is the barrister upon the solicitor in English law. To attack the apothecary was for the physician to threaten his entire livelihood—for people preferred the apothecary. There were found, however, men whose principles were higher than their pockets. These boldly attacked the apothecaries and the whole system. When attacked the apothecaries declared that they cared for the poor who could not pay the physician's fees. It was a difficult situation, for the authorities and the people were with the apothecaries, who were men of broad political influence. Their cause, however, was against the truth and the few bold opponents trusted to the invincibility of this fact.

In the year 1687 we recognize the first seed of the dispensary, in the ruling of the College of Physicians requiring, "All the fellows, candidates and licentiates to give gratuitous advice to their neighboring poor." From this moment was heard the question, still asked to-day—"Who are the poor?" The effort moreover was much frustrated by the apothecaries charging exorbitant prices for drugs; prescriptions, in consequence, were thrown away. The situation was most complicated.

The controversy involving all grades of society, professional, political and lay, had been going on for nearly a century when, as was the custom of those times with such widely discussed questions, the dispensary and the agitation which it caused became the subject of prose and verse by Pope and lesser lights. Garth's, "The Dispensary", is, however, the literary product which did through ridicule, what Jurist, Scientist and Statesman, with profound thought, so often fail to do.

Our modern dispensary, then, may be considered to be in its 200th odd year, according to the Parish Register, but sadly underdeveloped and deficient for its age. When, however, we consider the struggle for existence which this tough, though underdeveloped product has had and the calumny and slander which it has withstood we realize that it has triumphed because it stood for general welfare rather than for individual selfish gain.

In 1688 came the next great step in dispensary development. The laboratory of the college was devoted to the preparation of medicines. The problem seemed solved. The apothecaries, however, raised another



very modern cry, namely, that the scheme was a *money-making one* for the purpose of underselling them, and by this charge they succeeded in arousing opposition in the college itself.

Two classes thus arose in the college—Dispensarians and Antidispenarians—classes which, with some modification, exist to the present day.

In 1696 the most significant act took place. Having failed to receive the support of the city authorities, the college called upon its members to subscribe £10 each—the money to be “*expended in preparing and delivering medicines to the poor at their intrinsic value.*” Fifty-one subscribed—by no means all the members, but among them were names which stamped the move as genuine and lofty. Millington, Boyle, Wren, Willis—all founders of the Royal Society (the latter being at that time president of the College), Sir Hans Sloan, 16 years the college president and founder of the British Museum—Edward Browne, son of Sir Thomas, and many others of like position.

This one of the many medical wrangles, growing fewer fortunately in later days, I have taken time to trace because it prepares us to consider intelligently many modern features of *Dispensary Abuse*.

## 2. DISPENSARY ABUSE.

There is *abuse, misuse and neglect* embodied in this word ABUSE.

A. The patient is culpable in—

1. Receiving, under false representation, charitable aid.

B. The physician is culpable in—

1. Poor or hurried work.

2. Selfish ends—practice getting. Under this head comes the medical parasite whose one question is, “What is there in it for me?”

3. Manikinizing the patient. Under this head comes the physician who regards the patient as a model or a figure to be used for experiment and teaching.

C. The institution is culpable in—

1. Pauperizing the public.

2. Under-equipping the department.

3. Employing the dispensary merely as a channel for hospital patients or teaching.

4. Destroying the clinical accuracy of the physician because of poor dispensary organization or inadequate equipment.

5. Depriving the practitioner of a legitimate source of income.

I will consider throughout this address some of these abuses, but I



would like to take up here that most commonly mentioned, namely *receiving under false representation charitable aid*.

That some physician was being deprived of some patients has been the bogie-man in every dispensary administration. This can never be accurately measured. But until it is adequately dealt with there will always be a large body of men, influential and otherwise, opposed to the dispensing of free medical aid. Men thinking themselves unjustly treated turn to justice. The law is made or invoked. Consequently we had the following law in New York, issued by the State Board of Charities:

“Any person who obtains medical or surgical treatment on false representation from any dispensary, licensed under the provisions of this article, shall be guilty of misdemeanor and on conviction thereof shall be punishable by a fine of not less than \$10 and not more than \$250,” with imprisonment for failure to pay fine.

This was conspicuously posted in every dispensary and remained unheeded, becoming fly-specked and brown with age. *The making of laws alone will not correct the situation*. I believe there is only one rational means of dealing with this whole question—a means which should be a necessary part of every large charity. This is in thoroughly organized investigation work, in order that injustice, favoritism and extravagance be avoided and that pauperism be not encouraged. Keeping the right hand ignorant of the doings of its fellow applies to the *spirit* of giving—and does not justify the philanthropist in pouring out his charity on one class of individuals while he thereby thoughtlessly deprives another body of a legitimate means of livelihood. There are complaints in this connection which can never be settled, they are raised by men who will always have a grievance against successful men and things. In most communities this group of individuals is made up of sons of misfortune, those who have failed to overcome obstacles of bad health or environment or who are too indolent to take the long journey of experience and who attempt “to enter not by the door, but to climb up some other way,” or to shortcut across the marshlands of assumed knowledge. President Butler characterizes the observations of such men as “vaticinations projected from the serene obscurity of an empty brain.” They will try the soul of any administrator, for, knowing that they know not, they employ their wits in hiding their ignorance and in opposing progress.

But, when these wailings of insincerity and incompetency are set aside, there are many large and real problems of dispensary abuse raised by true administrators and by hard working sincere practitioners, whose



legitimate and only source of livelihood is in the district served by charitable institutions.

### 3. INVESTIGATING, VISITING NURSE AND SOCIAL SERVICE WORK.

*This is an essential in dispensary administration.* Without it you may run a dispensary with elaborate showings in numerical attendance, but the quality of the work done is of very inferior grade, from the physician's, the patient's and the institution's standpoint.

In New York City the Charity Organization will investigate, at a cost of 25 cents, any case referred to them. A full investigation, with typewritten report, including an opinion, will be rendered. This is, of course, objectionable in many respects.

Though the social worker is not supposed to *investigate* in the strict sense of the word, the results are far more satisfactory to the physician than when this work is done by the Charity Organization, for the visiting nurse's and social worker's interest is more than that of mere inquiry, and in consequence much important medical as well as social information is obtained.

In the Vanderbilt Clinic this whole organization is known as "The Auxiliary." This includes five nurses, who during the year 1910 made 8,441 visits. A trained social worker was also employed, and she made 1,636 visits. The nurses carry medical aid to the patient and bring valuable information to the physician, and the social worker assists those in trouble or need. During the summer an additional nurse was employed, by whose aid 165 persons went to country houses for a vacation, 91 to convalescent homes, and 3,441 on day excursions. Volunteer workers, drawn from young women interested in charitable work render valuable assistance to the trained workers.

One of our mistakes in the Cornell dispensary was the long delay in organizing this service. The loss to the patient, to the physician, to the medical school and to medical research and to the city, I believe was great. The experimental stage in which all social work was, some years ago, caused the directors of the Cornell dispensary to hesitate, although the plan was urged upon them. Dr. Cabot, at the Massachusetts General Hospital, succeeded in overcoming the adverse criticism which declared the whole thing fanciful, chimerical, etc., etc., and used his great institution for one of the true functions of a wealthy plant, the testing out of scientific and philanthropic plans. In 1906 18 dispensaries only of the 67 in the Borough of Manhattan, employed visiting nurses. These numbered 44, and they made 46,514 visits during that year. Since then, however, directors of many institutions, emboldened by Cabot's success, have established similar services, so that now New York City



has scarcely a dispensary without some organized visiting staff of nurses or social workers or both.

Some dispensaries have, in addition, visiting physicians. In 1906 there were 23 of these, with a total of 82 physicians, who made 30,540 visits in the year.

I have said that social service and district nursing is an essential in dispensary administration. This statement is made because through this organization the *quality* of the work done can be estimated. To the managers of a dispensary who have no higher aim than obtaining patients for gross teaching material or as feeders to a hospital, or what we would like to believe is too ignoble to be possible, but which is alas at times a "stench in the nostrils," a patient getter for the attending physician, to such, social service and district nursing, or in fact any equipment beyond a drug store, is unnecessary. One has but to put up the sign "Dispensary" or "Out-Patient Clinic" in any large town, in order to have a good *numerical* showing in patients—a showing which is always put forward as an index of the success of a dispensary. Numerical records in dispensary work are a record of the population and needs of a district and serve as a guidance for the equipment required. As an index of its success as a healing, scientific, or philanthropic station, the number of patients attending is misleading and deadening. To those who have no higher ambition for a dispensary than that mentioned—may I repeat them? *Gross teaching material, hospital feeder and private practice channel*—social service and district nurse visiting will be considered as either "detrimental," "unnecessary" or "an extravagant refinement." The terms here used are quoted from opinions expressed by men with whom I have talked. I believe such opinions have been outgrown, and those entertaining them are no longer fitted to direct the policies of a modern dispensary.

The social worker and visiting nurse staff are then essentials, without which no conscientious body of organizers should open a dispensary. Once such a body of workers is set in motion the mass of complaints, which could not before be met by facts, dwindles materially, and the number of unsuitable cases, while not zero, is greatly reduced. Add to this organization a vigilant physician-in-chief, who scrutinizes the patients and carefully reports all suspicious cases to the proper investigating body, and the district physician loses, for the most part, those only whom he would not or should not charge and those who would not pay.

The detail of this work has been so fully set forth by Cabot<sup>9</sup>, <sup>12</sup> Williams<sup>10</sup>, Goldwater<sup>11</sup>, and others, and in the reports of the various hospitals and dispensaries that I have not rehearsed them here. I might,



however, mention that the care of the home while the wife or the breadwinner is ill in the hospital or attending the dispensary is a work which has far-reaching results—morally, civically and economically, and cannot fail to appeal to everyone. Where there is a hospital in connection with the dispensary the social and visiting nurse service can do valuable work in following the convalescents.

I have here the last report from the Vanderbilt Clinic Auxiliary,<sup>13</sup> which gives many important suggestions in the management of this social service work. Special funds are necessary for this work, but when possible the receipts from the clinic are used. A visiting nurse receives \$75 per month and carfare. There are four nurses and one director. The social service nurse or worker is not a regular graduate; she receives \$40 per month and \$5 for carfare. There are in the Vanderbilt Clinic one or two such workers, and in addition as many volunteers as possible. Between \$6,000 and \$7,000 a year is required to support this work in a clinic caring for about 50,000 new patients annually. The Day Camp was started by the Red Cross Society in 1910, and in 1911 it was taken over by the Clinic and run by special funds, but this is for tuberculosis cases only.

#### 4. DONATIONS, BEQUESTS AND VOLUNTEER WORKERS.

This social service and visiting nurse work should appeal to the philanthropic members of the community, whose interest I trust will materialize into donations, bequests and volunteer work. While a small social service could be conducted on appropriations from general hospital funds, an efficient organization can be run on independent funds only.

Before taking up another subject I would like to express an opinion which I feel sure has been entertained by everyone who has thought seriously upon dispensary work. The whole administration of out-door clinics is far below what it could and should be. The matter can best be brought to a focus by asking: What is the dispensary to the community medically, educationally, scientifically and sociologically?

#### 5. THE SCOPE OF DISPENSARY WORK.

With regard to the first of these. To the dispensary come all stages of disease—from very incipency to the dying state. This is not so of the hospital—cases not very ill are turned away as unsuitable to occupy a bed. What therefore does the dispensary offer? Opportunity to study and treat the stage of disease amenable to treatment. The stage when physiological changes only are the manifestation of ill-health. True, this



is the most difficult to study, requiring intricate apparatus—yet were these cases studied and kept track of, is anyone prepared to dispute the advantages which might accrue to the patient and to scientific research? What do we know of the early stage of cirrhosis of the liver—of Bright's disease—of the complicated arthritides—of pernicious anemia, all of them ultimately either hopelessly crippling or fatal diseases? Or that great group of cases called "bronchitis" and "rheumatism," so numerous that the dispensary physician dreads to see the case come and dismisses him with the hastily written regulation "bronchitis" and "rheumatism" mixture—requiring on an average of two to three minutes' attention. In the common bronchitis lies hid one of the most important pathological processes—being possibly the sole manifestation of an obscure toxemia, the beginning of cardiac incompetency or a forerunner of a fatal pneumonia or tuberculosis. When the so-called "rheumatic," who has in many instances been a victim of septic infection, with a curable focus, reaches the hospital, he is a hopeless cardiac case, or a deformed, misshapen mass. Organic change has taken place, and all the expensive machinery of the hospital, the clinical laboratory, x-ray apparatus, electriccardiogram, etc., is employed in investigating ruins. Where are these cases to be seen? In the Out-Patient Clinic and there only. In one malady we have had ample demonstration of what can be done in the early stage. The expert no longer waits for the tuberculous consolidation and cavity, but watches for the earliest signs of intoxication in the rapid breathing, the hurried pulse, the loss of weight, etc. Are these other diseases studied with any approach to the care with which the incipient stage of tuberculosis is investigated?

It was in the out-patient department that most of the valuable work in tuberculin and the gastro-intestinal diseases of children was done. I believe that there is in the dispensary a fertile field for accurate observation in serum therapy. Many of the cases now under vaccine treatment are frequent visitors to our great clinical laboratories. The laboratory in this matter I think has seized an opportunity deliberately neglected by dispensary managers.

I have by no means, in these few instances, presented the last argument to prove what great opportunities for scientific research and medical aid are offered in the out-patient clinic.

I pass on to the educational importance of the dispensary. The undergraduate and the physician have, in a well-organized out-patient department, opportunity to study and compare diseases, as well as to learn the more obscure educational features of the relation of physician to patient. This perhaps is the least in need of argument, as most medi-



cal schools are now making much use of the dispensaries in teaching work. The training schools for nurses have not, I think, made as much use of the dispensary for the training of their probationers as they might with advantage have done.

From a sociological viewpoint the visiting staff of nurses and social service workers have found a rich field for investigation, which has yielded information regarding tenement construction, places of indoor labor, hygienic conditions, milk and food supply, etc., which has enabled them to co-operate with the proper authorities in preventing and checking disease and in reducing human suffering.

When one realizes the enormous responsibility resting upon the managers of a dispensary, the wonder is how this can have been so thoughtlessly disregarded and the opportunity so recklessly neglected in years gone by. If in what follows I seem to propose too elaborate an organization, I want it understood that I believe this responsibility rests with every body of men who are participants in the planning and maintenance of a dispensary.

