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# THE MARITIME MEDICAL NEWS

A MONTHLY JOURNAL DEVOTED TO  
MEDICINE & SURGERY



Vol. XX.

HALIFAX,  
OCTOBER

NOVA SCOTIA.  
1908.

No. 10

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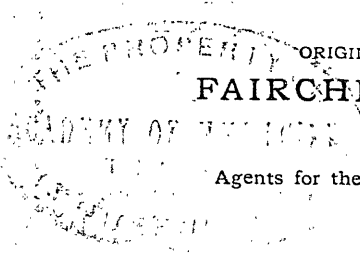
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# THE MARITIME MEDICAL NEWS

VOL. XX., OCTOBER, 1908, No. 10.

**Headache.** Under the title "The Treatment of Some of the Severer Forms of Headache," W. Harris contributes a paper to the *British Medical Journal* for August 8. Harris has elaborated the following anatomical classification of headache, on which he bases the appropriate treatment.

A. SUPERFICIAL. 1.—Diseases of the brain coverings. (a) Scalp-cellulitis; weight of hat or mass of hair. (b) Pericranium—*e.g.*, rheumatic. (c) Bone—*e.g.*, tuberculous or syphilitic caries. The brain substance itself seems to be insensitive to ordinary stimuli, and the actual mechanism of the production of the pain in headaches is mainly by means of painful stimuli to the nerves supplying the coverings of the brain and its vessels. In group 1, the nerves of the scalp, pericranium or bone, carry the painful impressions to the sensory centres. 2.—Reflex visceral neuralgias of the scalp; ocular, dental, pulmonary, cardiac, gastric, etc. In this group the morbid process affects the nerves of a viscus at a distance, such as the branches of the fifth nerve from chronic strain, or from iritis or glaucoma. The painful stimuli reach the Gasserian ganglion and set up irritability—so that other areas supplied by the fifth nerve become tender and appear to be the source of the pain. This is a true reflex visceral neuralgia. B. DEEP. 3.—Reflex cortical neuralgia. Visual "academy" headache; thunder storm; neurasthenic. Of the causes of headache

within the cranial cavity, the true neuralgic headaches, such as the neurasthenic or that produced by dazzling the eyes, emotion, a thunder storm, etc., are probably the neuralgia of the remedies. 4.—Toxæmic. Constipation and sluggish liver; influenza and other fevers.; foul air; alcohol, ether. This is a very important group of headaches, but the exact mechanism of the production of the pain is obscure. In some instances, as in fever, increased vascular turgescence probably plays a considerable part. Alcohol and ether headaches may also be due to arterial engorgement. Constipation and sluggish liver are well known causes of headache, which may be periodic and accompanied by vomiting. 5.—Increased intracranial pressure. This is the most important cause of headache, and produces the most severe and persistent pain. In cerebral tumour there is general increase of pressure from the growth, and the headache is apt to be diffuse. When the cortex membranes are involved, then the pain becomes localized, and is a sign of the utmost localizing value. Meningitis causes severe headache in two ways: first by involvement of the nerve endings in the meninges, and secondly by increased intracranial pressure due to œdema of the cortex. In acute or serous meningitis there is a rise of pressure due to the excess of cerebrospinal fluid. The same is true in hydrocephalus. Headache in cerebral syphilis is often most intense; even large doses of mercury and iodides do not

bring relief until the œdema of the brain and excess of cerebrospinal fluid, due to the meningitis, have subsided. In arteriosclerosis from contracted granular kidney severe headache is common and is usually vertical or occipital. Both in this condition and in chlorosis (anæmia) there is cerebral œdema, raising the intracranial pressure. Nitroglycerin is the drug that here gives the quickest and most relief. Intolerable headache, optic neuritis, convulsions, coma and death, may be produced by a loose fibroma in the lateral ventricle, acting as a plug and preventing the escape of cerebrospinal fluid. True migraine is the most important and commonest of the causes of periodical headache, and the writer holds that the severe pain in the head is due to raising of the intracranial pressure. The hemianopia, dimness of vision, the numbness in the tongue, cheek, or arm, and the temporary aphasia, are all suggestive of sudden arterial constriction in the cortex. The vomiting is also a most characteristic sign of elevation of the intracranial pressure. Antineuralgic remedies only do good by their depressant effect, and for that large doses are required. Local measures would be trephining and opening the dura; lumbar puncture; leeches to the scalp; fomentations, hot bottles, or ice bag to the scalp or neck. Indirect measures (by lowering the general blood pressure) nitroglycerin and the nitrites; cardiac depressants, such as opium, aconite, chloral, phenacetin and other coal tar analgesics, purgation, diaphoresis, and hot baths.

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**Premonitory Signs of Arteriosclerosis.** A. S. Gubb notes in the *Lancet* for July 11, that the initial manifestations of this affection vary according to the region in which its impact

chances to fall, kidney, brain, heart, liver, etc. The tendency thereto is notably influenced by heredity, although acquired by certain habits of life. We may have early migraine, epistaxis, baldness, etc. Constitutional symptoms comprise diminished mentality, energy for work, and power of concentration. Tendency to fatigue is shown by drawn features and physical depression. Small amounts of tobacco and alcohol render the patient morbidly irritable. Irritability of temper is common. Judgment is impaired and self-control lessened. Headaches are frequent. Sensory disturbances in one form or another are fairly common, such as neuralgia, tingling, numbness, slight paresis of the limbs with or without pain. Genuine insomnia is rare, though sleep is disturbed. Capiello has called attention to a peculiar sensation in the palm of the hand—a tingling along the palmar arch—when the radial artery is compressed sufficiently to arrest pulsation. A simple way of determining the existence of general arteriosclerosis is the estimation of the "stability" of the pulse. Under normal conditions the pulse-rate is eight or ten per minute higher in the erect than in the recumbent position, and when observation shows that such is not the case we may infer that the blood-pressure is markedly above normal, while if the ratio be reversed it may be taken as proved that not only is the arterial pressure unduly high, but that arteriosclerosis has reached the stage of giving rise to definite organic disease, an assumption which is confirmed should we find that the heart apex is displaced to the left. Exaggerated arterial tension with a small, hard, thready, but regular pulse, is a recognized sign of confirmed arteriosclerosis, but in minor degrees it also constitutes an early

premonitory sign; indeed, some weighty authorities believe that actual changes in the arterial walls are preceded by prolonged exposure to the ill-effects of persistent high-pressure, what Huchard calls the pre-sclerous period, such hypertension being due to spasmodic contraction of the arterioles probably dependent on toxic irritation of the vasomotor system. High arterial tension, it is true, is commonly associated with chronic renal lesions, but the presence of the latter by no means excludes the possibility of the mischief being due to arteriosclerosis; indeed, the renal lesion, may be, and often is, due to local arteriosclerosis. When in addition to an abnormally high blood-pressure we get some of the other signs just mentioned there is a strong presumption in favour of the existence of arteriosclerosis.



After first noting some **Nephropexy.** of the pathologic conditions calling for operation in floating kidney, A. H. Ferguson, in the *Journal of the American Medical Association*, August 15, describes and illustrates a technic for nephropexy which he has used for over three years, without having any relapses. He makes his incision parallel with the twelfth rib along its full length, cuts the presenting lumbar fascia obliquely below the twelfth intercostal nerve, thus bringing in view the perirenal fatty capsule, and exposes the kidney by vertically severing this fat. The kidney is delivered into the wound by traction with several artery forceps clamped on to the fatty capsule and aided by ventral pressure. As much of the fatty capsule as can be easily placed below the kidney is used as a support and for normal protection. Then he

reforms the normal bed of the kidney if it has been obliterated by fibrous adhesions, forcibly separating the encroachments of the liver and diaphragm in the renal fossa and cutting posterior and lateral adhesions if necessary. This he considers important. The further technic is described as follows: "To prepare the kidney for fixation, split the fibrous capsule over its convexity to within an inch or so of its lower pole and then peel it off the parenchyma of the organ, except at the lower end. Insert four catgut (No. 1 chromic) sutures, two to the anterior half and two to the posterior half of the capsule. With a long, round, curved needle the anterior sutures are passed subcutaneously from within outward and above the twelfth rib, while the posterior sutures are made to penetrate all the structures posteriorly at the upper angle of the wound, except the skin. In many cases only two retention sutures are indicated. Gently push the kidney into the bed prepared for it and pull on the sutures already described at the same time. The kidney must rest *in situ* without any tendency to displacement after these sutures are tied. Otherwise adhesions in the renal fossa have been overlooked or the fatty capsule has not been properly dealt with. When there is plenty of room the anterior suture or sutures may be fastened to the diaphragm. In order to deepen the renal fossa and at the same time to support and fasten the lower end of the kidney, raise a broad, thin flap from the anterior surface of the quadratus lumborum muscle and suture it to the lower end of the kidney. Two nerves, iliohypogastric and ilioinguinal are guarded from injury. Close the wound in the usual manner and leave room for a small cigarette drain at the upper angle of the wound."



**Treatment of Typhoid Fever.**

*The Practitioner* for August contains an article by A. K. Gordon, entitled "Some Experiments in the Treatment and Prevention of Infection in Enteric Fever." Gordon gives the following summary: (1) Medical izar oil is an efficient germicide in vitro for bacilli of the colityphoid group. (2) It can be given in large doses, in emulsion, without ill effects, for a long period. (3) It does not disturb the appetite and is well tolerated after two or three doses. (4) It does not increase peristalsis and checks diarrhœa. (5) It is diuretic and diaphoretic, and increases the elimination of toxins. (6) It causes disappearance of bacilli of the colityphoid group, and if given for a sufficient period the organisms will not reappear. (7) This germicidal effect upon the urine does not follow the use of other antiseptics which are usually given in enteric fever. (8) In the author's experience mortality was diminished by this treatment, and the course of the disease was favourable, especially in the acute stage. (9) Favourable results occurred even in cases in which izar oil was not given until the second week of the disease, and in a series from which all mild cases were eliminated.



**Operative Treatment of Gastric Ulcer.**

In discussing the operative treatment of hæmorrhage in gastric ulcer, in *Deutsche medizinische Wochenschrift*, (February 20), W. Braun finds that but few surgeons have hitherto felt justified in operating for dangerous hæmorrhage in this condition. The following reasons have been put forward for this opinion: (1) Many persons recover after one or more attacks of severe hæmorrhage when

treated medically; (2) Patients who have suffered severe loss of blood are usually too anæmic and too collapsed to stand a serious surgical interference; (3) the situation of the bleeding point and the certainty of the existence of an ulcer as against an erosion is difficult to determine; and (4) it is impossible to predict how far it will be necessary to proceed in order to cure a bleeding ulcer by operation. Braun has recently had two cases in which he considered that he was obliged to operate. The first was a case of repeated hæmorrhage, and the patient was pulseless and deathly pale. As it appeared to be certain that he would die without operation. Braun cut down upon the lesser curvature, and found the ulcer without difficulty. There were, however, dense adhesions both with the liver and posteriorly. As the patient was sinking fast, he merely applied tampons, and then tried to restore him by means of saline injections, etc. This proved of no avail, and the patient died shortly after the operation. *Post mortem* the bleeding point was found to be the pancreatic artery. In the second case he was able not only to check the hæmorrhage in a girl aged twenty-one years, but also to cure the ulcer permanently. He is inclined to accept that, while it is practically hopeless to operate during marked collapse, when the bleeding takes a more chronic course, but persists in spite of all the medical and dietetic measures, one may attain good results by careful operation. Experiments on dogs have shown that the afferent vessels of the stomach can be ligatured without producing necrosis, and that for the first few days after the ligature the vessels are rendered impermeable. He next deals with the technical points in

connection with the ligature of these vessels. The right gastric artery is easily reached and secured by acupuncture in the gastro-hepatic ligament. The left artery has so many small branches that in order to limit the blood supply to the smaller curvature it is necessary to apply the ligature as far toward the cardiac end as possible. The gastro-epiploica dextra must be dealt with in a similar manner. All these ligatures can be applied without difficulty and in a short space of time. The gastro-duodenal artery is also comparatively easy to ligature if the smaller omentum is tied and divided, the pylorus pulled down, and the artery secured between the head of the pancreas and the pylorus. The least easy of all to ligature is the splenic artery. The author is of opinion that for many reasons ligature is little suited for hæmorrhage issuing from the vessels in the submucous network. The best chances are offered in cases of ulcer of the lesser curvature, since the left gastric artery and the coronary artery are easy to find and to ligature. These ulcers form about 25 to 30 per cent. of all gastric ulcers. Ligature of the gastro-duodenal or splenic artery may be employed for ulcers, especially perforating ulcers, of the posterior wall. The former may also be carried out for duodenal ulcer. It thus appears that the number of cases in which ligature is likely to prove of value is limited somewhat narrowly. In the severest cases the ligature or acupuncture should be associated with a jejunostomy, while in acute or chronic recurrent forms, which do not lead directly to death, gastro-enterostomy, either alone or combined with ligature, must be considered.

### Incisions in Pelvic Surgery

The advantages and disadvantages of the three methods of reaching the disease in pelvic surgery, the vaginal, abdominal and Pfannenstiel incisions are enumerated and discussed by E. E. Montgomery, in the *Journal of the American Medical Association*, September 12. The vaginal route is indicated (except in virgins and nullipara with small vaginas) for retro-uterine collections and is of special value in exploring and treating diseases of the tubes and ovaries, and particularly in obscure cases in determining the existence of ruptured ectopic gestation. Some forms of malignant disease of the uterus, some uteri containing small fibroids and occasionally inflammatory conditions of the appendages which justify hysterectomy, are best treated through the vagina, particularly in fat patients. The advantages of the vaginal incision are: the drainage from the most dependent part of the peritoneal cavity, the possibility of cure in many cases without more radical procedures, the quicker and easier convalescence, the avoidance of ventral hernia and adhesions, and the frequent possibility of excluding ligatures and raw surfaces from the peritoneal cavity. Its disadvantages are that it is often a blind procedure, extensive adhesions having to be separated by touch, intestinal injuries and sinuses are liable to be overlooked and fæcal fistulas may form, extensive adhesions may be unrecognized or form later, causing disaster. The median incision is certainly the one of widest application, allowing every step to be guided by sight and affording free access for manipulation, control of hæmorrhage and repair of injuries to viscera. On the other hand, it is a more serious operation

with greater discomfort and delay in natural drainage, and there is greater chance of infection. The third procedure, the Pfannenstiel incision, is a curved incision, the convexity downward, just above the symphysis pubis, passing through skin, superficial fascia and aponeurosis, exposing the pyramidales and recti muscles. These are separated from each other in the median line, and the peritoneum is opened vertically. Montgomery has used this incision over two hundred times and found it especially useful in operation on the intrapelvic viscera. The muscle fibres, being so much more elastic than those of the aponeurosis, permit a much more free exposure through a relatively small incision, and in round ligament operations it is in just the right place. It is specially valuable, also, in operations on the bladder and in extirpation of the uterus for small growths. In closing the wound, Montgomery usually closes the muscles and peritoneum with a continuous catgut suture tight enough to keep the surfaces in apposition but not to constrict the muscle tissue. A second continuous suture closes the aponeurosis and a third the skin. Care is needed to avoid bleeding between the layers, or a hæmorrhage may form, which, if infected, may imperil the stability of the subsequent support. The merits of the procedure are the large exposure with a small incision, the lessened danger of hernia from the interior and middle lines of suture being crossways to each other, and the resulting scar being largely hidden by the pubic hair. Its disadvantages are that it is of limited application and not suitable for the removal of large fibroids and that the necessarily large opening of the cellular tissue makes it unsuitable for treatment of intrapelvic

suppurative conditions on account of the greater risk of infection.



**Exophthalmic Goitre.** In the *Medical Record* for September 19, Andrew J. McCosh finds that the medical treatment of exophthalmic goitre has been rather disappointing and that an increasing number of these cases are coming to the surgeon for relief. One of the strongest arguments for the theory that this disease is caused by hyperthyroidism was the fatal results of removal of the thyroid. This was supposed to be due to toxicity of the thyroid juice squeezed into the wound during the removal. The author believes that it is rather due to an acute exacerbation of the disease at the time of operation. Tetany has resulted from the removal of the parathyroids in some instances, but the author has never had any such result, and has not found the parathyroids constant, or taken any especial care in avoiding them. In over two hundred operations on the thyroid the author has seen no signs of tetany. He believes that when medical measures have failed to give relief operation should be tried. The antitoxic and cytotoxic sera of Beebe and Rogers have undoubtedly done much for some patients, but not all are cured by them. The chief point in operation is the question of how much of the gland it is safe to remove. The author advocates removal of about sixty-five to eighty per cent. of the gland. If too little has been taken away it is possible to remove more later. The author has performed twenty-three operations on twenty-two patients, with one death, due to acute thyroidism after a second operation. Of nineteen patients who can be traced, four are cured, twelve

operated on within a year are markedly improved. One has not been benefited after removal of about 40 per cent. of the gland.



**Treatment of Neurosis of the Stomach.** Dr. Wm. Meyer describes in the *Annals of Surgery* for May, a condition of intractable vomiting not due to pyloric obstruction, and publishes five cases which show that this is amenable to operative treatment. This affection, which he calls neurosis of the stomach, consists in frequent attacks of intense gastric pain and irregular vomiting sooner or later after ingestion of food. Careful analysis of the contents of the stomach fail to reveal any disease except, now and then, some hyperacidity. On abdominal section a thorough search of the entire accessible part of the stomach and duodenum, both anteriorly and posteriorly, fails to reveal the slightest abnormality. The disease is usually found in unmarried women. The author, in the first place, endeavours to impress on the practitioner the fact that cases of this condition of so-called gastric neurosis clearly belong to the borderline between medicine and surgery, and that, after he has exhausted all other therapeutic means, a simple abdominal incision, which will probably reveal some kinking or adhesions, is apt to effect a permanent cure. It is stated that in cases of this kind gastro-enterostomy is clearly contraindicated, and may, indeed, have fatal results. This operation, the author holds, is indicated only in cases of pyloric stenosis, and for the purpose of putting at rest recurrent gastric ulcers that may have developed in the distal portion of the stomach. The reason of the prompt improvement after laparotomy in cases of intract-

able vomiting not due to pyloric stenosis is acknowledged to be somewhat obscure. It is, the author thinks, most probably of a mental character, the patient's mind being set at ease by the confident assurance of the surgeon that now the cause of all her trouble having been found, everything must be right. Still, it may be that the handling and stretching of the gastric walls or the entrance of air into the abdominal cavity may exert a curative influence.



In the May number of **Autoprotection** the *Monthly Cycloped-ia and Medical Bulletin*, Chas. DeM. Sajous asserts that we should look to the autoprotective resources of the body, and the laws through which drugs influence them, for scientific therapeutics. He adds that the entire trend of medical thought is in this direction and that the study of immunity has captivated the best minds of modern times. He urges that when a disease is due to the presence of pathogenic bacteria, our aim should be to so enhance the defensive properties of the blood with our remedies that the disease-breeding agents will promptly be destroyed and converted into eliminable end-products. He believes the defensive powers of the body are enhanced by drugs which stimulate the activity of those organs producing internal secretions and which he has termed the "adrenal system," viz.: the pituitary body, the thyroid gland (including the parathyroids) and the adrenals. His fundamental principle is that immunizing medication is the foundation of rational therapeutics. He uses the term "antitoxigen" to indicate the group of agents which, through their action on the adrenal system, produce an excess of auto-

antitoxin in the blood. The most active antitoxigens in infections and intoxications include some of the drugs now known as alteratives whose physiologic action has remained obscure. Thyroid preparations are very active and provide the blood, he believes, with an excess of opsonin. Iodine and mercury also have this power. Creosote, too, has this action ascribed to it. The most active of the tonics also excite the adreno-thyroid centre, but only sufficiently to enhance general nutrition. Strychnine is placed here and the beneficial action of digitalis in heart disorders is stated to be due to a marked stimulating action on the adreno-thyroid centre. Strophanthus, apocynum, convallaria and other heart tonics act in a similar way, but with less vigor. The true hypnotics markedly depress the adreno-thyroid centre.