#### 6. THE MEDICAL STAFF.

Mention has already been made of a chief of clinic or chief of out-patient department. In this connection we may consider the whole subject of *The Medical Staff*. What makes the positions on such a staff unsought and why are men of no great experience the only ones obtainable?

The great objection to out-patient work is the unremunerated grind. We may as well face the situation squarely. A man finds that anywhere from two to four hours daily are consumed in the out-patient work. In most institutions the equipment consists mainly of a drug shop, and the chief work is in hasty examinations (for the number of workers is few and the patients many) and the writing of prescriptions. The physician finds himself rushed and fagged—he has neither time nor equipment to properly study the cases, and after a few weeks of enthusiastic effort, the beginner lapses into a routine worker, turning out, with a prescription, as many patients as possible. I believe the out-patient clinic is responsible for developing most of the slovenly habits of examination which men, fresh from accurate hospital work, acquire. It is obvious then that in order to make the work worth while these conditions must be corrected. Two ways are open—*salaried positions* and *equipment* and *time* adequate to the proper study of cases. In plain words—payment in money or experience.

Over the administrative part of the out-patient department a lay-



man can quite well exercise all the supervision necessary. This position, which is largely clerical, can be given to a salaried man, whose hours would be from 9 a.m. to 5 p.m. His office, "clerk of the out-patient department." This clerk could be directly under the chiefs of clinic and subservient to the superintendent of the hospital. His duties to consist of overseeing all the lay workers—druggists, clerks, porters, cleaners, etc., and the preparation of a monthly financial report. This clerk can also quite satisfactorily differentiate the patients for the various departments. To a physician this work is profitless and time-killing.

Over each department, medical, surgical, gynecological, etc., is a *chief*. For this position a man whose experience will give him authority among his workers is necessary. Such a man can scarcely afford to give his time without a salary, yet, if he amounts to anything, mere money return will not repay him. IF HE IS TO DO NOTHING BUT ASSORT CASES, OVERSEE HISTORIES AND DO OTHER CLERICAL AND FLOOR WALKING WORK HE WILL FEEL THAT, MEDICALLY, HIS TIME IS WASTED. HE MUST HAVE TIME TO STUDY THE IMPORTANT CASES WITH THE ATTENDING PHYSICIANS—TO FOLLOW UP THE LABORATORY EXAMINATIONS—TO TRACE SOME OF THE CASES TO THE HOSPITAL—TO ACCOMPANY CERTAIN CASES TO THE X-RAY ROOM, ETC., AND FROM TIME TO TIME TO VISIT CLINICS IN HIS OWN AND OTHER CITIES. EVERY IMPORTANT CASE IN HIS CLINIC SHOULD BE KNOWN TO HIM. THE CHIEF SHOULD BE MADE TO FEEL THAT IN THE DEVELOPMENT OF THE CLINIC HE HAS THE HEARTY SUPPORT OF THE MANAGERS, AND IT SHOULD BE THE AIM OF THE MANAGERS TO LEAVE HIM AS FREE AS POSSIBLE FROM ROUTINE AND DETAIL IN ORDER THAT HE MAY KEEP HIMSELF POSTED ON THE BEST EQUIPMENT AND METHODS. This can not be accomplished without one or more assistants to the chief, or in exceptionally large clinics two chiefs, whose days of attendance are three a week, and whose time does not exceed from two to four hours. The *assistant chiefs* need not be salaried.

In addition to these men, I believe a staff of *visiting physicians*, selected from the prominent practitioners of the city, is needed. These men would spend an hour or so in the clinic, and for them would be saved the more important and difficult cases. Where instruction is given these positions could be held by the teaching staff. But the idea is to have regular visiting physicians as one finds in the hospital. Thus to the attending staff the interest and profit in their work would be



greatly increased. In the Cornell dispensary this was done on one day a week only, and then the visit was very brief, but the opportunity was absurdly lies, not in the idea, but in the fact that the enormous amount so eagerly sought by the attending staff that the work of the department usually stood still while everyone in the clinic gathered to get information regarding cases which had caused discussion among the attendings. In the Vanderbilt clinic this has been more fully developed, with great success. The weekly amphitheatre demonstrations and section class teaching will be valuable in this respect, but should not be considered as equivalent to the visits of authoritative consultants.

It will be seen that such a plan has for its object the raising of the standard of work done in the clinic. None of this will be appreciated or utilized, however, if the staff of attending physicians be made up of men who have no training or who are of slovenly methods. So far the majority of out-patient clinics have offered nothing but profitless routine, consequently the only men available for this rich field were those of little or no experience. If the out-patient department by good organization and proper equipment, be made valuable to the attending physician, I believe competitive examinations for attending staff and diplomas, similar to those for hospital service, would be feasible. At any rate, men of high standing would be applicants, and the best from these could be selected. Such, however, is only possible if the diagnostic and therapeutic work is supervised by a visiting staff of men of recognized ability, whose devotion and earnestness is such as is to be found among hospital visiting physicians. Assistant attending physicians could be appointed, who would be assigned certain work of which I will speak later.

With regard to the number of attending physicians required, I quote from Dr. Hooker's<sup>14</sup> report on dispensaries in New York City: "It is a difficult matter to determine just how many new patients a year each physician could be expected to treat with satisfaction and success, but it would seem that this could not be larger than 1,000, or approximately 20 each week, calculating three clinic days a week for each physician, and even that is a good allowance. Upon that basis, however, it is found that in 13 dispensaries in New York City, or about 18 per cent. of all, the attending physicians have more work to do than can be reasonably expected of them, and that in the majority of these this excess of work is far beyond the limit of reason."

I present here a table by which, at a glance, the amount of work done by each physician in the New York dispensaries can be determined. It reveals one of the rotten planks in the dispensary structure.



With our present standard of out-patient work, the idea of a competitive examination for position of attending staff seems absurd. The of material that comes to out-patient clinics is so handled that there should not be many applicants for these positions.

A question which here presents itself is: Shall dispensary positions be steps in promotion to that of hospital visiting? It will be seen that the above plan embodies a system of promotion in itself and that the aim should be to develop the dispensary to such a high standard that promotion to visiting physician of the out-patient clinic is on a part with that of hospital visiting, and that the position of attending physician would carry almost similar recommendation as (dare I say, *more than*) hospital interne.

Dr. Cabot<sub>15</sub> says: "The dispensary or out-patient department of a modern hospital is usually treated as an appendage of very minor importance. . . . In the wards of the Massachusetts General Hospital there are treated each year about 5,500 new patients, while that humble appendage, the dispensary, treats about 20,000. I think the proportion is not very different in other hospitals. Yet the amount of money expended on the 5,500 house patients is not far from \$225,000, or \$41 per patient, while that expended on the 20,000 out-patients is \$51,000, or about \$2.50 per patient." Dr. Cabot then asks the question: "Is the house case worth spending twenty times as much money on as we spend on the dispensary case?" and in what follows he presents many forcible arguments to prove that the work of the dispensary is equal in importance to that of the hospital. This question, however, can be answered practically in one way only, namely, by first equipping the dispensary with the same or equal facilities enjoyed by the hospital. First among these may be placed the clinical laboratory.

#### 7. THE CLINICAL LABORATORY.

For ten years now the clinical laboratory of Cornell has been a working part of the dispensary. I think that we can say confidently that this association which has existed since the opening of the dispensary has been of incalculable value to the community and one of the great attractions to physicians. By means of this all blood cases have been thoroughly studied—the application of serum therapy has been possible—besides many studies with regard to transudates, exudates, sputum, eye, ear, throat and nose, genito-urinary diseases, etc., have been possible and in most cases the dispensary worker has followed the investigations in the laboratory with obvious advantage to himself. The laboratory is of course not for the exclusive use of the dispensary, but is



used freely by several hospitals. The laboratory staff is quite separate from that of the dispensary and consists of experts whose opinions are sought by the visiting and attending physicians<sup>16</sup>. The laboratory staff is on a par with the visiting physician, and as such forms one of the degrees in the scale of promotion.

When I speak of the clinical laboratory, I do not mean a small room under the stairs, with a sink and a few bottles with reagents. Such a room may be useful for the routine examinations, but I believe its usefulness is very limited. Accompany photographs<sup>17</sup>, representing the type of laboratory which I believe should be in close proximity to the dispensary will be found in the publication referred to below (see reference No. 17).

#### 8. MEDICAL MEETINGS.

A medical meeting once a month, though held a few times only before I resigned from the dispensary, and I believe not kept up since, was found to be most stimulating. The meetings were informal, cases of interest being shown rather than papers read. If there is already a hospital society, as is the case at Johns Hopkins, patients and reports from the dispensary could be presented there, the important point being to stimulate the dispensary worker to the thorough study of his cases with an opportunity to present his results.

#### 9. MEDICAL RECORDS.

I shall not attempt to go into this very large subject in detail. It alone would constitute a topic for one evening. That it is an essential to dispensary administration I believe everyone now admits. It has had a hard fight for recognition, but the day for the big book, with a single line for each patient, has passed, though such was the custom in New York City, with its thousands of out-patients, *only ten years ago*. There is some justification for this, however, when it is remembered that the Pennsylvania Hospital in Philadelphia began the systematic recording of its ward cases as late as 1873, the hospital at that date being in its 118th year, and the record system for ward cases instituted at the founding of the Johns Hopkins Hospital in 1889 was considered an innovation in hospital case recording, while that of the out-patient department in the same institution was quite a new departure.

I believe the crucial point of any record system is in relieving the attending physician, as far as possible, of all clerical work by assigning the routine recording, not requiring expert medical training, to lay clerks. A nurse or porter can procure old histories from the file and



place them on the table ready for the attending physician. It may be found serviceable for an assistant attending to take the history of new cases, the examination being made in company with the attending physician. The records should be under the supervision of one or two historians who are appointed from among the older attending physicians and whose duty it is to check up the diagnosis and quality of the work, the whole being under the supervision and scrutiny of the chief of clinic. By means of a card index of names and diseases it is possible to prepare another important feature of the dispensary system, namely, *The Medical Report*.

#### 10. MEDICAL REPORT.

With such an equipment it will be possible to bring out every year or two a medical and surgical report,<sup>18</sup> and for this purpose a well-kept disease index system and the medical meetings will be found necessary and helpful. May I touch here on a point, somewhat foreign to this address, but in some respects directly concerned with it. In every large city the lack of co-operation leads to the same individual being cared for by a number of hospitals and dispensaries—these are either drifters, with no serious malady, or individuals with a slowly progressive serious or fatal disease. They begin their illness in one institution, become repeaters, then drift to another and finally land in a hospital where they perhaps improve to re-enter the same or other hospitals in one of which they finally die and are perhaps autopsied. To make this more definite I present the following cases which I personally followed up and of whom I have records,<sup>19</sup> several having been published:

Case 1.—Seen in the Bellevue out-patient department. Physician took patient to the university clinical laboratory, as at that time there were no facilities for blood examination in the out-patient department. Diagnosis: Hodgkins disease. Patient entered hospital later. Work all repeated by same laboratory, whose workers were not aware that the case had been examined before.

Case 2.—Patient entered New York Hospital Medical Service. Diagnosis: *Pernicious anemia*. He came to Cornell O. P. D. apparently in *acute cardiac incompetency* and was diagnosed as such. He entered City Hospital medical service. Diagnosis: *Pernicious anemia*. Later entered Metropolitan Hospital. Diagnosis: *Alcoholism*. Re-entered City Hospital, where for some time he was not recognized as case who had been in previously. Diagnosis: *Pernicious anemia*. Death. Autopsy.

This chain of events covers a period of four years and in each instance varying phases of this destructive disease presented themselves.



For example, during the Bellevue Hospital period the gastro-intestinal features were present and not found at any later date. It was only by personally tracing up these records that this consecutive story was obtained.

Case 3.—Patient entered New York Hospital Medical Service. Diagnosis: *Pernicious anemia*. He entered the City Hospital Neurological Service. Diagnosis: *Multiple sclerosis, secondary anemia*. Death. Autopsy. The bone marrow at autopsy being typical of pernicious anemia, the early record was looked up, with the result above stated. This patient when in the City Hospital had developed the cord features of pernicious anemia, the blood features having been present especially when he was in the New York Hospital.

Case 4.—Admitted to Roosevelt Hospital. Suspicious gland removed and examined by Dr. Ditman, who diagnosed *malignant growth*. Location not determined. Improved. Left hospital. Few months later entered City Hospital, with obscure pulmonary signs and sciatica. The scar in neck caused an investigation, with the result that information as given above was obtained. Death. Autopsy. Tracheal malignant growth and growth pressing on sciatica.

In the cases above cited each set of workers was quite ignorant of the findings of the others.

Case 5.—Patient entered Cornell O. P. D. Diagnosis: *Hanot's cirrhosis*. Studied with care. Presbyterian Hospital. Death. Autopsy.

Case 6.—Patient entered Cornell O. P. D. Diagnosis: *Banti's disease*. Bellevue Hospital.

Cases 5 and 6 are given in detail in the Cornell Dispensary Report, Vol. I., and show what can be accomplished by co-operation between institutions.

I have mentioned a few only. What applies to co-operation between institutions applies also to co-operation between the various departments of a hospital or dispensary. The body, by our system of specialties, is of necessity broken up into many parts, but co-operation between the many observers must be in order to have a consecutive story of disease.

An argument on this subject that will appeal to the financiers is the unnecessary expense caused by duplicating apparatus, X-ray, etc., on account of the lack of co-operation between different institutions and the different departments in each institution. This extravagance is further added to by repeaters and drifters not accurately recorded. It is im-



possible to wholly prevent this, but certainly much more could be done than at present to bring together the valuable links in the chain of pathological events and to prevent the unnecessary waste of time and money in repeating the same investigations upon the same individual in several institutions.

#### 11. TEACHING.

Everyone now agrees that where teaching is done the work of the hospital and dispensary is infinitely more careful and of a higher standard and more thorough than where the physicians have not the keen mind of the students to check up the conclusions and criticize the methods.

The University of Pennsylvania has for some years appropriated \$200 a year for the employ of normal cases for teaching physical diagnosis—this is a questionable practice. I think it is safe to say that *the time is not distant when hospitals and dispensaries will be seeking university affiliation in order to hold a first rank position in any community.* The real answer to this question lies in the attitude of the patient towards the two types of institution—the large majority prefer the teaching institution.

To those who feel that the presence of students is detrimental to the development of the clinic I would say that wherever I have found trouble between patient and doctor, with regard to going into the clinic, it is to be explained on one of two grounds—either the patient is a crank or the doctor has not used the ordinary courtesy which every fellow creature, whatever the relative stations in life, owes to another. Occasionally the patient has an ignorant fear of what is going to be done to him, but the large majority of refusals fall under the other two heads. In the Cornell dispensary during one year 900 cases were used for teaching purposes at 270 demonstrations before 180 students. In most instances the patients *sought the opportunity to be studied in clinic.*

A man's or an institution's success depends not only upon the work accomplished, but as well upon the good men discovered and helped to success. Knowledge is progressive, and the greatest and first duty of the teacher is in stimulating the younger generation in this progress. Ibsen's Master-Builder portrays the worst qualities of a master mind. When the older generation fears the younger knocking at the door, there results jealousy, selfishness, and what can best be expressed by the term "cold water teacher."



## 12. DIRECTORS' MEETINGS.

I would suggest that to these meetings the chiefs be admitted to make reports and to state the requirements of the various departments. The star chamber method is impressive and awe inspiring. I recall the definition of "admirare" given by my teacher in classics—"to stand in awe," "to be spellbound." With this understanding of the term the star chamber method is *admirable*, but, standing awe stricken and spellbound does not conduce to the intelligent co-operation of the workers and, without co-operation, there is little or no progress. In his inaugural address, a president of one of our universities stated that he would rather have five big men as its leaders in instruction than fifty little men on its staff, and yet later in this same address he proposes a "Committee on Efficiency." I quote this because it seems to touch a vital point in the psychology of the relation between professor and president, or directors and medical staff. A committee on efficiency, spying out the doings of the worker, destroys his spontaneity and makes of him an eye servant and a time server. It is safe to say that with his committee on efficiency this president will be compelled to employ his fifty little men because with such methods he will be unable to procure the services of even five big men.

It must be remembered that in professional and scientific undertaking it takes time to get results. A mistake made by some managers is that of constantly pulling up the plant to see if it is growing. *Transplanting*, on the other hand, has many valuable features, but already I have perhaps outstepped the strict limits of my subject.

## 13. THE BUILDING.

On this head I speak only from the physician's and teacher's needs as we found them at Cornell.

The best arrangement seems to be many *small, well-lighted rooms*, where cases can be shown to sections. In this way the routine work of the dispensary will not be interfered with by the teaching, and a number of cases can be in progress at a time. The amphitheatre is of questionable value. For larger clinics I would recommend the wicker couch on a slightly raised platform *in the middle of the room*, so that students can draw up *chairs* close to the teacher and case.

The clinical laboratory should be within easy reach of all departments.

Special treatment and investigation rooms are also, in some respects, essential, and under any circumstance aid greatly in expediting the



clinical work. For example, a room for stomach work, serum therapy, contagious diseases, radiography and photography and a zander room.

Record room. This room would be used for all records prior to a certain date; and here physicians could consult the records in preparing reports, etc.<sup>20</sup>

#### 14. COST OF MAINTENANCE.

I now come to what is the most practical and at times the most serious aspect of this whole question—*cost of maintenance*. I have brought it in last because from what has been said it will be thought that there is no means of deriving any appreciable income from such an out-patient department. As said before, the index to the size of the plant needed is the population of the district served and the number who attend the clinic. May I repeat, this latter is *no index to the quality of the work done*. The population of the Borough of Manhattan in 1900 was 1,772,000; for that borough there are 67 dispensaries in which there were treated in one year 956,173 new patients, which means 41 patients to each physician in the smallest dispensary, and 5,867 patients to each physician in the largest dispensary. The largest clinic in New York City is the Good Samaritan, which cares for 82,176 new patients a year; Mt. Sinai comes next, with 78,656; Gouverneur next, with 53,338. These are located in thickly-populated districts. The fourth on the list is the Vanderbilt clinic, with 47,600; this draws from all over the city, but its immediate neighborhood is of the semi-tenement type and much less thickly settled than any of the others. Perhaps the extreme with regard to neighborhood is to be found in the Presbyterian, with 29,737, which draws its patients from a very good neighborhood, with only a moderate tenement population. I therefore take the Vanderbilt as a representative, for it embodies many of the good and so-called objectionable qualities developed to an advanced degree—teaching and university connection. It is probably the most completely organized out-patient department in New York City. Through the courtesy of Mr. Grimshaw, superintendent of Roosevelt Hospital and the Vanderbilt clinic, I have been able to consult some rather detailed figures. It is found from these that it is impossible to run a dispensary of the size of the Vanderbilt and still have a financial surplus.

What are the possible sources of income? I believe your institution has as yet no endowment, and that your dispensary, including the tuberculosis work, must be conducted on the funds obtained from the hospital. This is a *serious handicap*, and it is to be hoped that the in-



fluent citizens of Toronto will realize that a properly endowed, well-organized out-patient clinic by acting as a quarantine department is a *powerful safeguard to the health of the city and its homes* against the menacing diseases daily occurring in any large community, the first on the list being tuberculosis.

The dispensary whose figures I quote has an endowment which yields \$5,000 annually, but under Mr. Grimshaw's able management it has been possible to lay this sum aside for new buildings and other equipment and to run the dispensary on *its own earnings*. It must, however, be stated that the Social Service and Day Camp are maintained by a separate fund. This work as stated above requires between \$6,000 and \$7,000 annually in a dispensary caring for nearly 50,000 new patients a year.

*Sources of Revenue.*<sup>21</sup>

TABLE EXPLANATORY OF SOURCES OF REVENUE.

1. Prescriptions.—10 cents on all medicines from any department, 5 days' supply. Renewal and double supply 10 cents. 5 cents for bottle.
2. Surgical Treatment.—10 cents for any operation or dressing, not including medicine.
3. Sundries.—Suspensory bandages and orthopedic apparatus charged for at cost or a little over.  
Zander room.—10 cents for each treatment.  
Special apparatus charged for according to value.
4. Sale of Eye Glasses.—Commission allowed clinic by eye glass makers on glasses sold in the clinic.

Four per cent. to ten per cent. are free patients, most of whom are from the tuberculosis clinic.

From the prescriptions alone over \$16,000 was collected one year and over \$14,000 another, the total receipts from all sources amounted in one year to over \$29,000, another year to over \$26,000. In 1909 there was a surplus of \$2,638.77, and though there was a deficit in 1910 of \$775.38, this occurred after \$1,000 had been contributed towards the Auxiliary (Social) Service, which is supported by separate funds and only occasionally receives contributions from the clinic receipts.

Probably the next in importance to sources of income is the extravagance due to overcrowding and the duplicating of apparatus. To



avoid the first of these, Goldwater, of Mt. Sinai, has advocated districting the city, as is done in some of the European centres, Berlin and Paris especially.

Unification just now is under discussion in New York; that is, bringing all municipal hospitals and dispensaries under State control. Mr. McAneny, president of the Borough of Manhattan, stated that the investment of the City Hospital plant amounted to \$20,000,000, and that the corporate stock budget recently for hospitals was \$6,400,000. The borough population is nearly 2,000,000. The city hospitals are now divided into five departments, namely: Bellevue and Allied Hospitals, Gouverneur, Fordham, The Health Department, The Charities Department.

By our many centres of *unco-operating* effort we are indeed a house divided against itself, and patients are transferred from institution to institution due to some technicality or regulation, and time and money are wasted in duplicating apparatus and work. By uniting the efforts of your three hospitals, St. Michael's, Toronto General, and Children's, you have made a move by which this extravagance and waste of energy can be greatly reduced and strength through union acquired.

Not long ago, by the union of two of your teaching institutions, Trinity and Toronto, you took a step for which you have been amply repaid.

#### 15. THE ONTARIO EDUCATIONAL SYSTEM AND TORONTO'S POSITION IN MEDICAL EDUCATION.

In the (1910) Bulletin of the Carnegie Foundation for the Advancement of Teaching, the Toronto Medical School is referred to as "Of ideal construction and admirable equipment" (p. 78), and "among the best on the continent" (p. 323), "the teaching wholly in charge of full-time instructors" (p. 79), and the graduates are considered as having "passed through a scientific and clinical discipline of high quality" (p. 15). Your lower entrance requirement is reported as "minimized by conscientious adherence to a strict interpretation of the announced standards and compensated by the addition of a fifth year to the curriculum."

When, at the World's Fair, Ontario received the highest award for its educational system, the secret of your success became plain. By the high standard of education of your people you have more power than through great wealth, for you accomplish the union of two of the strongest forces in a community—the university and the Government,



both of the province and the municipality, and the bond is, I repeat, the high standard of the Ontario educational system.

It is not money wealth, then, that has enabled you to bring your medical school of "ideal construction and admirable equipment" in strong union with your municipal hospital, making your clinical facilities "adequate in respect alike to extent and control" (p. 108), but wealth of high ideals in the ruling majority of a thoroughly educated community. "The high quality of instruction offered by McGill and Toronto to students who enter on less than a four years' high school education proves that our trouble in the United States has been at bottom not less one of low ideals than of low standards. Indeed, where ideals are low there are no standards, and where ideals are high the standard, even though low, is at any rate so definite that it furnishes a sure starting point towards a clearly apprehended goal" (p. 326).

Will it not be possible for these same ideals which you have demonstrated in your preparatory and high school educational system, in your municipal and state government, and in your university management to set the standard of your out-patient clinic and so inaugurate a new epoch in the administration of this great department of medicine?

It has been said "Learn by your blunders and you will know how to do the thing right." It would seem better advice, however, to learn from the blunders of others and not try to do a thing till you are reasonably sure that the method is right. You seem to have adopted the latter course, for New York is a fertile field of dispensary blunders and doubtless for this reason you have asked a New York man to address you.

#### 16. SUMMARY AND CONCLUSION.

The standard of out-patient work should be raised and the opportunities afforded attending physicians should be greatly increased. These can be accomplished.

By requiring that the out-patient department shall consist of three distinct parts supported by separate funds.

1. Medical and surgical and specialties department with their equipment—clinical laboratory, zander room, etc.
2. Tuberculosis department with its equipment—Day Camp, etc.
3. Social Service and District Nursing Department.

By making the staff of workers adequate to the number of cases, three new and ten old patients maximum. The aim should be to *avoid energy sapping*.



By decreasing to a minimum the clerical work required of the physician by assigning this work to a layman. The aim should be to *avoid time leaks*.

By establishing a thoroughly equipped clinical laboratory, X-ray plant, zander room, etc., with experts in charge.

By appointing a medical staff selected with scrutiny or by competitive examination or both. Salaried chiefs with unsalaried assistants. Staff of visiting physicians of recognized standing. The superintendent, with an administrative clerk, to relieve the chiefs of all administrative work, but subservient to chiefs.

By thoroughly organized and supervised history, name and disease card index system.

By section class teaching, with one or two weekly clinics open to the general practitioner.

By directors' meetings monthly, at which the chiefs should be admitted with voice in directing the policies of the dispensary. Dry rot the fate of most dispensaries.

By monthly medical meetings, at which it is expected the chief workers shall report from time to time.

By periodic publication of a medical (scientific) report.<sup>18</sup>

By increasing the earning capacity of dispensary by charging small fees for drugs, apparatus, surgical appliances, etc.

*License should be withheld* till it is shown that certain of these policies are foundation stones of the undertaking.

#### LIST OF REFERENCES.

1. "A short account of the proceedings of the College of Physicians, London, in Relation to the Sick Poor," 1697. Referred to in the preface to "The Dispensary."

2. "The works of Sir Samuel Garth," containing "The Dispensary," Dublin, 1769.

3. Dr. Garth was one of the famous Kit Kat poets, and his poem, "The Dispensary," is one of the literary products of his time. For an account of Garth see Cushing, *Johns Hopkins Hospital Bulletin*, Jan., 1906.

4. For wood cut of the home of the first dispensary see "The Gold Headed Cane," London, John Murray, 1827, being the college building during the period in which the dispensary was organized there, pp. 103, 104, 105.



5. Unpublished. I quote from memory.
6. Annual Report, 1910.
7. From Dr. Hooker's (unpublished) report.
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9. "Suggestions for the Reorganization of Hospital Out-Patient Department." R. C. Cabot, M.D. *Maryland Medical Journal*, March, 1907.
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16. "Some Observations on the Organization of Hospital Staffs." J. A. Blake, M.D. *Med. Rec.*, June 24, 1911.
17. "Hospital and Ward Clinical Laboratories." C. N. B. Camac, M.D. *J. Am. Med. Ass.*, July, 1900.
18. This is, of course, quite another publication from the business report of the superintendent. The meaningless lists of cases under various diagnosis are now obsolete and have little place in any publication, with the exception possibly of the fracture cases, though it is doubtful if such lists are much used. Such lists may be classified with the numerical attendance of patients as each is a spectacular, though false, index of the quality of the work done.
19. Cornell University Medical College Dispensary Medical Report. Vol. I., January, 1905. Vol. II., May, 1911.
20. Many of these requirements are to be found in the following publications: "Construction, Management and Maintenance of a General Hospital," D. J. Mackintosh, Edin. C., 1909. "Organization, Construction and Management of Hospitals," Ochsner and Sturm, Chicago, 1909.
21. Anyone wishing more detailed figures regarding salaries, etc., will be gladly supplied.



## CURRENT MEDICAL LITERATURE

## MEDICINE.

Under the charge of A. J. MACKENZIE, B.A., M.B., Toronto.

## GAS IN THE STOMACH.

1. Gas in the stomach is rarely anything but swallowed air, as true fermentation takes place in the stomach only as a result of actual stasis.

2. Slight, unobtrusive eructation of gas after a full meal is not to be looked upon as a morbid phenomenon. Any slight epigastric sensation and occasional eructation are readily exaggerated in the mind of the hypochondriacal.

3. Belching is really a voluntary act, either attempted, permitted, or performed in a more or less exaggerated manner to give relief from a real or fancied distress referred to the stomach. The sensation of distress may arise from any organ adjacent to the stomach.

4. The most exaggerated form of belching results from temporary or habitual emotional states, the air not being raised from the stomach, but merely gulped into the pharynx and brought up again.

5. If belching gives actual relief from distress it is fair to presume that the presence of air in the fundus of the stomach is at least a contributing factor in causing the discomfort.

6. Belching, which originally has relieved, may be carried to extremes, particularly in the emotionally excitable. Such a reasonably induced aerophagia often obscures grave underlying disturbances of the circulatory system and the upper digestive tract, the belching being continued after all air has been forced from the fundus.