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**Diagnosis of Gastric Lesions.** In a paper entitled "Abnormal Motility of Stomach, A Valuable Factor in the Diagnosis of Gastric Lesions," appearing in the *Medical Record* for September 12, Milton R. Barker considers abnormal motility a sign of great diagnostic value in stomach disorders. Loss of gastric motility, shown by long stagnation of stomach contents after a meal and partial or complete absence of mucus from the contents, characteristic of cancer, and search should be made for the Oppler-Boas bacillus which gives a positive diagnosis of cancer. A large accumulation of mucus in the stomach is an important element in diagnosis of chronic gastritis; this is due to a faulty contact of the food with the coat of the stomach causing gastric immotility, which prevents the escape of the mucus from the organ. In gastric ulcer

there is abnormal motility due to irritation. Any portion of a test meal is absent from the stomach in a comparatively short time. Mucus is absent, being digested at once by the overacid secretion, and expelled quickly because of exaggerated motility.

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**Granular Kidney.**

W. B. Warrington states, in the *Lancet* for August 22, that the cardinal symptoms on which a diagnosis of granular kidney is made are: (1) Cardiovascular changes; (2) ophthalmoscopic examination; (3) manifestations of chronic or acute renal toxæmia; (4) the urine. The cardiovascular changes come first in importance. In some cases the most pronounced changes fall on the vascular system, general arteriosclerosis being present, and the kidney substance being comparatively slightly affected by fibrosis. In other cases the kidney is profoundly fibrotic and greatly reduced in size and weight. The causes of arteriosclerosis are those of granular kidney—the working of products of defective metabolism, of which the two best known are gout and lead. In granular kidney the thickening of the arteries can almost invariably be recognized. High arterial tension is a normal feature of granular kidney, and when it falls, unless this is brought about by therapeutics, it indicates a condition of failure of compensation. Enlargement of the heart is usually present, and in young subjects can be readily made out, the clinical indications being displacement of the apex beat downwards and outwards, and a well localized and forcible apex beat. In older subjects the hypertrophy is not infrequently masked by the emphysema so often present in the subjects of granular

kidney. Auscultation at the apex shows the first sound to be muffled and to be of low pitch, while the second aortic sound has a characteristic, clear, high pitched, ringing tone. Headache in granular kidney is often a symptom of chronic toxæmia, but it may be due to the high blood pressure and the disease of the arteries. As regards the urine, the granular, "compensated" kidney behaves like that of a healthy person. A large amount of urine is excreted, and hence the specific gravity is low. Albumen is often absent altogether. Casts, though scanty in number, are nearly always present. At any stage of the disease an acute nephritis may be added to the old standing disease, and may be thought to be the primary mischief. A diagnosis of uræmic asthma should not be made until the other causes of dyspnoea have been excluded; among these may be mentioned pleural effusion, bronchitis, œdema of the lungs and of the glottis, dilatation of the heart, pericarditis, and hydrops pericardii. The ophthalmoscope often confirms the diagnosis of granular kidney in obscure cases. Only the arterial changes are absolutely distinctive of renal disease, however. The most characteristic feature is the appearance of small, glistening, woolly-whitish patches often arranged in a striate fashion around the macular region. These are degenerative in nature, and are permanent. Hæmorrhages and papillitis occur, but may disappear. From the standpoint of treatment the cases may be grouped as follows: (1) The compensated kidney, where the excretion of urinary products is not greatly interfered with. Here the treatment should be chiefly prophylactic, alcohol, condiments, and strong broths and meat extracts being for-

bidden. (2) The acute exacerbations, where the treatment resembles that of acute nephritis. (3) The cases with cardiac failure; here the freshly made infusion of digitalis combined with some vasodilator is of special value. (4) The more chronic symptoms of renal toxæmia. (5) The hopeless cases, where the desires and tastes of the patient should be met as far as possible. For toxæmic symptoms hot rectal saline injections at a temperature of 110 F. are of great value. Morphine should not be withheld in these cases; it is invaluable for restless, painful nights with cardiac dyspnoea. It is very doubtful whether the excretion of sodium chloride has anything to do with the production of uræmia or œdema.

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#### Pathogenesis of Carcinoma.

Following up the work on which von Leydon and Bergell recently reported, P. Bergell and A. Stricker, writing in *Deutsche medizinische Wochenschrift* for September 19, 1907, deal with experiments conducted on a sarcomatous tumour in dogs. The first publication showed that a substance isolated from animal livers when brought into contact with carcinomata as well as sarcomata, caused necrosis and fluidification. The action was believed to be an enzymic one. A theory was constructed on the basis of these experiments by which it was supposed that malignant growths depend on the absence or insufficiency of a ferment hydrolytic action of the organism, which is probably specific. Bergell and Lewin have shown further that the substance which can call forth a local specific disintegration is absent or lessened in the livers of carcinomatous animals as compared with healthy animals. These observations, however, have

but a slight therapeutic value. On applying the substance to human carcinoma, the disintegration was an extensive one, but it was associated with toxic action. The experimenters failed even in curing inoculated tumours in mice, since the dissolving of the tumours was always accompanied by a dangerous toxic action. It was considered advisable to continue the experiments with growths which were like those of the human subject, and for this reason the inoculation sarcomata of dogs were chosen. The results obtained were that the injection of specific liver ferment caused a regressive metamorphosis even in advanced sarcomata at a time when a spontaneous cure was quite excluded. This led, as far as can be determined up to the present, to the complete disappearance of the growth. In one case the glandular metastatic growths disintegrated together with the primary growth. In the regressive stage, no mitosis, such as is so freely seen in the progressive stages, is seen. The process of regression after injection is analogous to that of spontaneous cure. The writers warn the reader not to exaggerate the importance of these experiments for human therapy. They discuss the question as to whether the substances inhibiting growth described by Reinke in his experiments with salamander larvæ and their fermentative substances, and also whether the ferments of which Bier spoke in his experiments with the injection of blood of an animal of different species, are identical with their liver ferment substance.



Edward Milton Foote

**The Sigmoid.** says, in an article contributed to the *Medical Record* for August 29, that carcinoma of the sigmoid is of interest to the

surgeon because it grows slowly, and for a long time does not produce metastases. It is accessible, and situated in a part which can be sacrificed with impunity. Removal can be complete only in an early stage, before the lumbar glands have been attacked. The author quotes three illustrative cases. Early symptoms include pain, which when obstruction has occurred, is in distinct peristaltic waves; increasing constipation; loss of weight; and obstruction. Tumour is not recognized early, nor is there anything to be gained from examination of the stools; diarrhœa alternating with constipation is a late symptom, and blood in the stools is not always present. The disease is usually annular, and gives rise to symptoms of obstruction before more than an inch or two of the bowel has been involved. It is mild in type. Physical examination may not show much in a stout person. The bowel should be examined with the finger, through a tube, and with the endoscope. Pumping air or water into the rectum is of value, since the rectum will hold only one pint, while the sigmoid will hold an entire quart of liquid. The condition must be differentiated from chronic constipation and sigmoiditis. In sigmoiditis the condition is more markedly inflammatory. If the disease is in the left iliac fossa, with constipation for only six months, with local pain and impairment of strength, in a person for middle life, it is probably malignant. Treatment by freeing the tumour and the involved lymphatics, dividing so much of the mesocolon as to bring the affected intestine into the wound, stitching the loop of intestine into the peritoneum of the abdominal walls, and cutting off the protruding loop is without danger, and is the best procedure.

**Diagnosis of Appendicitis.** In an article entitled "Differential Diagnosis Between Appendicitis and the Diseases of the Uterine Adnexa," appearing in *Deutsche medizinische Wochenschrift* for July 2, Rinne says that such differential diagnosis is always difficult and often impossible. Both anatomically and pathologically the appendix and the uterine adnexa are closely related to each other, the appendiculoovarian ligament affording means of communication between the lymph and blood-vessels of the broad ligament and those of the cæcum and appendix. Subjective symptoms, therefore, due to the diseases of one organ may easily give rise to symptoms in the other set. The site of the inflammatory tumour, if any is present, is of value in the differential diagnosis in the early part of the disease only; the appendicular abscesses are more lateral, and increase in the downward direction, the pelvic abscesses are placed more deeply in the pelvis and increase upward. In the latter disease, too, the uterus may be sensitive

on pressure. The history of former appendicular inflammation on the one hand or the history of gonorrhœal or puerperal infection on the other are of great value in the diagnosis. The initial pain of peritonitis due to an appendicitis is usually general in character, or is felt most in the epigastric and the umbilical regions; there is almost always present a reflex spasm of the overlying muscles, and meteorism develops late in the history of the attack. Gonorrhœal peritonitis due to the disease of the adnexa begins with a stormy picture, but very soon the symptoms become milder in character. Meteorism is uniformly present, reflex spasm of the muscles usually absent. In chronic inflammations the diagnosis is still more difficult. It is best, therefore, in all cases of doubt to act as if appendicitis is present and to advise operation. Moreover, all right-sided gynæcological inflammations ought to be operated upon by the abdominal and not by the vaginal route, for only the former allows the examination of the appendix, which may be involved.





# EDITORIAL.

## THE DYAS CASE.

ON the first of October there was filed by Mr. Justice Drysdale, in the Prothonotary's Office at Halifax, a decision relating to a case which has more than ordinary interest to the medical profession, and demands something more than a mere passing notice.

In August, 1901, Ira Everett Dyas, a native of this province who had apparently been prosecuting his studies in the United States, having returned to Nova Scotia, applied for registration. It may be noted that at that time the present Medical Act which requires a professional examination in all ordinary cases had not yet gone into force, and the present list of accredited Colleges had not been adopted. Dyas was therefore, in accordance with the regulations of that date, simply asked to produce certificates to show that he had attended during four academic years at any of the Colleges up to that time recognized by the Board, the usual courses of instruction and that he had passed satisfactory examinations in the various subjects of each year. Such certificates were not at once forthcoming, but before the date of the October meeting of the Board, everything necessary seemed to have been produced, his certificates were accepted and at the same meeting the Board authorized his registration. These certificates included mainly a matriculation examination certificate from Tufts College Medical School, certificates of having attended during three full sessions at that school and of having passed very satisfactory examinations in all subjects of each of those years except Pathology, togeth-

er with certificates of having completed a fourth *Annus Medicus* at the College of Physicians and Surgeons, Boston, passed all examinations, including Pathology, and obtained the diploma of the latter school. After his registration, Dyas at once started in practice at Freeport, Digby, but later removed to Amherst. He had not been long stationed here before reports of his methods of practice and professional incapacity were subjects of common remark, and indeed were brought to the notice of the Board. Some of these were of a particularly serious character, but the Board did not feel that any action could be taken in that direction. Apart altogether from any professional delinquencies, however, his general illiteracy was so manifest that the members of the profession in Amherst were ashamed to have such a man associated with them, and the impression gained ground that evidently the Medical Board had in some way been imposed upon or surely Dyas would never have been admitted as a member of a learned profession. Copies of two documents of a somewhat public character, productions of Dyas, were submitted to the Board, which clearly established the illiteracy of their author. The question then arose how could such a man have succeeded in passing the examinations preliminary or professional at any reputable college. Surely personation or fraud must have been practised in some way, before the certificates which had been handed in by him were obtained. Copies of the documents above referred to were accordingly forwarded to Tufts College for the purpose of having them compared

with any examination papers purporting to be written by Dyas, which might have been preserved by the college. The astounding reply was to the effect, that in the first place Dyas had never passed the Tufts Matriculation Examination, but was evidently admitted on certificates of school standing in Nova Scotia; that after admission he attended two full sessions at Tufts, and in the capacity of a "special" student endeavouring to overtake back work, was there also for a third session; that during his stay there he had appeared and reappeared in all fifteen times for examination, but as a result had passed in only one subject. He then, in the words of the Secretary of Tufts College "left the school, evidently finding himself totally unequipped to study medicine with us, and finding that he never could succeed in taking the degree from the school." The Secretary of the Board thereupon called upon Dyas to hand in again the certificates by means of which he had secured his registration as already referred to, all of which were received back except the one relating to the Preliminary Examination, the absence of which was curiously accounted for by Dyas saying that it was in the possession of his brother, a medical student in the States. These certificates being forwarded to Tufts for inspection, were returned, each of the three relating to the examinations of the three sessions at that school being endorsed as fraudulent, by Dr. C. P. Thayer, the Secretary of the college at the time of Dyas' attendance there and whose signature they apparently bore. Accompanying this was a sworn declaration giving in detail Dyas' course from his entrance to his leaving the school.

Dr. Dyas was now notified of the fact that his certificates had been de-

clared fraudulent by the authorities of Tufts, and was summoned to appear before the Discipline Committee to make any statement or explanation he might wish prior to the Committee's report being made at the next meeting of the Board. The Committee met August 31st, 1906, and Dyas was present, attended by counsel. On behalf of his client, Mr. Mellish placed before the Committee a solemn declaration made by Dyas, in which he denied in toto each and every statement made in the affidavit from Tufts, reflecting on his course there, and reaffirmed that he had passed in every subject (except pathology) which he knew, as he declared, by the notices posted on the bulletin board shortly after each examination. A copy of the declaration being sent to the Secretary of Tufts, and the serious nature of the difficulty before the Committee being pointed out, Dr. Briggs, the present Secretary of Tufts, decided to come to Halifax and submit the records of the school to the Committee.

On October 21st, Dr. Briggs, accompanied by the Dean, Dr. Williams, appeared before the Committee and went carefully over the case and exhibited the records of the school which in every way substantiated what had been reported regarding Dyas. The Committee, after careful consideration of all the evidence, therefore concluded that Dr. Dyas had secured his registration by means of fraudulent certificates, and so reported to the Board, recommending in accordance with this finding and with the advice of counsel, "That the entry of the name and qualifications of Dr. Ira Everett Dyas be erased from the Medical Register of Nova Scotia, such registration having been fraudulently obtained, and he being in addition by such action guilty of in-

famous conduct in a professional respect." The report of the Committee was unanimously adopted at the Quarterly Meeting of the Board, January 17, 1907, and notice was given that at next quarterly meeting, April 18, 1907, a motion for such removal on these grounds would be made. Dr. Dyas was again informed of the intention of the Board, and notified to appear. At that meeting, Dyas was present, attended as before by Mr. Mellish, as counsel. It was contended that the records were not evidence, and that the original examiners must be produced and the personal evidence of Dr. Thayer must be taken, and further, that the Board had no jurisdiction in the matter. The Board, notwithstanding these assertions, after due deliberation, saw no reason for modifying the decision which had been come to, but at the same time thought it advisable to defer passing the resolution of erasure until after a special meeting had been called, at which the representatives of Tufts, including Dr. Thayer, should again appear with their records. A meeting was accordingly held July 17, 1907, at which Dr. Briggs and Dr. Thayer were present as requested. Dr. Dyas also appeared, supported by Mr. Mellish and Mr. A. MacKay, as counsel. Technical legal objections were again urged by Dyas' solicitors against the evidence submitted and as regards the jurisdiction of the Board, and as there was no legal authority present in their own interest, the Board adjourned, leaving the matter in the hands of the Discipline Committee to secure reassurance from their solicitor and report in the evening at the regular Annual Meeting. At that meeting the entire matter was carefully reviewed and as the

Board was fully satisfied that the registration of Dyas had been improperly obtained and that they had authority to cancel it, the motion for erasure was unanimously passed and immediately acted upon. The end, however, was not yet. From the first Dr. Dyas' cause had been espoused by persons from whom a different procedure would naturally be expected, and it soon became apparent that an attempt would be made at the ensuing session of the legislature to annul the Board's action. Special legislation was also expected with reference to another "case" which had been dealt with by the Board. To anticipate action with reference to such cases the Board at the suggestion of Dr. Dissett, one of its members, caused to be distributed throughout the province a circular, calling attention to the necessity of having their efforts towards maintaining an educated and fully qualified profession protected, or at least not interfered with by mistaken legislation. This circular, supplemented particularly by the vigorous support of the profession in Cumberland, prevented the passing of any specific personal legislation. A Bill, however, was passed ostensibly of a general nature, but really for the purpose of affording Dyas a possible chance of outwitting the Board. *Hinc illæ lachrymæ*, or at any rate, hence the appeal made by Dyas, to meet which, necessitated the attendance in Halifax for a third time of the representatives of Tufts College. The case came on for hearing on the 18th of September and extended over two days, Dyas being represented by Messrs. J. J. Ritchie and A. MacKay, and the Board by Mr. W. B. A. Ritchie and Mr. J. M.

Davison. The evidence of Drs. Briggs Thayer and Bates, of Tufts College, was taken, also the evidence of the Register of the Medical Board. The Records of the College, and the Minutes and Records of the Board relating to the case were also submitted, and Dyas himself was examined and cross-examined.

On the 28th the Judge heard the arguments of Counsel on the evidence submitted.

The great difficulty which presented itself all through the investigation from the very first was this, that the signatures to the Tufts certificates appeared so true, that not only were these certificates readily accepted as genuine by our Registrar, who was familiar with Dr. Thayer's handwriting, but even Dr. Thayer himself would at no time declare they were not his signatures. Of one thing, however, he had of course no doubt, namely, that he never made out any such papers in Dr. Dyas' behalf. The ground therefore taken by the Board was, that no matter how Dyas became possessed of the certificates, he was not entitled to them, and must have known this.

The following is the brief and concise decision of Mr. Justice Drysdale, after a patient hearing and careful consideration of the case:

"After hearing all the evidence submitted, I have come to the conclusion that the finding of the Board was a correct one and that the appeal herein ought to be dismissed. The

defendant's certificates used showed pass-marks over a period of three years in thirteen subjects, whereas the evidence satisfies me beyond reasonable doubt, that correct certificates from that institution should have shown failure in most of the subjects mentioned. As to the certificates used by Dyas, I have only to say in the words of the resolution, they were incorrect, and of this I am fully satisfied.

The authority of the Board to erase the name of Dyas was raised, and it was argued that the power of the Board under the Act, was limited to erasing his qualifications only, but on a careful examination of the Act, I conclude that the Board has the power after a proper enquiry, to erase any entry proved to the satisfaction of the Board to have been fraudulently or incorrectly made.

The decision of the Board will be confirmed."

Not only the Medical Board, but the profession generally, will appreciate the prompt attendance at much personal inconvenience and at the College's expense, of the official representatives of the Medical Faculty of Tufts College, both at meetings of the Board and at the final hearing of the case. The Board is also to be congratulated in that their verdict after a prolonged investigation extending into two years, has been sustained by one of such well known acumen and justice as his Lordship, Mr. Drysdale.



# THE SURGICAL RIGHTS OF THE PUBLIC.

By JOHN C. MUNRO, M.D.,

*Surgeon-in-Chief, Carney Hospital, Boston, Mass.*

(Read before meeting of the Canadian Medical Association, Ottawa, June, 1908.)

IN accepting the courteous invitation to address your Association to-day, I realize deeply the compliment that you bestow not only upon myself, but upon the great number of American surgeons that are your friends and neighbours. A political boundary divides your people from my people, but in our profession there is no dividing line, for the medical and surgical property of one people is, or ought to be, that of the other. The customs and the methods of education of the Canadian differ in minor details from those of my own countrymen, but there are grievances, slight wrongs, and evil tendencies that crop up equally in both our peoples, and it is to call your attention to and to enlist your sympathy in some of these that I venture to express the results of observation extending over a period of twenty years.

While listening some time ago to an interesting address by Prof. Muller, of Munich, on the German system of insurance of the labouring classes against sickness and death, I was impressed by the fact that the insurance was established not as a charity, but because the poor have the right to be protected against the various accidents and illnesses incident to our complex modern life. At that time it occurred to me that against unnecessary suffering, disease and death the public, both rich and poor, has an equal right to be protected by means other than that of insurance. In other words, if modern surgery can lengthen life,

can protect against malignancy, can nullify suffering better than can be accomplished by other therapeutic measures, the public has the right to know accurately when and to what extent this is possible.