7. Gas is complained of in a variety of abdominal abnormalities when careful questioning shows belching is not practised. The patient presumes the distress is due to gas. This is particularly common in the discomforts associated with disease of the biliary tract, appendix, and colon.

## PYLOROSPASM IN INFANTS.

UNDER THE CHARGE OF C. J. MACKENZIE, B.A., M.B., TORONTO.

Pyloric spasm in infants is a condition not infrequently met with, but spasm of the cardia has been reported only five times in infants under two years of age. Another is added by Morgan in the *Medical Record*, July 22, 1911.



The condition began at the age of three weeks in a child which had already weight and which by the third month weighed sixteen pounds, but the weight fell to seven and a half at nine months. At first there was only a small amount vomited at each feeding, but this gradually became worse until it was thought necessary to use nutrient enemata, and there was a marked condition of marasmus. The mother first noticed a small tumor in the epigastrium and the condition was diagnosed as pylorospasm.

When the true condition was recognized there was no fluid passing into the stomach, and the finest bougie would not pass. A No. 8 (French) soft catheter was tried, and after a little time it passed in and was kept there for four days, regular feedings being made and retained. The tube was then withdrawn at night and reinserted in the morning, and the child allowed to nurse from the bottle once in the 24 hours. This was increased day by day until by the second week it was unnecessary to use the tube. There was no return of the condition. Previously he had been able to take 100 to 150 C.C., which he retained, evidently in a dilated oesophagus, until he was laid down, when it would run out of the mouth and nostrils.

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#### RADIUM TREATMENT IN CANCER OF THE DIGESTIVE TRACT

In the *Medical Record*, Sept. 23rd, Einhorn describes the method of making radium application to incurable cases of cancer of the digestive tract. The oesophagus, stomach and rectum are the parts to which it is applicable, and the writer has devised apparatus for making the applications. In the case of the oesophagus and cardia the application is easily made on a whalebone bougie as carrier; for the pylorus use is made of the method of swallowing a metal olive to which a silk thread is attached, and when time has elapsed for this to pass the pylorus, as shown by a difficulty in withdrawal, a bougie with an eye is threaded over the string and thus guided till it passes through the orifice. In this way an application of an hour may be made, the instrument remaining in position; if a longer period is thought advisable, e.g., six hours, it is necessary to have a detachable capsule at the end of the introducer, which is threaded on the string and then pushed along to the part, the stem being withdrawn. Application to the rectum is simple.

In two cases cited 70 mg. of the strongest pure radium bromide was used for a period of six hours at a time. In both these cases the application was followed by the relief of dysphagia, which had been due to



cancer of the cardia. Applications were repeated three times, but the history does not cover more than a month in one case and six weeks in the other. However, even this much relief is an unspeakable boon to the sufferer. The writer has a number of other cases which have been reported previously, in which relief of the most pressing symptoms, obstruction, pain, and bleeding has been achieved.

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### SALVARSAN IN NERVOUS DISEASES.

In the *Medical Record*, July 1st, Wolbarst reports two cases in which Salvarsan was given to patients suffering, the one from paresis, the other from tabes, in which the results were not good.

The first was a typical case of general paresis, positive Wassermann reaction, in whom in spite of anti-syphilitic treatment the symptoms were constantly getting worse; expansive ideas, delusions, general irritability, uneasiness, and frequent attacks of despondency, uncertain gait, marked scanning and spluttering speech; the urine showed traces of albumin, with granular and hyaline casts.

Injection of .5 grammes was given with a rather indefinite reaction on the following day. Two weeks after there was a clear improvement in the disappearance of expansive ideas and the return of a cautious and prudent attitude, and the gait was better; in some respects there was an increased degeneration, being more excitable and irritable, his intelligence increased and he was able to play games. A month after Wassermann was still markedly positive.

About this time he had an apoplectic seizure, probably due to an embolus, and on this account his physical condition was not so good, but three months after he was hardly back to the condition he was in before injection. Two months later he had another apoplectic attack which ended fatally.

The improvement was marked and remarkable for a parietic. He should probably have had another dose, but this was opposed.

The other was a well-developed case of tabes, though of only five months' duration, and he suffered from a chronic interstitial nephritis.

He had a dose of .5 grammes intramuscularly. The arsenic did not appear till the third day in the urine. There was a resultant suppression of urine to 10 ounces in 24 hours, a stupor appeared and he died on the twelfth day.



## WHOOPIING COUGH AND ITS TREATMENT.\*

Whooping cough is an infectious disease, specific, contagious, and epidemic, occurring principally among children, and characterized especially by a paroxysmal cough. Except the knowledge of its epidemicity and its very great contagiousness, one does not know the parasitic agent of this affection.

*Symptomatology.*—After a period of incubation, without symptoms clinically, of from seven to eight days, the whooping cough commences and passes through three stages:—

A period of invasion, or catarrhal stage.

A period of acme or stage of characteristic fits of coughing.

A period of decline.

*I. Catarrhal Stage.*—The commencement of whooping cough is like that of a somewhat peculiar tracheo-bronchitis. There supervenes at the same time as a coryza with frequent sneezings an obstinate cough, provoked by an incessant laryngeal tickling. Numerous scattered sibilant and sonorous rales, varying in site and in intensity, are heard on auscultation. But this, apparently common bronchitis, is occasionally accompanied by a little conjunctivitis and by photophobia. Moreover, there occurs in the evening a slight rise of temperature; the child becomes sad and miserable, sleeps badly, and loses its appetite. The duration of this period is from eight to fifteen days; then by degrees the cough is modified and becomes convulsive.

*II. Stage of Coughing Fits.*—At this period the cough, with its special character, constitutes, so to speak, the sole symptom; there is no bronchitis, there is no fever, and, in this respect, Rilliet and Barthez are right in saying that whooping cough is an apyretic disease.

*The Fit of Coughing. (a) Causes.*—The fit of coughing is provoked by a large number of causes (an effort of deglutition, emotion, too much noise, examination of the back of the throat); often spontaneous, at least in appearance, it is generally preceded by prodromal symptoms.

*(b) Prodromal Symptoms.*—The prodromal symptoms consist of a sensation of tickling or of itching in the larynx, a sudden fit of sadness, lastly, an instinctive immobility; the children stop playing and their facial expression quickly changes; in the words of Trousseau, "They plan their crisis."

*(c) Fit of Coughing.*—This breaks forth; an inspiration precedes the paroxysm; it is followed by violent expirations, in a prolonged series of jerking expiratory coughs, succeeding each other, slowly at first, then more rapidly, without interruption. Then there occurs a pause in forced

\*Translated from the *Medical Times* from the *Annales de Médecine et Chirurgie Infantiles Supplement*, October 1st, 1911. (Edited by Dr. Fenier).



expirations lasting ten to fifteen seconds. During this time the child shows signs of asphyxia; the face is congested, the eyelids are tumefied, the veins of the neck are turgescant and the eyes are bloodshot; anxious and cyanised, he stamps convulsively and lays hold of or rests against either the bars of his bed or anything surrounding him. At last the expiratory pause comes to an end; a long, laborious whistling inspiration has followed it and marks the termination of the fit of coughing. This long whistling characteristic inspiration is the end of the spasm. But this inspiratory stop is of very short duration. Almost immediately there occurs a fresh series of convulsive expiratory efforts, then another stop, and the cycle is renewed as many as three or four times or more, until the ejection of the abundant colorless mucous secretions, or even alimentary mucous, puts an end to the paroxysm and to the fit of coughing.

(d) *After the Fit of Coughing.*—The patient, depressed and very calm, sometimes falls into a profound sleep. If the distress persists without the fits of coughing, if especially it is co-existent with fever, one must fear a broncho-pulmonary complication. The duration of the fits of coughing is very variable; from several seconds to several minutes or a quarter of an hour. The number of stops is in direct proportion to the duration of the fits of coughing: one can count as many as twenty or thirty in the same fit of coughing. With regard to the number of fits of coughing in a day, these are likewise variable: they are more frequent at night: their number is, moreover, increased when the disease is more grave (twenty to thirty per day in average cases). The fit of coughing is, however, not always so characteristic. It may consist of attacks of vomiting, of hiccough, with spasm of the glottis, terminating in a whistling inspiratory effort.

*III. Stage of Decline.*—At the end of five or six weeks the fits of coughing gradually diminish in numbers, the bronchial catarrh reappears, and at the same time the cough becomes looser and auscultation reveals the presence of rales less sonorous and bubbling. The catarrh at last disappears and complete cure supervenes in some ten days.

*Complications.*—But complications may occur.

*I.—Mechanical Complications.*—Mechanical complications may be produced consequent on the efforts of coughing during the paroxysms.

(a) *Ulceration of the Fraenum Linguae* is the most frequent and the least grave; transverse small superficial ulceration due to the friction of the tongue against the inferior incisors during the efforts of coughing.

(b) *Haemorrhages*, especially epistaxis: buccal hæmorrhages, sub-conjunctival hæmorrhages; visceral hæmorrhages (hæmophysis, menin-



geal or cerebral hæmorrhages, followed by hemiplegia).

(c) *Complications connected with Abdominal Hypertension.*—Involuntary evacuation: rectal prolapses, hernias.

(d) *Pulmonary Emphysema.*—Rupture of the tympanum, very rare.

*II. Infectious Complications.*—There may be infectious complications. These are especially broncho-pulmonary inflammations; trachea-bronchitis, frequent, not very grave; above all broncho-pneumonia nine times out of ten. It is from this complication that sufferers from whooping cough die: it is therefore the formidable complication. When it appears the cough quickly loses its paroxysmal character, respiration is accelerated and perspiration is increased; one notes the working of the *alae nasi*; auscultation demonstrates the presence of fine sub crepitant rales or a souffle which vary from one day to another. Pulmonary congestion, pleurisy, pericarditis, albuminuria are very rare complications.

There may be at the same time (a) measles, which presents a remarkable affinity for whooping cough; (b) pulmonary tuberculosis or glandular tuberculosis (tracheo-bronchial adenopathy which occurs as a sequel during convalescence).

*III. Nervous Complications.*—Lastly there may be nervous complications: Spasms of the glottis, capable of causing death during the bouts of coughing. Convulsions may supervene during the fits of coughing or during the interval between the paroxysms. It is in infants a dreadful complication, which tends to coma or death.

*Diagnosis.*—The diagnosis in the early stage is difficult if there is simply a common cold, but it is extremely simple when one already has a knowledge of epidemicity or contagion. In the presence of a paroxysmal cough, with signs of asphyxia, one ought to easily eliminate spasm of the glottis and foreign bodies in the larynx. One must not confound it with (a) Acute bronchitis with fits of coughing: but here there is no crowing inspiratory effort; (b) tracheo-bronchial adenopathy, in which there exists a cough, called whooping cough, but without inspiratory crowing. Diagnosis is sometimes difficult by reason of the possible co-existence of the two affections. In true whooping cough one should be able to provoke the fit of coughing by tickling the uvula with the finger or by pressing on the trachea.

Treatment should be:—

(a) Prophylactic. Isolate the patients.

(b) Hygienic. Put those affected with whooping cough in a large well-ventilated room. Maintain quiet near the invalid.

(c) Anticatarrhal. Emetics; fumigation.



(d) Antispasmodic. Belladonna, opium, bromides, bromoform, inhalations of ozone, baths of compressed air.

The large number of medicaments devised demonstrate their slight efficacy.—*The Medical Times*, Nov. 25, 1911.

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#### TYPHOID GERMS THIRTY-EIGHT YEARS IN THE BODY.

At the Gesellschaft der Arzte, Clairmont presented a female patient, æt. 49, from Eiselberg's wards, who had typhoid fever when she was 11 years of age of a severe type. After recovery or in the convalescent stage she took on a form of cholelithiasis, cholecystitis, and peri-cholecystitis, with finally complete closure, that brought her to hospital. The operation revealed a large tumor the size of a large hen's egg, hard and thickened with an old chronic inflammation of the wall of the gall bladder, which was adherent to the anterior wall of the abdomen, colon, and stomach. The mucoid gall contents of the thickened bladder contained the typhoid bacilli, from which pure cultures were obtained. In this case she had carried the typhoid bacilli about with her 38 years.—*Medical Press*.

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#### CAUSATION OF THE PRE-SYSTOLIC MURMUR.

Though there has been some difference of opinion as to the cause of the pre-systolic murmur in mitral stenosis, the weight of opinion has been decidedly in favor of its being due to the contraction of the auricle forcing the blood through the narrowed or distorted orifice. Mackenzie, in "Diseases of the Heart," shows that when the musculature of the auricle becomes incapable of causing a wave in the jugular tracing that the murmur may disappear, to be replaced by one diastolic in time, while the pulse takes on the irregularity of rhythm which has been called the ventricular type.

In the *Medical Record*, July 1st, Hart reports three cases in which the pre-systolic murmur and thrill were present coincident with a ventricular type of pulse, and he argues from this that the murmur is not always due to the auricle, but must be at least at times of ventricular origin.

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#### VACCINATION IN PORTO RICO.

In the *New York State Journal of Medicine*, September, Hoff, colonel of the U. S. A. Army Medical Service, who was put in charge



as chief surgeon of the Department of Porto Rico in 1898, tells of the effect of vaccination.

At that time smallpox was epidemic, and had never been absent during the Spanish regime, the average of deaths for ten years before being 621 in a population of a million. There had been vaccination laws under the Spanish, but they had never been enforced. A vaccination farm was started. In 1899 there were 242 deaths, all before the conclusion of the vaccination campaign. After that there was not a death for several years.

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## SURGERY.

UNDER THE CHARGE OF H. A. PERFECT, M.D., C.M., SURGEON TO THE  
TORONTO WESTERN HOSPITAL.

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### THE CONTROL OF VENEREAL DISEASES.