It is not assumed for an instant that protection and alleviation in the case of many diseases cannot be obtained by means that are not surgical. We have merely to witness the results of vaccination, serum inoculation in diphtheria, and a host of similar remedies. As a matter of fact, it is interesting to note that the public has practically asserted its right to be protected against smallpox, diphtheria, malaria, yellow fever and other well-known diseases.

During the extraordinary surgical advances that have been made in the last decade our profession has been so busily engrossed in grasping the new developments that come crowding one upon another that it has rather lost sight of the poor public and its right to a share in the general progress. We have been inclined to let the people discover for themselves the immense amount of time, money and suffering that can be saved to them, and yet we are in the position of placing before them a host of well-established facts on which we base our advice as regards surgical treatment. More and more have surgery and medicine grown to be scientific and accurate. To a greater extent can surgeons promise definite results. The changes in technique and operative principles that are constantly taking place lead

steadily to better results because they tend ever to greater simplicity.

Is it not a good time to stop and view ourselves from the standpoint of the lay public—a public that in the main is intelligent, progressive and full of common sense?

However much we may deplore the fact that surgery is necessary, that it may be an opprobrium—which I doubt very much—we must be willing to admit that, given ideal conditions, enormous temporary and permanent benefit can in numerous instances be vouchsafed by operations, and by operations alone. Surgery has its own field. It readily yields to other and simpler therapeutic measures when satisfied that it itself is without avail. At the same time it is keenly alert to invade the vast field of internal medicine when the latter fails to accomplish the ideal; ready to retire at once if some new discovery demonstrates that disease can be conquered by means other than surgical. What surgeon is there who would not gladly throw down the knife if a serum or any simple remedy were discovered that would definitely cure malignant disease? Some such remedy is bound to come in the course of time; slowly, it may be, but none the less surely. In the meantime innumerable types of disease are safely and happily treated by the mechanics of surgery, and it ill becomes us as surgeons to belittle the aid that we can give, for the mere reason that at some future time surgery may become obsolete.

Every year I am told we have attained the highest limit in technique. This is far from the truth, because hardly a week passes without a surgeon somewhere in the world de-

monstrating a discovery or reviving some long-forgotten fact that reduces mortality, shortens convalescence, or aids in the restoration of normal functions.

It should be made clear at the outset that the public must expect of surgeons not absolute efficiency, but a reasonable degree of it. Such a degree can be acquired by any surgeon who has aptitude, a love for constant self-improvement, and a readiness to make sacrifices to his ideals. Of this type there are many in your country as well as mine. The masters of surgery, on the other hand, are few in number. It is to them that we of the rank and file must look for the instruction and inspiration which should constitute a large and by no means unimportant part of their work. It is only a relatively small proportion of the people that can have the direct benefit of their skill. To their teachings the medical as well as the surgical practitioner must listen, and in the light of the accomplishments of the advanced surgical clinics of the world it is not an exaggeration to assert that diagnoses, especially of abdominal and cerebral diseases, are more accurately made by the surgeon or by his medical *confrère* who follows his own cases to the operating table than by the internist who limits his observations to laboratory, personal and post-mortem examinations. The failure of the public to realize this fact accounts in great measure for the many sometime curable diseases that are brought to the surgeon after they have reached the incurable stage. The co-operation of the internist and the surgeon in all cases potentially surgical is something that can be demanded consistently by the people. Each one is a healthy check on the

other; their combined judgement is safest for the patient.

With the emergency operations and the problems suddenly forced upon the doctor far from surgical centres this paper has nothing to do. Every surgeon admires and respects the men who meet the difficult problems of this kind, alone, ingeniously and fearlessly. The history of medicine is full of heroes of this class, and no one has greater appreciation of their work than the active surgeon in the large city.

I would deal here rather with the question of elective major surgery as attempted in our large and small surgical centres by men without surgical skill or training, by amateurs, and by the nondescript commercial type of doctor that operates for the fee and not for the benefit of the patient.

The internist and the family doctor, assuming that he is a general practitioner, cannot keep pace with the constant advance made along surgical lines. It is physically impossible for him to keep in touch with the best surgical literature and progress. If, therefore, a patient comes for advice concerning a disease that theoretically or practically can be classed as surgical, the patient has a right to the opinion of a practical surgeon for or against intervention. This applies not only to the commoner diseases, like gall-stones, appendicitis, cancer, etc., but to the less common borderline diseases in which both medical and surgical treatment is of value. The internist, prejudiced at the start against surgery or slow to follow the best advances in the world's clinics, may presume to decide a question that is or ought to be purely surgical. Such a decision may be as much beyond

his province as it would be were a surgeon to attempt to decide as to the nature of an anæmia without a blood examination. This breach of faith with the public—for it can hardly be called anything else—is in my experience one of the most common factors that leads eventually to incomplete operative success. The public, slow to grasp the full significance of such conditions, is, nevertheless, gradually awakening to its rights in this respect.

The remedy is simple. No doctor need be so narrow or prejudiced that he cannot seek counsel in doubtful cases. To ask for surgical advice does not imply any necessity for accepting its verdict. That lies with the patient. Let him be given the facts according to the best modern lights, and the decision will rest with him whether to accept an operative risk or not.

Worse than this is the hesitation, narrowness or ignorance—call it what you will—that allows the internist to deal with a surgical lesion until forced to advise surgery, not as a preventive or as a curative measure, but as a last resort. Every experienced surgeon will agree with me that with all his so-called boldness in operating he has never had the courage to assume the responsibilities endangering the lives of his patients that the indifferent or ignorant practitioner assumes at times in advising against surgical intervention or in withholding operative relief. The surgeon with his knife in the presence of appendicitis, gall-stones, cancer of the stomach or intestines, empyema and a host of similar diseases is the embodiment of conservatism when compared with the practitioner who elects to treat such diseases medically.

After a patient has decided upon operative treatment he has the right to demand, first of all, asepsis, proper anæsthesia and intelligent after-care. He should realize, however, that, although absolute asepsis is the ideal to which all surgeons aspire, practical asepsis alone can be guaranteed in the light of our knowledge at the present time. We should teach the public that the highest degree of asepsis is best attained by a permanent corps of surgical workers trained under responsible heads; that a properly equipped hospital with such trained assistants entails less risk to the patient than the haphazard equipment of the private house or the irresponsible regime of many of the private hospitals which are open indiscriminately to operators, each with his own methods of operative technique.

I think it can be safely said, indeed, that a morning's work at a private hospital, with its multifarious and changing authorities, is rarely carried through without many lapses in asepsis, for the most part harmless, but occasionally calamitous in result.

Breaks in asepsis are the result of some sin of omission or commission on the part of the operating staff, including the surgeon, his assistants and operation nurses. Too often is the blame for septic calamities ascribed to the sponges, the suture material or the dressings. That any one of these may be at fault is possible, but in the well-conducted operating room proper examinations and control of the material should prevent such accidents save in very rare instances. Too many times have I seen a sterile catgut blamed for the result of a slovenly, dirty surgeon or assistant. So long as surgery is an

art and not a mechanical trade, lapses in asepsis are occasionally bound to occur, even in the best clinics, in spite of all reasonable precautions. The important point for the surgeon, and for the public as well, is to recognize and make use of the means best fitted to reduce these chances to a minimum. We must all recognize that there is some risk attending any and every operation; a risk that often is so small that it may be practically disregarded.

Under the immeasurably diverse conditions of heritage, environment and physical and mental defects, it is out of the question to allow for every possible accident, and this fact the patient as well as the surgeon must recognize where an operation is undertaken. Provided the surgeon uses precautions that are reasonable in the light of modern scientific knowledge, he can be assured that he has done all that should be expected of him. The patient, on his side, must be willing to take certain chances provided the result sought by operation is going to lessen the sufferings and dangers that are inherent in the existing lesion or disease.

The public should realize that the dangers, immediate and remote, from anæsthesia are very small. Such dangers do exist, however, and it is the surgeon's duty to minimize them in every possible way. A skilled anæsthetist, preferably a permanent member of the surgical corps, will cause far less damage than the student or the friendly family practitioner who etherizes occasionally, and who is more interested in the operation than in giving the anæsthetic. In my own experience the worst and most dangerous etherizers are the unskilled pupil house officers.



To the credit of certain individuals of this class, however, it must be said that after a month's training some of them develop into first-class anæsthetists, generally at about the time they are ready to graduate to a higher grade. These show their ability early and exhibit, as it were, an in-born talent in this line; others never learn to be satisfactory etherizers, no matter what or how long their experience.

Another class that rivals the student in dangerous etherizing is the graduate with long experience in general practice. He rarely gives ether safely or in a way that aids the operator. His experience has been won mainly at the bedside of the lying in patient, and in anæsthetizing a patient for a major surgical operation he applies methods similar to those which he uses in his obstetrical work.

An unskilled etherizer will make certain of the difficult operations impossible; he will prolong beyond safety an operation that should be short, and he will increase in any case the chances of a post-operative pneumonia. These acts are not generally known by the laity, but that does not warrant neglect on the surgeon's part in this particular. The public has just as much right to demand a skilled anæsthetist as to demand a skilled surgeon.

Much the same could be said of the unskilled assistant, the ever-changing house surgeon, and the general practitioner who assists in major operations at rare intervals. It is difficult for the latter to realize the essential points in aseptic technique; not being accustomed to the ways of the surgeon, he modestly hesitates to give what assistance he would like to give, and often, being

ignorant of the consecutive steps of an operation, he delays and hampers the surgeon to a degree that he little realizes. I believe that every surgeon who has had much experience in this line will confess that in not a few cases he has been obliged to substitute a partial or a less difficult operation because he was unwilling to expose his patient to the added risks that would come with the unskilled helper.

As soon as the public appreciates that the after-care of major surgical cases, especially of those in which the abdomen has been opened, is just as important as the operation itself, it will insist that the immediate convalescence be guided by the surgeon himself or his capable assistant. To operate from choice in a serious case far away in the country, placing the responsibility of the after-care upon the family doctor, who at the same time is in charge of patients with all types of disease, is unjust to the doctor and to the patient and it leaves a loophole for divided responsibility in case of calamity.

No surgeon can safely outline the treatment of any abdominal case if he allows for the innumerable contingencies that he knows to be possible. If every patient passed through the stage of convalescence in a routine way the problem would be easy, but, as a matter of fact, such is far from the truth.

Another demand that the public can and should insist upon with the surgeon that is attached to a public hospital is that any and every major operation, especially if it involves the abdomen, should be performed by the surgeon himself or under his direct supervision. He is appointed to the hospital staff presumably for his special surgical fitness. His posi-

tion presupposes long training in anatomy, pathology and assistance at surgical operations. The public seek the services of a hospital because of the skill of its staff, and it has the right to demand that the full responsibility of all major operations should be taken directly by the staff. In order to attract students, to become popular, or to shirk labour, the surgeons of many hospitals delegate more or less operative work to immature and irresponsible house pupils; because of this the public suffers. Many times have I seen a young, inexperienced house surgeon struggling with some difficult problem at the operative table, a problem that has arisen suddenly and unexpectedly, and I have wondered if the complacent surgeon who has deserted his post would be willing to subject one of his own family to this amateur surgery. Much in the way of minor surgery can be properly delegated to one's assistants, but to place the responsibility that attends major operations upon a young surgeon with the experience of a few months is fundamentally wrong, while occasionally it is criminal.

Granting the fact that a hospital staff is or should be selected because of its capacity, both collectively and individually, it behooves those of us who are responsible for the selection of our co-workers to be both catholic and discriminating in our choosings. We must acknowledge that it is through the work and enthusiasm of the individual that surgical progress is maintained, and if we are to exact the respect of the public for our hospitals each individual member of the staff must in some one or more respects live up to the highest surgical standard, while at the same time his general qualifications are those of the

broad general surgeon. This significance of the individual was aptly expressed as follows at a dinner recently given to Cardinal Logue: "The potency of the individual is greater and nobler than the influence of class, or organization, or even institution." To no type of man does this apply better than to the surgeon of our large hospital. How frequently do we see the progress and advancement of the entire institution dependent on the activity, breadth and scientific enthusiasm of a few, often against or in spite of the narrow opposition of the many.

To some extent the criticism as regards the house pupil pertains to the amateur surgeon who operates now and then for the excitement or for the fee, without pretending to be reasonably skilled in technique or reasonably posted in surgical progress. The smaller hospitals that are luxuriantly cropping up throughout the country are in this respect not only capable of doing much harm, but they are actually guilty thereof. The large and promiscuous staffs in control of these hospitals always include a few ambitious men eager to attempt surgery beyond their ability. The term of service of the staff constantly shifting, allows but a limited experience to any one member, and divides the interest and responsibility of the staff as a whole. It would be far better, as I pointed out some years ago, if such a hospital should select two of its younger members to train themselves for the necessary surgical work by acquiring thorough anatomical, pathological and technical foundations, and should compel them to keep in line with modern surgical advance year in and year out. Two well-trained men of this sort should be able to take proper

care of the surgery of a large district, and take care of it well, whereas at present much of the work is badly done by innumerable half-trained general practitioners, who, while doing the best that they can, are not giving the public what it has the right to demand.

This would also do away to a great extent with the present system of calling upon the consulting surgeon from the large centres, who only too often operates hurriedly and on insufficient examination and knowledge of the patient, because he relies upon the data furnished by the family physician. In other words, too many major operations are done under these circumstances without satisfactory study of the patient and his disease, and the after-care is delegated to practitioners without the surgical training and experience that the public can justly demand. This system trains the consulting surgeon into hasty and snap diagnosis and he necessarily gambles now and then on the chances that he can pull out of a difficult situation if he happens to be caught. But what of the patient under these circumstances? He rarely loses his life, to be sure, but I believe that any experienced surgeon will agree with me that at times an operation is not complete or satisfactory, or that a secondary operation is required later, because of the insufficient data, the inadequate assistance, or the imperfect operating-room equipment.

That the small hospital is invaluable to the town in which it is situated no one can deny, but, under the conditions under which most of these hospitals are conducted at the present time, that such an institution should undertake, except in case of necessity, the serious surgical problems, I

believe to be ill-judged at least. It is only a question of time before surgeons will demand that no doctor assume the responsibilities of major surgery without required special courses of training and apprenticeship. If surgeons do not demand it the public will.

Furthermore, a patient who supports himself and his family by his daily wage should insist that he be kept in the hospital for as short a time as possible consistent with good surgery. He should not be allowed to lie around the ward waiting for the surgeon, engrossed in outside affairs or indifferent to his responsibilities, to make up his mind to operate. Neither should he be kept for an undue length of time for the purpose of teaching students. In the large clinics a decision for or against operation can be made within forty-eight hours in most cases. The necessity imposed upon the surgeon of earning his living away from his charity clinic is responsible for much of this form of neglect, and the blame, therefore, really rests on the public itself, badly educated in such matters and encouraged by an indifferent profession.

Could our hospital trustees but see the wisdom of encouraging the surgeon to earn his living in the same building in which he devotes so much time to the pauper sick, both classes of patients would be benefited. This fact is so obvious to anyone who has carefully considered the subject that it is unnecessary to enlarge upon it here.

The public has certain rights in the question of surgical fees. The surgeon has equal rights, but he seldom obtains them. To take up the abuse of medical charity would lead me too far from my subject; that

such an abuse exists, especially in the eastern part of the States, is too flagrantly evident to need any confirmation here. To some extent the existence of this abuse is responsible for the overcharges to which surgeons are occasionally driven. All patients except paupers and some wage-earners should be compelled to pay a fee for medical and surgical care commensurate with their earning capacity, just as they are obliged to pay for their provisions, their luxuries or their dissipations. The wealthy should pay liberally for major operations; they should not be robbed. The self-respecting wage-earner, whether on daily wages, a salary or in independent business should not be treated as a pauper. He should be compelled to pay some fee in proportion to his earnings, the number dependent on his income, etc. The public has abused over and over again the medical charity that flourishes to such a degree in our large cities. May it not be because of this abuse that the struggling surgeon is guilty at times of squeezing all that he can from his wealthy client? Our practices need reforming without doubt, but the abuse in this respect is infinitely less than that practised by the public which is competent to pay.

That surgeons divide fees with the family doctor bringing them surgical cases is a well-recognized evil. Fortunately it exists to a much smaller extent in the East than in the West. That it is fundamentally wrong and pernicious goes without saying. It is based on commercialism alone. As soon as the public realizes that it is deliberately sold by its family doctor—in whom it has full confidence—to the surgeon that allows the largest graft, and that it is not sent to the surgeon best equipped for taking

charge of the case, the public itself will stop the practice at once and emphatically. It seems inconsistent with American character that a patient should be bartered voluntarily.

To enter upon the relation of animal experimentation as applied to the development of surgery is very tempting. Its bearing on the principles of surgery and on surgical technique is of tremendous import, so far as the great mass of the people is concerned. The latter has learned to trust in the unselfish honesty of the medical profession, and the responsibility is far more serious than the anti-vivisectionists can realize if humane surgical advance is checked by the indiscriminating and narrow bigotry of ignorant partisans. I believe that if a deliberate and thoughtful expression of views of the practical surgeons of the world were taken to-day an overwhelming majority would gratefully acknowledge its obligations to animal experimentation, as instanced in the daily relief of suffering and prevention of disease. It is almost pathetically comical that we should be confronted time and again by the ignorant and probably thoughtless views of two defunct and famous surgeons upon this subject. Both men lived at the very dawn of modern scientific surgery; neither was young enough to grasp the significance of the new surgical discoveries while each one had been a too-dominating power in certain narrow lines of surgical advance to be willing to accept the broader teachings of others. One directed his genius to mechanical problems; the other demonstrated advancement by means of human experimentation, all of which had to be worked out at a later period by laborious scientific research. The thoughtless and pos-

sibly hasty views of these men have been hurled at the thousands of modern surgeons by the opponents of animal experimentation, but I am confident that if Bigelow and Tait were alive to-day their dominating geniuses and grasp of the truth would enrol them as most enthusiastic and powerful allies in the struggle against the anti-vivisectionists. The layman, as a potential surgical patient, is more keenly interested in this controversy than he realizes. When the surgical thunderbolt strikes him or his family he wants and demands as his right the use of every nicety that will diminish risk and lead to recovery. I know, and you know as practical surgeons, that we daily use the results of laboratory research, and that if we were deprived of all that has been handed down to us as a result of animal experimentation our surgery would lapse back to a degree frightful to contemplate. This is the side that the layman must seriously consider when he is urged to oppose the profession that has always worked and struggled on behalf of suffering mankind, and that will fight for the principle of animal experimentation because it knows it is just, humane and merciful.

There is one more protest that may be made in behalf of the public. We hear much loose talk about the direful nervous shock that follows operation, and the public is well trained to expect a long and tedious convalescence on that score. With certain ill-balanced, badly-trained people this may be the case, especially if the patients are cared for by over-fussy or unscrupulous physicians, but as a general rule in my experience the post-operative effects are grossly exaggerated. Most patients can be trained out of such calamities as easily as

they can be trained into them. With all the traumatic neuroses that have cropped up since suits for personal damages have been so frequent, it is incumbent on our profession to avoid augmenting this class of patients by ill-timed and ill-judged encouragement. In my own experience the patients that suffer most from post-operative neuroses are those that were allowed to become septic by culpable delay in submitting to operation. The bad result can be traced to the sepsis and not to the operation. The contrast is so marked in what might be termed control operations in non-septic cases that one who has observed it readily recognizes the difference. When we consider that a generation ago most operations and accidents were serious because of the septic complications, it is not difficult to understand why the laity at the present time has such a dread of anything associated with surgery. It can be stated conservatively that the lay public is about a generation behind in its realization of the advances accomplished in the science and art of surgery. I believe that I am not unduly severe if I accuse our medical brethren of being about five years behind.

Criticism and censure of existing conditions is not a difficult task. Of one, however, who condemns so freely you have the right to demand some suggestions for reform or reconstruction. In a short general address like this I can enter upon this phase only to a superficial extent.