The Committee of the American Medical Association on the Control of Venereal Diseases by a Municipality made a report in the section of preventive medicine at the last meeting of the American Medical Association, held in Los Angeles in June last. Doctors Guy L. Kiefer, Health Officer of Detroit and chairman of the committee, and Dr. George W. Kober, of Washington, District of Columbia, the other member of the committee, made the following recommendations:

- (1) The inauguration of a campaign of education, in co-operation with a society specially organized for that purpose.
- (2) The requiring of reporting of all cases of venereal disease by dispensaries, hospitals and juvenile courts.
- (3) The requiring of the reporting of all cases among prostitutes.
- (4) The establishment of special clinics under boards of health for the treatment and control of venereal diseases.
- (5) The enactment of a law requiring the reporting of all cases by physicians.
- (6) The establishment and maintenance by the municipality of hospitals of sufficient capacity to care for all highly infectious cases.
- (7) The establishment of laboratory facilities for diagnostic purposes, such as are had for other contagious diseases.
- (8) The amendment of all birth registration laws so that births are required to be reported within twenty-four hours.
- (9) The enactment of laws or regulations for the control of midwives and physicians who attend maternity cases.



(10) The enactment of laws requiring the reporting of specifically infected eyes.—*The Physician and Surgeon*.

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#### SKIN ANTISEPSIS.

Dr. J. R. Hersey, Wheeling, West Virginia (*The West Virginia Medical Journal*, August, 1911). In an article read before the Ohio County Medical Society, the author considers the different means of disinfecting the skin for operation; first, that of the hands of the operator, then that of the field of operation.

Walker's rules for disinfecting the operator's hands, he thinks, are ideal and worthy of recapitulation:

1. Wash with soap and running water five minutes.
2. Cleanse subungual spaces with not too sharp orange stick.
3. Wash with soap and sterile brush in running hot water again for five minutes.
4. Dry and rub the hands and arms with a sterile towel.
5. Thoroughly brush the hands with a seventy per cent. solution of alcohol for three minutes.
6. Brush the hands in a 1-2000 bichloride solution two minutes and finally,
7. Pull the operating gloves on out of a 1-2000 bichloride solution and wash off their exterior with sterile water.

As to the field of operation he also believes iodine to be the ideal antiseptic. Its germicidal power has been determined by Dr. Kinman under the direction of the late Dr. Senn. The author then refers to the method used by Dr. Grossich, of Fiume, in a recommending manner.

The patient, if possible, is washed and shaved on the day before the operation and the parts are then covered with a sterile dressing and on the following day (preceding the operation) he applies a 10 to 12 per cent. tincture of iodine as follows:

1. After the patient was on the table the operation field was painted with the tincture of iodine with a sponge held in forceps.
2. Over the whole body of the patient a sheet was laid, with the opening coinciding with the place of operation.
3. After the anesthesia was fully accomplished a second painting of the operation field.
4. After completion of the operation the row of sutures was again painted and a sterile dressing applied.



At the end of seven days, the sutures which now appeared dry and stiff, were removed. If for any cause the dressings were removed before the seventh day the row of sutures was again painted.

The author holds, that Grossich's disinfection with tincture of iodine (15 per cent.) is a decided addition to the difficult problem of skin asepsis and wound healing.—*Pediatrics*, Oct., 1911.

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### THE CONTROL OF BLEEDING IN OPERATIONS FOR BRAIN TUMORS.

The following is a synopsis of an article appearing in the July issue of *Annals of Surgery* by Cushing:

1. Cushing's paper is filled with practical suggestions for hemostasis in brain operations. For the scalp he regards a properly applied tourniquet as the most efficient means for controlling hemorrhage. In addition to bone wax for diploetic and emissary bleeding, he makes use of the increased cerebral tension. As soon as the primary trephine opening and secondary perforator and burr opening has been made, he breaks up vascular attachments between the skull and dura by immediately passing a separator between the two. The cerebral tension plasters the dura against the bone and by the time the lateral margins of the flap have been cut many emissary vessels are spontaneously occluded. For dural hemostasis several "especial tricks" are detailed (small pledgets or tips of gauze; sterile absorbent cotton, dry or wet; bits of living tissue, muscle and partially organized blood clot). For inaccessible bleeding points in the dura or brain small silver "clips" are pictured and described. The oozing of cavities resulting from the removal of tumors is best controlled during their contraction by packing with dry absorbent gauze, replaced as necessary, and finally filling with normal salt solution. The dura is accurately closed and drainage obviated. The wisdom of operating in two or more stages is repeatedly mentioned. "But far more tumor operations have been carried to a successful outcome by the courage to withdraw temporarily after a bad start than by banging at hazards."—*Boston Med. Surg. Journal*, Oct. 26th.

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### DIFFUSE SEPTIC PERITONITIS.

R. S. Fowler, Brooklyn (*Journal A. M. A.*, November 4), gives a brief statement of his experience in 194 cases of acute septic peritonitis



due to appendicitis. In 188 cases operation was performed. In eighty-three cases in which treatment consisted in giving fluids by the mouth, saline enemas every three or four hours with the Fowler position, sixty patients recovered (72.3 per cent.) and twenty-three died (27.7 per cent.). In thirty-nine patients treated by the elevated head and trunk position, and fluids administered by the mouth only, thirty recovered (76.9 per cent.) and nine died. Combining these two series, we have 112 cases in which the Fowler position was maintained and fluids given by the mouth, the recovery percentage being 72. In fifty-eight cases in which the so-called ideal treatment was used, *i.e.*, the Fowler position, Murphy proctoclysis and nothing by the mouth, thirty-nine patients recovered and nineteen died, a mortality per cent. of 34.5. It would seem that the proctoclysis method was apparently at a disadvantage, but Fowler believes, nevertheless, that it should be used in the majority of cases. As regards time of operation in the operated cases, the figures given by him in each table seem to indicate the advantages of early operation, *i.e.*, in the first forty-eight to seventy-two hours.

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#### SURGERY OF THE COMMON DUCT.

John B. Deaver, Philadelphia, Pa., notes that there are three important anatomical features of the common duct: the portal vein may lie behind and to the right of the duct; the point of junction of the common and hepatic ducts varies considerably; and there are vessels and lymphatic glands in intimate relation with the common duct. Pathological abnormalities of the duct cause partial or complete occlusion. The common causes of obstruction are gallstones, pancreatitis, cancer of the duct or its papilla, cancer of the head of the pancreas, cicatricial stenosis of the papilla from duodenal ulcer, stricture of the duct from ulceration, together with the presence of a stone, pressure from adjacent structures, and hydatid cyst. The most frequent causes are gallstones, pancreatitis, and cancer of the pancreas, and of these three gallstones furnish by far the most frequent cause. Common-duct stones are always due to gall-bladder stones, which have migrated into the duct. The symptoms are jaundice; ague-like paroxysms, with chills, sweating, and fever; and pain in the hepatic region with epigastric distress. Medical treatment is of little value, and surgical treatment is not always possible. One of the chief contraindications to operation is the long continuance of severe jaundice, for in the patients hemorrhages after operation are frequent and severe. Myocarditis is a frequent



cause of death. The use of digitalis and the promotion of diuresis by means of an abundance of water administered by the mouth and by means of saline injections will save many cases. Free incision is necessary; after locating the common duct and the stone the latter may be pushed into the opened gall-bladder if possible. If it is in the supraduodenal portion of the duct this should be incised and, after the stone is removed, drained with a fishtail drain. When in the retroduodenal or pancreatic portion of the duct the stone should be dislodged into the supraduodenal portion or pushed into the duodenum. Drainage of the bile to the surface contributes to the safety of the patient.—*Medical Record*, November 4, 1911.

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#### ABDOMINAL INCISIONS.

A plea for larger incisions in operations on the abdominal viscera is made by J. E. Moore, Minneapolis (*Journal A. M. A.*, August 12). He says that there is no valid reason why an opening should not be amply large to permit the introduction of the hand, or, if need be, an arm, for a thorough exploration of the whole abdominal cavity. With our present technic a large opening will heal as readily as a small one. He says that once he was quite proud of the fact that he could operate for appendicitis through an opening just large enough to admit his index finger, but his pride received jolts when he had to operate again for overlooked conditions. He reports a case which showed him fully the error of his ways; a case of wrongly diagnosed appendicitis when the trouble was really an inverted Meckel's diverticulum. Two incisions had to be made, whereas one, properly located, would have been sufficient. The making of large incisions of course will not prevent oversights when a thorough examination is not made. Even when a state of affairs is found accounting for the symptoms, a careful search should be made for other conditions which may exist. The appendix is so frequently the seat of trouble that the tendency is to make a rapid diagnosis of appendicitis and it is probably the most frequently wrong diagnosis that is made. The location of the incision is not so important as the size. Useful and anatomically correct as the McBurney incision is, it is undoubtedly the one responsible for the greatest number of oversights because it is most satisfactory when small. It can be made large, but this causes greater damage to the muscles and nerves than a median incision and its location is not nearly so satisfactory for general work. The muscle splitting incision, Moore says, should be restricted



to cases of suppurative appendicitis in which there is no indication for going far into the abdomen, and to unmistakable cases of chronic appendicitis without complications.

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#### ASEPTIC OPERATIONS.

From bacteriological studies made in von Eiselsberg's clinic Drs. V. Hecht and R. Koehler (*Wiener med. Wochensch.*, No. 11, 1911) draw the following conclusions: (1) Complete asepsis is only attainable by direct disinfection, that is, by sterilization of all objects employed in operative work, such as instruments, sutures, dressings. (2) Ideal asepsis of the hand does not exist. All the methods hitherto devised effect at the most a diminution of the number of bacteria or a reduction of those liberated, but never a sterile condition of the hand. (3) The sterilized rubber glove alone furnishes an aseptic covering for the hand at the beginning of operation and a sovereign means of protecting it against bacteria. (4) Over closed cutaneous surfaces at the site of operation the application of a 1/2 per cent. sublimate-alcohol solution produces a transient complete sterilization. Tincture of iodine is not germicidal, but tans the skin. (5) No deleterious influence of air infection could be determined in general, but separation of operating rooms appears justified from a bacteriological viewpoint.

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#### AN EASY METHOD OF DIAGNOSING FISTULOUS TRACT.

Dr. J. M. Lynch (*Med. Rec.*, June 3, 1911) points out that a fistulous tract is seldom straight, and the variations in calibre at different places make it very difficult to follow its course with a probe. For this reason he has employed for the past eight years an injection of a mixture of peroxide of hydrogen and a saturated solution of methylene blue for tracing the ramifications of fistulous tracts. The peroxide will carry the methylene blue into the finest ramifications, staining them, so that during operation it is a very simple thing to follow it.

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#### PROSTATECTOMY.

E. S. Judd, Rochester, Minn. (*Journal A. M. A.*, August 5), gives an analysis of all the cases of prostatectomy operated on previous to April 1, 1911, in St. Mary's Hospital, Rochester, including 461 operations for benign hypertrophy, seventy-four for cancer, and seven for



tuberculosis. Cancer and hypertrophy were noticed together in several cases. No specific etiologic factors were determined in these cases and the conditions calling for operation were twice as frequent in country dwellers as in those living in the city and only a small percentage had had specific infection. The majority were operated on between the ages of 60 and 70 years. Only eleven were under 45, and fifteen were over 80. Four hundred and seventeen of the 542 patients were married, ninety-four were widowers and nineteen were single. The average duration of symptoms before operation was 5.96 years. The aim was to operate on patients whose symptoms were dependent only on prostatic enlargement, but it was not always easy to determine this point. If only a slight amount of residual urine is found in the bladder by catheterization in a case having marked secondary symptoms without great difficulty in voiding little benefit can be expected from operation, which will be accompanied, moreover, with great risk. On the other hand, if a large amount of residual urine is obtained with the catheter (and atony is excluded) the case is one for prostatectomy, even though the tumor is small. In late years the mortality in the hospital has been materially reduced and better convalescence obtained by spending a little more time in preparing patients for operation. With a permanent catheter in the ureter or through a suprapubic stab-wound the patient is in the same condition as after an operation so far as emptying the bladder is concerned. The secondary symptoms are relieved and the general health can be built up. The specific gravity becomes lower and operation should not be performed until it has risen again, which may take several weeks. As a rule, the Rochester surgeons do not consider it advisable, if the symptoms are slight and only two or three ounces of residual urine are found, to operate. Within the last five years they have used the cystoscope to great advantage in ninety-five per cent. of the cases in determining the presence of stone and selecting the type of operation. The perineal operation is the one ordinarily chosen, but the cystoscope may show conditions calling for a suprapubic operation. The mortality is not especially affected by the type of procedure. The suprapubic sinus as a rule is slower in healing, but is less likely to be followed by painful complication. They have been able to trace 90 per cent. of their patients and nearly all of them report they are absolutely free from pain. In seventy-four cases of carcinoma the immediate results have been quite as good as in benign cases, but, in such, symptoms exist. Several of the cancer patients are still alive after more than two years. Of the eighty-one operative patients who have died since leaving the hospital, thirty had carcinoma, and twenty are reported as having been



well for some time and then dying of other trouble. Twenty-nine died from kidney lesions before the end of the second month and in nearly all of them the autopsy showed evidence of old nephritis, with new nephritis superimposed. These patients, it would appear, had already had some sort of interference in kidney function before operation. The preliminary treatment is considered as the most important factor in the good results obtained during the past few years. By the use of the permanent catheter before operation in suitable cases they have been able to eliminate a considerable percentage of mortality from kidney disease.

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## LARYNGOLOGY AND RHINOLOGY

UNDER THE CHARGE OF PERCY G. GOLDSMITH, M.D., C.M., TORONTO.

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### SOME PRACTICAL POINTS OBTAINED FROM MR. GAY FRENCH'S CLINIQUE.

REPORTED TO THE MEDICAL TIMES BY H. MILES, L.R.C.P., LONDON.

*Case I.* was that of a youth who had been completely cured of recurring attacks of asthma by a nasal operation.

Mr. French, after introducing and explaining the case, went on to say that he did not think cauterizing the septum would cure all cases of asthma, but the result was good in about 20 per cent. The reason why nasal operations were so beneficial in asthma was because the mucous membrane of the nose was supplied by branches of the fifth nerve. There was a direct communication between the fifth nerve and the vagus, so that sensory impressions from the nasal mucous membrane were transmitted to the medulla, and thence to the vagi and its branches.

The patient in question had the following conditions:—

- (1) Deviation of the septum.
- (2) Pressure on the septum by the middle turbinals.
- (3) Swollen and water-logged middle turbinals.

Since the operation the patient has been quite free from any attack of asthma. The *modus operandi* of nasal asthma was that the fifth nerve internasal terminals were stimulated in some way. Centripetal impulses were started, and these were received by unstable nerve centres and passed thence to the pneumogastric filaments.

*Case II.* was that of a man, aged 65 years, who two years ago had



a gumma of the palate which broke down and formed an ulcer. Five months later the patient complained of a lump in the neck, which proved to be an enlarged gland caused by the ulcer, which on examination was found to be an endothelioma. After forty hours' exposure to radium this ulcer healed.