Fundamentally the great and important factor in remedying many of the evils to which I have called attention is a higher uniform standard of general and medical education. This in the States is being pushed forward most ably and energetically

by the Council on Medical Education of the American Medical Association, and we all owe our most loyal fealty to its endeavours. In addition to this general groundwork, I believe that so far as the making of surgeons is concerned, who shall be entitled to stand before the public as capable of dealing with the larger problems of surgery, much can be done even at the present time in the way of special training and special licensing. With regard to the latter, it may be best to adopt some form of approval by a recognized examining board somewhat similar to that which obtains in England. Thus, a candidate for the position of surgeonship in a responsible hospital or in a rural community would be obliged to prove his fitness for the work, his knowledge of anatomy, pathology and the science and technique of surgery.

A reform in the construction of our hospital staffs I believe to be equally important. Some such system as that in vogue in Germany should be adopted by our hospitals in the larger cities where there is opportunity for teaching. As constituted at present many of our public hospitals are overweighted by cumbersome surgical staffs that could be easily reduced a third or a sixth of their present number. A chief of staff should be placed in full control of fifty to one hundred beds. If in charge of a larger number his assistants or colleagues should be as capable of assuming full control as the chief himself. The latter should be allowed very great power in the selection of his assistants from among those who have demonstrated their fitness and ability while in subordinate positions. Thus permanent or temporary vacancies would be properly filled, and responsible positions in distant

hospitals would be open as prizes to tried, capable candidates. This would do away with the present system of graded rank, which, however efficient it may be in the army or in the commercial world, is poorly adapted to the profession of surgery and to surgical hospitals. Because a surgeon has performed his work regularly and perfunctorily while in a subordinate position, without advancing himself or his art, is no reason why he should be elevated to the head of a division when a vacancy occurs. As a result of this misapplication of civil service rules one such chief of service can and will block the progress of his division in a way little realized by the general public, or even by the practising physician. Let every man aspiring to become a chief of staff make good; do not hand him a gift with so great responsibilities just because he happens to be older than his colleagues. Have we not all seen certain surgeons, originally appointed by political favour, nearly paralyze the active service of a large hospital when placed in a position of responsibility? Has such a man the right to trade on his assumed ability at the expense of a public which cannot easily comprehend the exact state of affairs?

The same principle which applies to the visiting staff of a hospital applies to the student assistants. As I have indicated elsewhere, uniformity and permanency in the operating and ward staff is of the utmost importance in obtaining uniform and satisfactory surgical results. The routine, inexperienced work in the wards, the laboratory and the operating rooms should be done by students, delegated by the schools and accepted without competitive examinations, because such work

should be a part of the student's curriculum. For more responsible positions the selection should be by a process of elimination, dependent on the demonstrated ability and aptitude of the student assistants. The highest positions should be allotted for a term of years to selected candidates who are planning to enter upon a surgical career. These should be salaried, and they should be encouraged or compelled to undertake original work. When at last these men are graduated from their assistantships they will be in a position to offer themselves as candidates for junior positions on the staff, or they may emigrate to other cities or towns, where they will be entitled to undertake the surgery of their district, building up a surgical nucleus that is capable of developing indefinitely, varying only with the ability of the individual surgeon.

To elaborate this scheme is unnecessary. It is essentially that which exists in Germany. When we consider the splendid surgery that the Americans have shown themselves capable of developing in the face of our clumsy and restraining systems, one grows enthusiastic at the possibilities that lie before us, provided we could develop the art along better, safer and more liberal lines.

In dealing with the private hospital problem I can easily be misinterpreted, but I believe that much can be accomplished by which the public will be dealt with more fairly. It seems only right that the well-to-do patient should be treated as carefully and as efficiently as the pauper, but such is far from the fact in some of our large centres. Many of our private hospitals are run as money-making schemes. It is a great tempta-

tion to keep a patient in the hospital longer than necessary. It is easy to encourage the neurasthenic to waste weeks in an institution when we know that he or she would be far better off in the woods or at work. Without responsible residents in these hospitals emergencies endangering the life of the patient arise occasionally that cannot be dealt with properly. The same holds true, as I remarked earlier, with regard to the operating room equipment. If we are to have private hospitals the administration can and should be brought as near to that which exists in our best public hospitals as is possible, and until that is attained we are not dealing quite squarely with our patients, from whom we derive our incomes.

To kill the growing tendency towards a division of fees, it is necessary to keep the public informed as to the facts. Whether this should be done through our local or our national societies is not yet clear, but I believe that it is best undertaken by the larger body of men. A curious and annoying type of graft that is not infrequently worked upon the surgeon is that in which the family physician, who presumably knows the financial status of his patient, makes one price for operation to the patient and another (much smaller) price to the surgeon. To expose this it is necessary that the surgeon have his business dealings directly with the patient, thereby losing, of course, all future work that might otherwise come to him from the family doctor whom he has exposed. The public has a right to know how much it pays for surgical care and to whom the amount is paid. The moment we begin to juggle with it in this respect we lose the right to pose as a

profession the first object of which is not to make money.

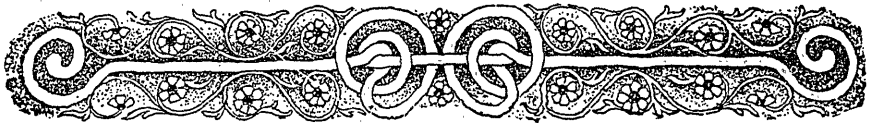
In conclusion, I would not have you infer that there is no other side to surgery than that of criticism and fault-finding. No profession is without flaws. Every profession reaches a higher plane each decade, and it is main'y by the elimination of the petty obstacles that our profession is destined to attain a level that can never be reached by others.

As a matter of fact, the public can feel that, taking American surgery as a whole, both that done by the masters and that done by the rank and file scattered over the length and breadth of this continent, there is no surgery in the world more intelligent, more skilful, and more considerate of the rights and feelings of the patient. The rate of advance is almost phenomenal. We in the States are wont to boast of our commercial progress, which is apparent to everybody. Few beyond those working in hospitals, laboratories and medical libraries realize that the

advance in our profession is parallel with that in our commerce. The advance in the one, however, is for the most part financial and scientific, as applied to finance, while the advance in the other is scientific, humane, educational and life-saving.

A significant quality that belongs to our profession is the generosity of the surgeons of one locality towards those of another in freely giving and receiving the good things that spring up in our art. It is a most refreshing sign of broad culture, and it does much to destroy the petty jealousies that are a heritage of past generations.

More and more do we see the internist and the surgeon working side by side; more and more do they appeal to the authority of the laboratory, and, finally, with all the petty bickerings and inconsistencies that are to some extent inevitable in all professions, any one of us when his name is called in the ranks of the American surgeon should be proud to answer "adsum"





# PRESIDENTIAL ADDRESS.

By JOHN STEWART, M.B., (Edin.)

(Read before the Annual Meeting of the Nova Scotia Medical Association, July 2nd, 1908.)

**M**R. PRESIDENT AND GENTLEMEN,  
To you sir, as President of the Maritime Medical Association, and to those members who do not practise in Nova Scotia, I feel that some apology may be due in regard to the subject of my address, but as I shall have occasion to refer to the sister provinces, and as medical legislation is a question of importance to all, I trust you will pardon the following observations on the Provincia' Medical Board of Nova Scotia.

Three years ago the Medical Society of Nova Scotia did me the honour of reëlecting me to a seat on the Provincial Medical Board, and two years ago when the able and accomplished President of the Board, Dr. Tobin, left for Europe, my colleagues elected me to the vacant chair. As President of the Board I have been gradually acquiring some knowledge of its work, and of the mutual relations of the Board and the Profession, and now, at the expiration of my three years of service I have ventured to make the Board and its work the subject of my address.

It has sometimes appeared to me that members of our profession, to say nothing of the laity who may happen to be interested in the regulation of medical practice, regard the Board as now a useless, now a meddling body; if we borrow the figure of the old fable, playing the part now of King Log, now of King Stork. The medica' student, or he who is just entering the profession, is apt to regard the Board as a tyrannical or arbitrary guard of the en-

trance gates, while those who have been fortunate enough to enter, cry out upon us as slothful servants, winking drowsily at practices which should not be allowed.

I wish first to draw attention to the constitution of the Board, and to compare it with similar bodies in the other provinces.

The Provincial Medical Board of Nova Scotia consists of thirteen members, seven nominated by the Government, (Governor in Council) and six by the Profession. The members appointed by the Government are permanent, or at least hold office during good behaviour. Those appointed by the Society are elected once in three years. In New Brunswick the Board consists of nine members, four appointed by Government every four years, five by the Profession every three years. In Prince Edward Island the Medical Society constitutes the corporate profession, and the Council, corresponding to our Provincial Medical Board, consists of seven members, all elected by the Society. In Quebec and in Ontario and British Columbia, the whole profession constitutes the College of Physicians and Surgeons.

In Quebec our Provincial Medical Board is represented by a "Board of Governors" or Council, elected every three years. There are forty members, fifteen from Quebec, nineteen from Montreal, three from Three Rivers, and three from St. Francis.

In Ontario the "Council" of the College of Physicians and Surgeons is elected thus: one by each University or College, seventeen territorial

(by the profession in general), and five are elected by licensed homeopaths. A similar arrangement holds in Manitoba. In British Columbia, the profession elects a Council of seven once in three years.

(In Newfoundland the Council consists of seven, all elected by the Profession and for life).

As regards Canada then, it is only in New Brunswick and Nova Scotia that the Profession is not competent to manage its own affairs, but while in New Brunswick the majority of the Board is elected by the Profession, here in Nova Scotia the majority is appointed by the Government.

If we inquire for the advantages we derive from this association with the Government, we may find difficulty in finding a satisfactory answer. Constituted as the Board is it may almost be considered a part of the public service, and from one point of view it would be very desirable that the Government, representing the public, rather than the members of the Profession, should take the initiative in framing and carrying out laws to regulate the practice of medicine. We may say that the presence on the Board of Government nominees, presumably men of the highest standing in the Profession, and holding office permanently, gives a dignity and a value to the deliberations of the Board which might not attach to the proceedings of a purely elective body. In the Medical Council of Great Britain five members in a total of thirty-four are appointed by the Privy Council, and these are men of the highest standing. There is also this advantage in having some members of the Board permanent, that there are always men present well acquainted with the business and methods of the Board. With a purely elec-

tive body, appointed once in three years it is possible that a new Board might contain not a single member acquainted with the routine and work of the Board. We might almost look on the members appointed by the Government as analogous to a second chamber.