"Radium," said Mr. French, "is not much good apart from its local action." It acts most beneficially upon slow-growing endothelioma. The endothelioma, as all know, is a growth of the connective tissue type or sarcomata. It may affect the pleura, peritoneum, membranes of the brain or skin, or it may be found in the walls of the blood vessels, serous membranes, lymph glands and elsewhere.

The histological characters of the tumor are that it consists of more or less tubular or acinous-like collections of endothelial cells.

*Case III.* was that of a patient suffering from frontal sinus suppuration. In this case there was orbicular cellulitis, with œdema. The lecturer here pointed out that in acute inflammation of the frontal sinuses there was great danger of acute osteo-myelitis of the skull.

*Case IV.* was also that of a man with frontal sinus suppuration. "Again I repeat," said Mr. French, "that one of the dangers of acute frontal sinus suppuration is acute osteo-myelitis, which leaves the skull like a cribriform plate." Another complication is septic thrombosis. In this case lumbar puncture showed the presence of pus cells in the cerebro-spinal fluid. The treatment was soothing and antiseptic—hot menthol vapor and poultices in order to get the condition into a quiet state.

*Case V.* was that of a girl who had had the double radical frontal sinus operation. The result was in every way satisfactory, and no disfigurement whatever could be detected. The sinus was washed out afterwards by a solution of peroxide of hydrogen (5 per cent.) by means of a spray.

*Case VI.* was that of a man, aged about 40, who presented characteristic specific scar of the soft palate. "This scarring," said Mr. French, "looks like the congested appearance you get after removal of the tonsil." The treatment had been mercury, iodide of potassium and an intravenous injection of "606." The beneficial effects of the latter were marvelous. The condition cleared up almost at once.

*Case VII.*—A case of tubercle of the larynx. "It is," said the lecturer, "usually the rule to speak of tubercular laryngitis as a primary and secondary infection of the larynx by the tubercle bacillus, but I will at once say that in my opinion the disease is always secondary and never primary. I doubt if primary disease of the larynx due to tubercle



exists. Now," continued Mr. French, "when a student is asked to describe the characteristic appearance of the mucous membrane in tubercle of the larynx he usually states that early pallor is the rule. Allow me to tell you that this is not so, for in six cases out of ten brick red congestion of the mucous membrane is the distinguishing character, not only at the commencement, but in the later stages. The appearance seen might be enumerated as follows:—

- (i.) Brick red congestion of the mucous membrane.
- (ii.) Pyriform swelling of the arytenoid cartilages.
- (iii.) Turban-like swelling of the epiglottis.
- (iv.) Finally the moth-eaten appearance occurs when ulceration eats into the affected parts.
- (v.) The inter-arytenoid ventricular bands and cords present the shallow, mottled, mouse-like appearance.

It is usually the laryngeal side of the epiglottis which becomes first affected, showing that infection occurs from below and not from above, and this in itself points to secondary infection from the lungs. "The cause of hoarseness in these cases," said the lecturer, "is the presence of granulations preventing complete adduction of the cords."

The treatment of the case would be as follows:—

- (1) Moist air;
- (2) Avoidance of dust;
- (3) Absolute silence;
- (4) An injection of menthol with guaiacol in olive oil;
- (5) Formalin, 2 per cent., as a vapor;
- (6) Cauterization;
- (7) Removal of a piece of the epiglottis;
- (8) Injection of guaiacol.

For the relief of pain and dysphagia equal parts of anæsthesin and arthoform, inhaled by means of a glass tube, gives immense relief. Later on, where ulceration is present, the following preparation painted over the parts gives satisfactory results:—

Lactic acid	50 parts
Carbolic acid	10 parts
Formalin	7 parts

As to the use of tuberculin in these cases, Mr. French remarked: "On the whole I think its administration in tubercular laryngitis is a failure, and I will tell you why: The infection is really a mixed infection entirely due to the tubercle bacillus, hence the failure of tuberculin to do any permanent good."



## PERSONAL AND NEWS ITEMS.

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ONTARIO.

Dr. W. J. Roche, M.P. and Secretary of State for Canada, had the degree of LL.D. conferred upon him recently by the Western University, London, of which he was the first medical graduate in 1883.

In the case of the Ontario Medical Council v. Dr. Beverly Wilson, the Leamington osteopath, who was recently tried for an alleged practice of medicine there, on 8th December, before Police Magistrate Selkirk, judgment was given in favor of the defendant. There is talk of an appeal.

An effort is being made to secure \$150,000, with which to enlarge and endow the Infants' Home in Toronto. The building has become too small and there is urgent need for funds for ordinary current expenses.

The Management Committee of the Hamilton Board of Education recommended two medical inspectors and the visiting nurses for the schools.

Dr. N. B. White has been appointed the physician-in-chief for the Isolation Hospital in succession to Dr. Hazelwood, who recently resigned. Dr. White will take a trip to Boston and other places to look into the best methods of managing infectious diseases. He will enter on his duties on 1st January.

Dr. W. H. Merritt was elected Mayor of St. Catharines by acclamation.

The Aged Women's Home in Toronto was injured by fire to the extent of \$10,000. The patients were all removed safely. The building will at once be repaired.

At the annual meeting of the medical and surgical staffs of Grace Hospital the officers were elected as follows: Dr. Bruce Riordan, dean; Dr. R. A. Stevenson, vice-dean; Dr. J. H. McConnell, secretary-treasurer; executive committee, Drs. Jas. Caven, A. O. Hastings, S. P. Sylvester, W. H. Harris, J. M. Cotton, and D. W. McPherson.

The County Council has decided to give an annual grant of \$400 to Belleville Hospital, payable in quarterly installments.

The General Hospital, completely transformed by a new wing at a cost of about \$35,000, was formally opened 29th November.

Dr. W. P. Kendall, physician-in-chief of the Muskoka Cottage Sanitarium and Muskoka Free Hospital for Consumptives, Gravenhurst, has been appointed a justice of the peace.



Registrar George Y. Chown reports that up to December 1 the number of students registered at Queen's University was 1,489, made up as follows:—Arts, extra mural, 303; arts, intramural, 616; theology, 27; science, 294; medicine, 247; registered in two faculties, 43.

The Board of Education, Hamilton, referred to the Internal Management Committee of 1912 the recommendation of the committee to appoint three nurses, two medical inspectors and one dental clinic for the public schools.

Dr. Vanderburgh, of Merritton, has been selected in succession to Dr. Comfort, of St. Catharines, to fill the office of surgeon of the county jail in that city.

The Lambton County Council has appointed F. Brock, Reeve of Dawn; W. A. Brock, Reeve of Enniskillen; H. A. Spearman, Reeve of Bosanquet; Dr. C. O. Fairbank, Deputy Reeve of Petrolea, and Dr. Morrison, Deputy Reeve of Sarnia, a special committee to procure an option on a site, have plans prepared and an estimate made of the probable cost of erecting a building that would accommodate fifteen patients suffering from incurable diseases. Dr. Morrison is the father of this movement to procure a hospital for sufferers from any incurable disease, he having brought the question up at the June session.

The contagious diseases in Toronto for November were: Scarlet fever, 3; diphtheria, 12; whooping cough, 2; typhoid fever, 5; tuberculosis, 17.

It is announced that next year's meeting of the Canadian Health Association will be held in Toronto. The officers elected for the ensuing year are as follows: President, Dr. C. A. Hodgetts, Ottawa; Vice-Presidents, Ontario, Dr. J. W. S. McCullough, Toronto; Saskatchewan, Dr. M. M. Seymour, Regina; New Brunswick, Dr. Boyd Fisher, Frederickton; Secretary, Major Lord Drum, M.D.; Treasurer, George D. Porter, Toronto. Lord Stratheona cabled \$2,500 to help defray the costs of the meeting of the association in Montreal.

A permit has been granted to the Toronto General Hospital to erect a building for private patients on Christopher Street, 300 feet west of Elizabeth Street. It will be five storeys high, of terra cotta, concrete, and steel construction, and will cost \$300,000.

Dr. Hastings, M.H.O., Toronto, announces he has established a new department in connection with the Health Department, which will be known as the Institute of Sanitary Instruction. Weekly lectures will be given by the Medical Health Officer and his associates on various sanitary and health matters, the first on Wednesday, Dec. 20, on "The Organization of a Health Department." In reference to these lectures



all the inspectors of the department must attend them, also any persons who have passed through the public schools and wish to qualify as inspectors. Examinations will be held at the end of the course, and only those who pass will be eligible for positions.

Because he practised medicine in this city without having an Ontario license, Dr. A. L. Lawler, of Niagara Falls, N.Y., was fined \$25 by Magistrate Alexander Fraser to-day. Dr. Lawler pleaded guilty. An information was laid against Dr. C. G. Harrington, another Niagara Falls, N.Y., physician, but was withdrawn. It developed that Dr. Harrington attended a member of an American lodge on this side, of which he is a physician. On this ground the charge was withdrawn. Both informations were laid by Inspector Charles Rose, of Toronto.

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### QUEBEC.

Montreal was recently literally hedged in with smallpox-stricken municipalities. The situation was extremely serious, in some districts the number of cases amounting to an epidemic. An active vaccination campaign was carried on.

A hospital for consumptives will be established in the City of Quebec at a cost of \$60,000. Towards its maintenance the Provincial Government will make a grant of \$3,500 a year.

Smallpox exists in a nearly epidemic state in Quebec, especially in the laborers' wards. In spite of the efforts made by the sanitary authorities to keep the matter secret, it is stated that there are nearly a hundred cases in St. Malo ward. A very drastic by-law was passed last spring to establish the compulsory vaccination under very heavy penalties, but this by-law was never firmly applied, and to-day half of the population are not vaccinated.

The Provincial Health Department, Quebec, is face to face with a very serious problem, owing to the action of the Sisters of the Presentation, Montreal, who conduct the Barford Convent, near Coaticook, in dismissing the majority of the pupils for the holidays when several cases of suspected smallpox existed in the institution. The children have spread all over the country, twenty-three municipalities receiving pupils from the institution.

The first annual meeting of the Canadian Public Health Association met in Montreal on 13th, 14th, and 15th December. H.R.H. the Duke of Connaught opened the proceedings. A number of papers of much interest to the public were read. Consumption, infant mortality and the purity of water supplies were given special attention.



McGill University set out to raise \$1,000,000 for an endowment fund. The committee having this work in charge raised \$1,500,000 in a few days. With a good cause and enthusiastic workers, it does not seem to be very difficult to secure money in large sums. The students in science gave \$2 per head, and those in medicine \$3.

The late Dr. James Bell, of Montreal, who died April 11 last, left an estate valued at \$34,574.02, his will being filed for probate in the Surrogate Court the other morning. His estate in Ontario consists of 200 shares of Crown mining stock and 10,000 shares of Silver Leaf mining stock. He bequeaths all his medical apparatus and books to his brother, Dr. John H. Bell, of Montreal. His widow, Edith Mary Bell, is left the rest of the estate.

Very definite steps are being taken throughout Quebec to lessen the sickness and death rates from tuberculosis. Organizations are being formed in various parts of the province.

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#### WESTERN PROVINCES.

An amendment to the Public Health Act of Saskatchewan makes it obligatory on hospitals of 25 beds and over to employ a resident medical officer.

Dr. J. C. Henderson has been appointed Medical Health Officer for Chilliwack, B.C.

A new hospital is to be erected at Stratheona, and the physicians of the town have approved of the plans.

The Alberta Medical Association has already begun active preparations for the meeting of the Canadian Medical Association.

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#### FROM ABROAD.

In the year ending on June 30, 1911, no fewer than 10,396 people were killed on the railroads of the United States, and 150,159 injured.

A striking falling-off in the natural increase in the population of England and Wales is shown in the report just issued by the Registrar-General of the United Kingdom. In the quarter ending Sept. 30 births exceeded deaths by only 81,645, as compared with 123,022 excess of births over deaths in the corresponding quarter of 1910, and 123,309 and 124,054 in the third quarters of 1908 and 1909 respectively. The number of births registered in England and Wales in the third quarter of 1911 was 222,601, a rate of 24.4 annually a thousand of population,



or 2.9 a thousand below the average birth rate in the third quarters of the ten preceding years. It was the lowest birth rate ever registered in any third quarter since the establishment of official civil registration.

French statistics just issued indicate that there will be an actual falling-off of 40,000 in the population of France in 1911, as compared with 1910. Last year the official registration figures showed that there was a slight decrease, not enough to justify belief that the trend would be downward permanently. The figures now presented, which cover the first six months of 1911, show that there were 14,000 fewer births and 26,000 more deaths than during the first six months of 1910. This made a net loss of 18,270 in the population.

In 1901 the sleeping sickness was found to be rampant in Uganda, and by 1905 no less than 200,000 natives had died from it. In one small district alone 20,000 natives had died, and the population of one village had dropped from 8,000 to 2,000.

The American Health Association met a short time ago in Havana. Dr. Simpson, Winnipeg, presided. Drs. Bell, Bryce, and Roberts represented Ontario.

Dr. Tahara, of Tokio, Japan, claims that after twenty years' research to have discovered a toxin from the body of the globe fish that is of much value in the treatment of leprosy and may prove a cure for the disease.

Report from Seattle, Wash., states that \$50,000 worth of opium was recently seized at Manila, P.I., on board the steamer Kumeric.

Report from Washington, D.C., on Nov. 13 states that of the samples of imported foods and drugs analyzed at ports of entry in this country during the past year, over 3,000, or nearly one-third, were found to be adulterated or misbranded. Of 9,500 samples of interstate foods and drugs examined by the Bureau of Chemistry, 3,113 were found to be adulterated or misbranded.

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#### BRITISH.

The agitation for and against the British insurance law continues in other than political circles. The National Medical Union has formed a plan to raise a fund of \$2,500,000 from which to make grants to physicians who refuse to treat beneficiaries under the law. Six thousand doctors are already pledged not to accept service under the Act.

Dr. Charles Mayo, of Rochester, Minn., was operated upon recently for an attack of appendicitis. He was suddenly taken ill and operated on in New York. He made a good recovery.



At a special meeting of the Royal College of Surgeons in England, held on the 9th inst., it was announced that the president, Sir Henry T. Butlin, Bart., had decided to retire from that office on account of ill-health, and Mr. Rickman J. Godlee, F.R.C.S., M.S., was elected to succeed him. In accepting his resignation with regret the Council conveyed to Sir Henry Butlin the expression of their deep sympathy with him in that he had been compelled to curtail the period during which he otherwise would have held the position of president.

On Nov. 16 Louis B. Schram, president of the New York Civic Federation, urged upon the Wagner-Smith Factory Investigation Commission the great need of state laws requiring the installation of safety devices in all buildings where industrial workers are employed, and also providing for more rigid inspection of such buildings than is at present the case. He furthermore recommended the establishment of a state museum of safety, along the lines of the American Museum of Safety now conducted in New York City by the Society of Mechanical Engineers. Stereopticon views showing what has been done in recent years in the introduction of safety appliances were displayed by Dr. William H. Tolman, director of this museum, and the latter also made an address in which he advised that statistics should be prepared which would indicate to what extent alcohol is a factor in causing accidents to workmen. Dr. Woods Hutchinson stated to the commission that his visits to several factories during the strike of the shirtwaist makers had convinced him that almost universally the conditions prevailing in such places are conducive to ill-health. As a rule, he found overcrowded workrooms, bad air and poor light, as well as inadequate exits.—*Boston Med. and Surg. Jour.*, Nov. 23rd.

A singular epidemic of poisoning occurred last week among the pupils of one of the public schools in the Brighton district of Boston. Some boys at play in a vacant lot found a number of tablets which had been thrown away in the backyard of a druggist's house. Supposing these to be candy, they partook eagerly thereof, and gave to eat to their companions. At varying intervals all were seized with symptoms of acute poisoning. The tablets proved to be "complexion pills," probably containing arsenic. There have been twenty-one cases of poisoning, but no deaths. The matter is being investigated by the Board of Health. The moral of the episode is obvious, as regards both the throwing away of medicine and the indiscriminate juvenile ingestion of supposed confectionery.—*Boston Med. and Surg. Jour.*, Nov. 23rd.

The Local Government Board for England and Wales has issued an order to go into effect on the 1st January, 1912, calling for the



compulsory notification of all cases of pulmonary tuberculosis. The names will be kept secret, but steps taken to prevent the spread of the disease. The fee for the notification of each case is two shillings and six pence.

A very important announcement is made to the effect that Dr. Charles E. de M. Sajons has become the editor-in-chief of the *New York Medical Journal*. Those who are familiar with the splendid work of Dr. Sajons in the cause of medical literature will be ready to congratulate the publishers of the *New York Medical Journal*.

The *Johns Hopkins Hospital Bulletin* for December has two highly appreciative articles of the great work that Prof. Robert Koch did for scientific medicine. As one reads these articles the thought comes into one's mind how much the world is the richer for his life's work. It may be said that the foundation on which our knowledge of infectious diseases is built was laid by him. He worked out the life history of anthrax, tuberculosis, cholera, relapsing fever, infectious conjunctivitis. One of his pupils, Gaffky, solved typhoid fever; Loeffler, diphtheria and glanders; Pfeiffer, influenza; and Kitasato, tetanus and bubonic plague. This is a great monument to any one man.

Sir Samuel Wilks died on 8th November in London in his 87th year. He obtained his degree in medicine in 1850 and became attached to Guy's Hospital, where he did his great work. He was assisted with the late Dr. Moxon in those remarkable pathological investigations that made their names famous, along with that of Sir William Gull. He held many important offices at the hands of the medical profession.

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## OBITUARY.

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### WILLIAM CAW, M.D.

Dr. Wm. Caw, who located in Parkhill forty-eight years ago when but twenty-one years of age, and who had practised medicine there ever since, died at his home on Sunday, 17th December. His generosity, his sympathy, his devotion to his profession, and his utter disregard of his own personal ailments endeared him to a large circle. He graduated from Victoria College in 1866. Hundreds attended the public funeral service in the church, and if the tears of genuine sorrow shed for him and the broken words of love and esteem which were spoken of him constitute riches, then Dr. Caw was rich indeed in those things which



are far above wealth as the world values it. He was the son of the late Rev. David Caw, Presbyterian minister at Paris, Ont. He was for forty years an office bearer in the Canada Bible Society. He was also for many years a member of the School Board and a director of the West Williams Agricultural Society. The schools and business places were closed on the afternoon of the funeral, and the bell on the town hall was tolled while the procession passed from the church to the cemetery. Rev. Mr. Carriere, of Grand Bend; Rev. Mr. Lohead, of London, a former pastor, and Rev. A. Graham, B.A., conducted the service. He is survived by one sister, Mrs. T. J. Wilson, and by his nephew, Dr. David C. Wilson.

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#### J. P. BRUCE, M.D.

Dr. J. P. Bruce, Colorado Street and Fortieth Avenue, Chicago, died 23rd December in University Hospital of pneumonia, after an illness of three weeks. Dr. Bruce, who was the second son of Mr. James Bruce, Egbert, near Barrie, Canada, was born thirty-five years ago in Peel Township, County of Bruce, Ontario, and in early childhood removed with his parents to Newton Robinson, Simcoe County, where he obtained his primary education and matriculation certificate. He then went to Chicago to study medicine and after a successful course began the practice of his chosen profession, which at his death had already become lucrative. He had great energy and perseverance. He was unmarried and is survived by his father, two brothers, W. J. Bruce, DD.S., Kincardine; Mr. H. E. Bruce, of the Carson-Pirie-Scott & Company, Chicago, and one sister, Mrs. C. E. McEachern, "The Willard," Toronto. The two brothers were with him when he died. The remains were removed for interment at Newton Robinson.

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#### HANS STEVENSON, M.D.

Dr. Stevenson died at Wakefield, Que., on 4th November, 1911. He was in his 59th year. He had practised for many years in Wakefield. He is survived by his widow and six children.

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#### J. E. TYNDALL, M.D.

Dr. Tyndall had lived and practised in Brandon, Manitoba, for a number of years. He was well known there and highly respected. He was in his 46th year. He was a native of the County of York, Ontario, where he received his education, and studied medicine in Toronto.



## WILLIAM STEVENSON, M.D.

Dr. Stevenson practised in Virden, Man. He studied medicine in Winnipeg, and graduated in 1894. His death occurred on 16th October, 1911.

## W. L. PIRT, M.D.

Dr. Pirt, of Carman, Man., was accidentally killed in an automobile accident on 31st October, 1911. He was 47 years of age.

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**BOOK REVIEWS.**


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## A TEXT-BOOK OF THE PRACTICE OF MEDICINE.

A Text-book of the Practice of Medicine, by James M. Anders, M.D., Ph.D., LL.D., Professor of the Theory and Practice of Medicine and of Clinical Medicine, Medico-Chirurgical College, Philadelphia. Tenth Revised Edition. Octavo of 1,328 pages, fully illustrated. Philadelphia and London: W. B. Saunders Company, 1911. Cloth, \$5.50 net; Half Morocco, \$7 net. Sole Canadian Agents, the J. F. Hartz Co., Ltd., Toronto.

The tenth edition of this well-known text-book contains 1,328 pages. There are 81 figures and six plates. The paper, typography, and binding do much credit to the publishers, Messrs. W. B. Saunders Company. The subject matter of the book is maintained at a high standard, and the author has spared no pains to keep his work up to date on all points. The classification of diseases is simple, but satisfactory, and in accordance with the most accepted views on nosology. Special attention is paid throughout to etiology, diagnosis and treatment. In this latter part the author gives prominence to his own experience, while not neglecting the opinions of those most worthy of consideration. Among some of the specially new diseases considered are the abortive type of the plague, masked chlorosis, polycythaemia, hypertonica (erythrocytosis), blocked pleurisy, angina major, angina minor, angina abdominis, hour glass stomach, appendix dyspepsia, fatty liver, heat cramps, serous meningitis, tic, and psychasthenia. Attention is given to new treatments, as 606, milk sugar in typhoid fever, serum in typhoid fever, tonsillectomy in acute rheumatism, Nastin's treatment for leprosy, Grawitz's treatment in pernicious anaemia, transfusion of blood



in pernicious anaemia, Holmgren's treatment of serofibrinous pleurisy, Oertel cure in myocarditis, salt-free diet in arterio-sclerosis, McBride's treatment of alcoholism, etc. All this goes to show how conscious the author has been to enable his readers to acquaint themselves with the latest and best. The author has given special attention to tropical diseases. This is very proper, as these diseases are now playing a much more important rôle than formerly, both in therapeutics and commerce.

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### DORLAND'S AMERICAN ILLUSTRATED MEDICAL DICTIONARY.

**Dorland's American Illustrated Medical Dictionary.** A new and complete dictionary of terms used in Medicine, Surgery, Dentistry, Pharmacy, Chemistry, Veterinary Medicine, Nursing, Biology, and kindred branches, with new and elaborate tables. Sixth Revised Edition. Edited by W. A. Newman Dorland, M.D. Large octavo of 986 pages, with 323 illustrations, 119 in colors. Containing over 7,000 more terms than the previous edition. Philadelphia and London: W. B. Saunders Company, 1911. Flexible Leather, \$4.50 net; thumb indexed, \$5 net. Sole Canadian Agents, the J. F. Hartz Co., Ltd., Toronto.

When a book reaches its sixth edition it should be nearly perfect. In this work several features are specially brought out. These are the many new words we find in this volume, the care given to the proper use of capitals, the clearness with which pronunciation is set forth, the care devoted to the etymology of words, the numerous dental and veterinary terms, the arrangement renders consultation of the book easy, the many short biographies of the noted names in medicine, many useful anatomic and other tables, the attention given to the dosages of drugs. The definitions in this dictionary are particularly clear. There is no useless verbiage, but there is no obscurity. It is a pleasure to find definitions that are terse, clear and accurate. Such can be said without stint in the case of Dorland's Medical Dictionary. The volume is sumptuously illustrated with a very fine series of figures and plates. The flexible leather binding renders much to the attractiveness and pleasure of using the book. One has no hesitation in recommending this work. The severest critic will be satisfied after a trial.

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### THE TREATMENT OF FRACTURES.

**The Treatment of Fractures,** with notes upon a few common dislocations, by Charles L. Scudder, M.D., Surgeon to the Massachusetts General Hospital. Seventh Edition, Revised and Enlarged. Octavo volume of 708 pages, with 990 original illustrations. Philadelphia and London: W. B. Saunders Company, 1911. Polished Buckram, \$6 net; Half Morocco, \$7.50 net. Sole Canadian Agents, the J. F. Hartz Co., Ltd., Toronto.

Dr. Scudder's book has now reached the seventh edition. It has undergone a thorough revision and has been considerably enlarged.



There are 990 figures scattered in the text. The use of x-rays has rendered much new work in the illustration of such works. This form of illustration now takes the place of tracings and drawings of fractures. The author in this edition pays special attention to the recent work that has been done on the operative treatment of fractures. The aim of the author is towards simplicity of methods, while making himself clear as to what should be done. The illustrations call for special mention as throwing light on the text. Among the many works on surgery this one can be recommended as filling a useful place in an excellent manner.

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### THE MAYO CLINIC.

Collected Papers by the Staff of St. Mary's Hospital (Mayo Clinic) for 1910. Octavo of 633 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1911. Cloth, \$5.50 net. Sole Canadian Agents, the J. F. Hartz Co., Ltd., Toronto.

The papers in this volume cover articles on the alimentary canal, hernia, genito-urinary organs, ductless glands, head, neck and extremities, technic, and general papers. Those contributing papers are Drs. E. S. Judd, H. S. Plummer, C. H. Mayo, C. Graham, J. T. Pilcher, L. B. Wilson, W. J. Mayo, W. C. MacCarty, B. C. Willis, Donald Guthrie, B. F. McGrath, D. C. Balfour, H. Z. Giffin, D. W. Palmer, W. F. Braasch, Justus Matthews, M. S. Henderson, and E. H. Beckman. The subjects discussed are quite varied, and their handling judicious and careful. These papers are a record of work done, and not compilations from the works of other writers. The paper and illustrations are all that could be desired and leave nothing further to be sought after. For such a superb production the publishers should reap their reward in a large sale to an appreciative body of readers.

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### A TEXT-BOOK OF PHYSIOLOGY.

A Text-book of Physiology for Medical Students and Physicians, by William H. Howell, Ph.D., M.D., Professor of Physiology, Johns Hopkins University, Baltimore. Fourth Edition, Revised. Octavo of 1,018 pages, fully illustrated. Philadelphia and London: W. B. Saunders Company, 1911. Cloth, \$4 net; Half Morocco, \$5.50 net. Sole Canadian Agents, the J. F. Hartz Co., Ltd., Toronto.

Professor Howell, of Johns Hopkins University, has done well in bringing out a new edition of this well-known text-book of physiology. We have always held to the view that medical practitioners should secure and carefully study some good work on physiology every few



years. For this purpose no better book could be found than the one from the pen of Dr. Howell. He has special opportunities for the study of physiology and has availed himself of these. He has also a clear method of expressing his views; and, while his book is on a scientific subject, it is interesting reading. Accuracy and readability are the tests of a work of this sort. The very latest views on physiology are to be found in the volume by Professor Howell. We can very cordially recommend this book.

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### MARSHALL'S MIDWIFERY.

A Manual of Midwifery for Students and Practitioners, by G. Balfour Marshall, M.D., C.M., F.R.F.P.S.G., Senior Gynaecologist, Royal Infirmary, Glasgow; Extra Academical Lecturer on Midwifery and Gynaecology, Glasgow. With nine colored plates and 125 illustrations in the text. Glasgow: James Maclehose & Sons, Publishers to the University, 1912. Price, 14s net.

This volume is the outcome of repeated requests to publish the notes of the author's lectures on this subject. The object of the author is to pay special attention to conditions frequently met with, while the rarer conditions receive less space. The illustrations have been drawn by the author. The work is divided into sections on the physiology of pregnancy, the pathology of pregnancy, the physiology of labor, the physiology of the puerperium, the pathology of labor, the pathology of the puerperium and obstetrical operations. Under the various divisions the subject is handled in a concise and scientific manner. This is a very useful manual. It would be well, indeed, if every one who may be called upon to attend confinements would master the details of such a book. It is such a book as one can most heartily recommend.

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### PROGRESSIVE MEDICINE.

A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by H. A. Hare, M.D., assisted by L. F. Appleman, M.D. Vol. IV, December, 1911. Price, \$6 per year in paper. Lea and Febiger, Philadelphia and New York, 1911.

The subjects covered in this volume are Diseases of the Digestive Tract and Allied Organs, Diseases of the Kidneys, Genito-urinary Diseases, Surgery of the Extremities, and a Practical Therapeutic Referendum. The writers of these sections are Drs. R. S. Lavenson, John Rose Bradford, C. W. Bonney, J. C. Bloodgood, and H. R. M. Landis. This volume maintains the high standard of the series to which it belongs. One could hardly see in what way these articles or volumes could be



improved. Important subjects are selected and placed in the hands of thoroughly competent experts. The result of this method is to produce from time to time volumes of real merit. This series constitutes an excellent working library. The publishers are entitled to much praise for their enterprise in bringing out such volumes quarterly.

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#### PREVENTION OF TUBERCULOSIS.

The Canadian Association for the Prevention of Tuberculosis' Eleventh Annual Report, with Transaction of the Annual Meeting held in London, Ontario, May 17th and 18th, 1911. James Hope & Sons, Ottawa.

This report contains much useful information on the subject of tuberculosis, in so far as treatment and prevention are concerned. It would be impossible to refer to the many excellent papers in this report, but it is to be hoped it shall be very widely distributed.

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#### PATHOLOGICAL TECHNIQUE.

Pathological Technic, including Directions for the Performance of Autopsies and for Clinical Diagnosis by Laboratory Methods, by F. B. Mallory, M.D., Associate Professor of Pathology, Harvard Medical School, and J. H. Wright, M.D., Director of the Pathological Laboratory, Massachusetts General Hospital. Fifth Revised Edition. Octavo of 507 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1911. Cloth, \$3. Sole Canadian Agents, the J. F. Hartz Co., Ltd., Toronto.

The mention of the names Mallory and Wright at once brings to one's mind the recollection the familiar old friend that has found a place on the table in the form of this book on Pathological Technique. This book is one that appeals in a very special sense to the most rigid ideals of Lady Hord. In this work we are told how to do things. It is the *vade mecum* of the pathologist. It is to him what the table of logarithms is to the mathematician, the field military book to the general, or the calculations of the strength of materials to the constructional engineer. Here will be found the methods of conducting investigations, of the preparation of specimens, the staining of bacteria, and everything pertaining to the practical work of the pathologist. The book is well written, well printed, well bound, well illustrated, and reflects credit alike on authors and publishers.

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#### MEDICAL DIAGNOSIS.

A Dictionary of Medical Diagnosis, a Treatise on the Signs and Symptoms observed in Diseased-Conditions for the use of Medical Practitioners and Students, by Henry Lawrence McKisack, M.D., L.R.C.P., London, Physician to the Royal Victoria Hospital, Belfast. Second Edition. London: Bailliere, Tindall & Cox, 8 Henrietta Street, Covent Garden, 1912. Price, 10s 6d.

The first edition of this work appeared in 1907. The errors of the first edition have been carefully eliminated, and every effort made to



secure as near perfection, this issue, as possible. The author follows the alphabetical method. This has some advantages. Under the names there is a very full and carefully prepared article. We have taken considerable pains to examine the claims of this work, and feel that it will fill a very useful place. As a working manual this book will be found helpful to all who wish to acquire a thorough knowledge of the subject of diagnosis. The book is well illustrated, printed and bound. It will, no doubt, command a large sale, and we heartily wish it the success it merits.

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### MODERN MEDICINE.

Scientific Features of Modern Medicine, by Frederic S. Lee, Ph.D., Dalton, Professor of Physiology, Columbia University. New York: The Columbia University Press, 1911; Lemcke & Buechner, 30-32 West 27th Street.

This little volume contains the eight lectures delivered at the American Museum of Natural History, and known as the Jessop Lectures. The author deals with a number of medical problems in a highly scientific manner. From this point of view it is a very valuable contribution to medical literature. It is impossible to go into details regarding the contents, but would recommend its careful study.

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### HISTOLOGY.

Aids to Histology, by Alexander Goodall, M.D., F.R.C.P., Edin., Lecturer on Physiology, School of Medicine of the Royal College, Examiner in Physiology to the Royal College of Physicians, Edinburgh. London: Bailliere, Tindall & Cox, 8 Henrietta Street, Covent Garden, 1912. Price, 2s 6d.

The "Aids Series" has long been known to the medical profession. Generation after generation of students have read these books to much advantage. This one is, for its size, well arranged and contains the essentials of the subject. These books are of pocket size and will prove very useful for students.

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### OPHTHALMOLOGY.

Aids to Ophthalmology, by N. Bishop Harman, M.A., M.B., Cantab., F.R.C.S., Eng., Lecturer in Ophthalmology, West London Post-graduate College; Assistant Ophthalmic Surgeon, West London Hospital, etc. With illustrations. Fifth Edition. London: Bailliere, Tindall & Cox, 8 Henrietta Street, Covent Garden, 1912. Price, 2s 6d.

This is a useful small volume on this subject. It has reached its fifth edition and contains the essentials of ophthalmology. The author



has displayed much skill in selecting the most needful points and omitting what is of less value. The account of disease is abbreviated, but still clear.

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### PHYSICIANS' VISITING LIST.

This visiting list is now in its sixty-first year. It was for many years known as Lindsay and Blakiston's. It is gotten up in very neat form, bound in limp leather, and with flap. The paper is first-class. There is some very useful tables and instructions on emergencies, poisoning, etc. The book is useful and some such a one should be in the pocket of every physician.

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### MISCELLANEOUS MEDICAL NEWS.

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#### INFECTIOUS DISEASES IN ONTARIO.

Typhoid figures for Ontario in the month of November are very encouraging. Last year there were 266 cases, with 50 deaths. This year 103 cases and only 13 deaths. There are similar decreases in scarlet fever and infantile paralysis. The report of the Provincial Board of Health, however, shows quite an epidemic of measles—108 cases, compared with 65 last year. Only two deaths occurred, whereas last year there were five.

The figures for tuberculosis are not entirely accurate, for notification in cases is not compulsory.

The report follows:

	—1911—		—1910—	
	Cases.	Deaths.	Cases.	Deaths.
Infantile paralysis .....	3	0	21	5
Cerebro-Spinal Meningitis .....	3	2	5	4
Smallpox .....	28	0	28	0
Scarlet fever .....	167	8	340	15
Diphtheria .....	210	18	224	14
Measles .....	108	2	65	5
Whooping cough .....	28	2	23	5
Typhoid .....	103	13	266	50
Tuberculosis .....	72	40	105	83



## STUDY AND PREVENTION OF INFANT MORTALITY.

The second annual meeting of the American Association for the Study and Prevention of Infant Mortality was held at Chicago on Nov. 16, 17 and 18 of last year. This association was organized on Nov. 10, 1909, as the result of a conference on the prevention of infant mortality held in New Haven, Conn., by the American Academy of Medicine. The proceedings of this conference were fully described at the time in an editorial in the issue of the JOURNAL for Nov. 18, 1909 (vol. 161, p. 754).

The purposes of the association, as summarized by Dr. William H. Welch, are as follows:

“To educate and enlighten the public. To stimulate better sanitary organization and administration throughout the country. To urge the organization of a Federal Department of Health. To promote more adequate registration of births. To correlate existing activities now working independently. To stimulate investigation into causes of infant mortality. To formulate a definite programme of prevention.”

Since its organization, the association has continued zealously in pursuit of these purposes. At its recent session there were section meetings on birth registration, city milk supply, continuation schools in home-making eugenics, midwifery, nurses' associations and social workers. Dr. L. Emmett Holt, of New York, and Dr. J. H. Mason Knox, of Baltimore, discussed the relative value of existing methods of preventing infant mortality, and Dr. Hastings H. Hart, of the Russell Sage Foundation, described the work of similar organizations in Europe. Other addresses were made by President Jordan, of Leland Stanford University; by Professor Davenport, of the Carnegie Station for Experimental Evolution; by Dr. George B. Young, health commissioner of Chicago; and by Dr. James Lincoln Huntington, of Boston.—*Boston Med. and Surg. Jour.*, Nov. 23rd.

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MICHAEL SERVETUS.

In the year 1511 there was born at Tudela, Spanish Navarre, the celebrated Michael Servetus (Miguel Servet), who, with William Harvey, must be considered the discoverer of the circulation of the blood. According to others, his birthplace was Villanueva, Aragon, and the year is given as 1509. In his nineteenth year he left Spain and entered the University of Toulouse to study law, where he became acquainted with the teachings of Luther, and after a few months, spent, however,



more in theological than in juridicial studies, he went to Basel. In 1531 appeared, in Hagenau, Alsace, his well known book *De Trinitatis erroribus libri septem*, in which he denied the divine trinity and thus became the forerunner of unitarianism. Attacked simultaneously by Catholics and Protestants, he left Germany and went to Paris, where he studied medicine and received, on account of his brilliant researches, the title of doctor of medicine. Unquestionably, Servetus was one of the first to speak of the circulation of the blood, even if he did not discover the fact. The great work of William Harvey, to whom we usually attribute the discovery of the circulation of the blood, appeared in 1651, nearly one hundred years after Servetus; but the question is still an open one. Servetus mentioned also the rôle of the valves of the heart in the movements of diastole and systole, which, according to him, do not exist during uterine life, but are set in motion at birth. These studies and his audacious criticism of certain teachings of Galen, which he published under his French name, Villeneuve, changed the attitude of the medical faculty, which now became his enemy and forced him to leave Paris. In 1534 we find him in Lyons. The following years he spent partly in Paris, partly in Lyons, practising medicine. In 1541 he met in Lyons the archbishop, Pierre Paulmier, who offered him asylum in his see of Vienne. Here he continued his theological teachings and his attacks upon Calvin, the result of which was his *Christianismi restitutio*. The consequence was that in 1552 Servetus was accused of heresy and arrested; he escaped, however, and in 1553 arrived in Geneva, where he was again arrested, and on October 27, 1553, burned at the stake.—*New York Med. Jour.*, Nov. 4th.

#### THE MAKING OF A PHYSICIAN.

There are five factors in the making of a good physician, according to E. P. Lyon, St. Louis (*Journal A. M. A.*, May 27): (1) good raw material; (2) a good model or ideal; (3) men to do the work; (4) a place to work in and tools to work with; (5) time to do the work. And failure in any of these points may give bad results. He does not attempt to formulate all the qualities of a good physician, but mentions first the capacity for accurate observation. The good observer is partly born and partly made and the latter part need only be considered. The power of observation can be cultivated. It improves by practice. Next in importance is skilled direction or instruction, and he speaks especially of the study of anatomy as of first importance in cultivating this power. What is true of anatomy, however, is true of every other science so far as development of observational power is concerned and intensity



and accuracy should be our watchwords rather than breadth of view and general impression. The teacher of anatomy should give his whole time to the medical school and should specially cultivate his powers of imparting knowledge, and the medical college should provide all the needs for its impartation. Besides being an exact observer the good physician must be, in the author's opinion, an experimenter. Most physicians, he admits, do not know how to experiment. The three essentials of experimentation are the varying of one factor at a time, the use of repetition and the quantitative estimation of the results. The practicing physician has hardly ever made use of this last. Especially experimental sciences are physics, chemistry, physiology, pharmacology and bacteriology. Like anatomy, they cultivate observation, but demand also experiments, and each has its own methods. Physiology and pharmacology, on account of their use of living material, come especially close to medicine in subject matter and in methods. To the powers of observation and knowledge, how to experiment, the physician must add ability to judge correctly, and the best medical studies to develop this power of interpretative judgment is pathology. Lyon emphasizes the necessity of the research professor in charge of each scientific department. He should have the needed facilities for this, and also for training students. Good teachers are better than fine buildings and if proper instructors are secured they can attend to the equipment if allowed to do so. Teachers are more important than equipment. Lastly, the good physician should be a man of character, and for influencing the student properly to make him such the teachers should also be men of character. Character is the *sine qua non* of the good physician, and the principal way we can influence the medical student, who is the physician in the making, is by surrounding him with characters which are worthy of imitation.

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## MEDICAL PREPARATIONS, ETC.

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### WORDS OF APPRECIATION.

The following letter, relating to the treatment of opium and other addictions, will interest many. It is addressed to our old friend, the Antikamnia Chemical Company, and reads:

"Gentlemen,—Illness, dating from the very day of my former letter, must be my plea for my silence and my seeming indifference to your courtesy, and your exceptional kindness in sending me your little 'Vest-pocket Box.' I want you to feel that I sincerely appreciate your goodness in this little matter. I am in charge of the Woolley Sana-



torium, Atlanta, Ga., an institution conducted exclusively for the cure of opium and other drug addictions, and am using Antikamnia Tablets extensively after withdrawing morphia, and I am free to say that I do, in reality, regard your product as 'A Succedaneum for Morphia.'

"Our institution is probably the largest of its kind in the South, and if my views should prove of value to you at any time, command me."

MARION T. DAVIS, M.D.

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#### APOLLINARIS WATER.

Apollinaris Water has been awarded the Grand Prix at the Dresden Exhibition.

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#### FRAUDS.

Is it possible to finance more than are already on the market and how are we to get rid of those that are a menace to life and health? The last year's work in investigating methods of compounding prescriptions in many drug shops has served as a warning to physicians. A sense of increased responsibility rests with the profession which should not be necessary.

Diagnosis and medical care in diseased conditions is a small part of a doctor's duty to-day. He must now see that the druggist uses pure ingredients in exact quantity as called for, in order to get desired results. The labors of Hercules read like a play compared to this task. Only united efforts of honest druggists, physicians and the press persistently carried on will create and enforce legislation which must hark back to the manufacturer and wholesale drug supply sources. Substitution and adulteration have undoubtedly caused thousands of fatalities for which "inexact medical knowledge" or "ignorance and experiments of the doctor" have been blamed.

False labels on noxious and useless mixtures, accompanied by fraudulent literature, have deceived both physicians and laity. Some of the best known and widely accepted ready-to-take remedies are the most fraudulent. Of this class are the so-called cod-liver preparations. This fact was brought forward at the medical convention in Baltimore last spring, and analysis of several are on file in laboratories of highest repute.

The Scott's Emulsion house is secure in a knowledge of honest dealing with the public for thirty-five years, and this food-remedy has the endorsement of chemists and physicians, who also know the frauds. The Emulsion is 50 per cent. finest grade of cod-liver oil, combined with the purest hypophosphites of lime and soda, and the Emulsion does not contain a drop of alcohol. It is an absolutely reliable food-remedy.