But the proportion of the Board named by the Government in New Brunswick and Nova Scotia seems unduly great. It is the fact that the Government has unlimited power over the Board, for according to one of the clauses, the Government has power to remove any member of the Board. If we suppose the contingency of special legislation, in which the Government and the Profession were opposed, it is quite conceivable that we should be powerless. And to show you that I am not conjuring up a chimæra, I may tell you that by special legislation a few years ago, we were compelled to place upon the Register the name of a practitioner who was unable to come up to the registrable requirements of the Board. And during the last session we have good reason for knowing that another attempt was to be made to secure the readmission to the Register of a name erased by order of the Board, and we believe it was due only to the action of the Profession and of the County Society more immediately concerned, and the vigorous and resolute attitude of those members of the Profession who sit in the House that the attempt fell through.

As regards any financial assistance from the Government there is none, not in Nova Scotia at all events. The Board has to purchase its own books and stationary, pay postage on all communications, and provide its own safe for storing documents.

It seems to me that the Constitution of the Board is worth some con-

sideration. And let me also say that I think we should take a deep interest in our part of it, the election of our representatives. Too frequently this has been done in a hasty way. Careful consideration should be given to our choice. It is a graceful honour to a colleague to name him for the Board, but the general welfare of the Profession should be considered and only men who may be relied on to take an interest in the work of the Board, men so far as possible, of known business capacity, men of judicial mind, men whose opinion is likely to have weight with their fellows and with the public, should be elected.

Let us now turn to the duties of the Board. It is scarcely necessary to say in such a gathering as this that the main object of the Board is the true interest of the public. We are but human: it is perhaps impossible to separate our own interests from that of others, and some of the functions of Medical Boards and Councils are related to our own protection. But any one who is acquainted with the work of such bodies must realise that these duties are by the way, and that indeed, whether we do it consciously or not, we make the public weal our aim.

We cannot, perhaps, expect the public to think so. To them we are a trades union. The keynote to the aim of Medical Legislation is to be found in the preamble to the Medical Act of Great Britain, introduced in 1858. "Whereas it is expedient that Persons requiring Medical Aid should be enabled to distinguish qualified from unqualified Practitioners."

But it may interest you to know that we had a Medical Act in Nova Scotia thirty years before.

Our Registrar, Dr. Lindsay, prepared a very interesting report on the Medical Legislation of the Province in 1897, in which he shows that the first Medical Act in Nova Scotia was passed on May 29, 1828, and was entitled "An Act to exclude ignorant and unskilled persons from the practice of Physic and Surgery."

The object of these Acts, often wrung from Governments with great difficulty, has, as Dr. MacAlister, the very able President of the Medical Council truly says, been "not to put down quackery or even to advance medical science. The object in view was simply the interest of the public."

We all know the cheap and easy sneers at our expense. The sneers and threadbare jokes will continue. Human nature is the same in all ages, and there is something indefinable and ungenerous in the human spirit which makes it strangely resentful of benefactions. But we, who know better, must be charitable, and charity suffereth long.

Any conservation of our own interests must be incidental and secondary to the more noble aim of succouring humanity.

Among the duties devolving on the Provincial Medical Board are the regulation of examinations, examining degrees and diplomas and keeping the Register. It is the Board that admits to a place on the Register, and the Board has the power to erase a name from the Register.

As I have said the object of keeping a Register is to guard the public from being imposed upon by unqualified persons. And the object of examinations is to test those who aspire to practice and to sift out those judged unfit. A corollary to this is that those who pass the Board are judged fit to be entrusted with the medical care of the public. And the

more stringent the examination the more capable the successful candidate. Then why should there be, as there often is, a complaint of the Board's firmness in carrying out the law as to examination and admission to the Register.

Another duty of the Board is the regulation of professional conduct. There is no profession from which a higher ethical standard is required than ours. There is no more favourite gibe levelled at us than the hackneyed phrases about medical etiquette. There is nothing in the etiquette that binds us but the Golden Rule, to do to others as we would be done by, to put ourselves in the other man's place.

No amount of legislation can implant the instincts of a gentleman in the soul of a money-grub, and alas! too often the cause of offence can be assigned as undue love of money or selfish advantage.

But in duty to ourselves and to the public, we should have some authority competent to deal at least with prominent offenders. There are certain well recognised offences against the Code of Ethics, and the tribunal to decide on these, the tribunal to carry into effect the judgment of the general conscience of the Profession is the Medical Board.

Some who hear me may have appeared to the Board and have been disappointed. Bear with me when I say that when a complaint is lodged with us we deem it our duty to investigate, and that we generally find there are two sides to the question, and when "doctors disagree" who indeed shall decide?

I may instance a case in which a medical man of the highest standing complained to us that a neighbouring practitioner was employing an unregistered man. On enquiry the

accused vehemently denied the charge, and more than that, the parties who furnished sworn testimony to the truth of the accusation promptly forwarded sworn testimony in rebuttal!

There is another function of the Board, and it has sometimes appeared to me that the profession regards it as its main function, and that is the prosecution of quacks. Now this duty, in which, perhaps, we come more directly to the help of the public, is that in which we incur most opposition. As long as we wrangle among ourselves the public looks on in amused contempt, but let us lay a finger on the adorable quack, 'et us endeavour to limit the sale of the unlimited nostrums that deplete the pockets of trustful ignorance, and we draw down on ourselves the unlimited wrath of the Sovereign People.

An account of the dealings of your Board with quacks would furnish painful, if amusing reading. We are rarely successful in securing conviction, and if we succeed in this, we almost always have to pay the costs. It is almost impossible to get a jury to convict a quack.

The whole question opens up a wide vista. It is, I suppose the same in substance as the evergreen debate of Free Trade and Protection.

A man may say, away with all restrictions, let the man's work tell: let every one be a rule unto himself as to methods of healing, rules of practice, standard of fees. But does any one seriously think that free license, for it is not liberty, in the practice of medicine would be best for either public or doctor?

It has sometimes appeared to me and to my colleagues, that some of our brethren regard the Board as a wondrous prodigy, with eyes before and behind, and octopus tentacles

which reach into every nook and corner of the Province. An indignant letter arrives expressing surprise that proceedings have not been taken against such and such an irregular practitioner. It may be the first notice the Board has had of its existence. And the information given is often too meagre to be of any service to the Board.

According to Section 35, chapter 103 of the Revised Statutes, 1900, "The person laying before the Registrar a charge under this section must submit to the Registrar in writing the following information:

(a) The full name and the place of residence of the person charged, with his occupation, if any, other than his so practising;

(b) The precise date or dates of the acts constituting practising, professing to practise, advertising, etc., the pretending to be a physician, doctor of medicine, surgeon or general practitioner; also the place where the acts of practice, etc., were done;

(c) The name or names of the patients visited or advised professionally by the person charged, with the addresses of such patients and persons;

(d) The character of the disease or ailment treated or dealt with, and all particulars of the treatment or advice given;

(e) The name and address of any druggist who may have filled prescriptions or sold medicines to the person charged;

(f) The names of any other persons who know what services were rendered by the person charged to the patient or patients and who could, on being summoned as witnesses, prove what passed between the person charged and the patient or person professedly advised or treated;

(g) Copies of any newspapers containing advertisements of the accused; copies of any card, poster or local advertisement used by such person where practising;

(h) Any other facts in detail which would be helpful in establishing in the charge.

Detailed information of this kind should not be difficult to secure, but it is never furnished to the Registrar. And here I wish to express the high appreciation which the Board entertains of the way in which the Registrar and Secretary, Dr. Lindsay, does his work. His long acquaintance with the duties of the office has made him familiar with every detail; he is most careful and precise; documents and papers extending over a period of many years are available at a few moments notice, and I will venture to say that no man is better posted in the laws regulating medical practice in this province, in the Dominion at large, and in the United Kingdom.

We owe much to General Laurie in securing the amendment of the Medical Act in Britain, but it is to Dr. Lindsay we owe the fact that this province was the first in Canada to secure reciprocity with Britain. In him the Board, and the medical profession throughout the Province, whose Council the Board is, have a most trustworthy, competent and loyal official.

In these remarks I have from time to time indicated the difficulties which beset the Board in carrying on its work. I should like now to note more particularly some of these difficulties.

First, I would place a general want of interest in the work of the Board. Those who have sought its help in vain have some excuse for neglecting us, those who happily have

not required our assistance may easily forget our existence. For my own part I cannot help thinking that matters might be improved if there were a larger direct representation, and I think a movement in this direction was inaugurated at our last meeting in Lunenburg, where there was a proposal that each county, or at all events each Medical Society should elect a member. Any change in this direction would require time and the action of our legislature. Perhaps the ideal composition of a Board would be a member from each Society, a few elected in our general annual meeting, and a small number nominated by the Governor in Council. These last, if permanent appointments, and selected judiciously, as representatives of professional standing and public service, would be free from the disturbances of transitory questions and would give continuity to the life of the Board, changing as it otherwise would do with each election.

There is another lion in the way, of which I would speak with plainness but with restraint. I have already referred to the curious, but unmistakeable attitude of hostility which the general public adopts towards what they imagine to be the privileges or perquisites of the medical profession. Now, however, willing a Government may be to amend our Acts or to further measures of public safety and utility to which our experience may urge them, they cannot legislate effectively without the consent of the public. And the impossibility of securing convictions against unregistered people; the opposition to any interference with the sale of nostrums, show the temper and the folly of the public.

I regret to say that persons in authority, who should know better,

have frequently exercised opposition to our action.

I may give a few examples. A few years ago a man who failed to come up to the requirements of the Board and could not be registered, held an appointment under the Federal government as examiner of troops going to South Africa, and all our attempts to restrain him from practice have been unavailing.

Some time ago it was brought to the notice of the Board that the qualifications on which a certain practitioner had registered were doubtful. We communicated with the institution in the United States, from which the diploma was issued. The authorities interested themselves in the matter. The secretary and Registrar of the College came down here and inspected the documents, and pronounced them to be forgeries. The procuring of registration on falsified documents is conduct "infamous in a professional respect" and the name of this man was erased. This is the case to which I referred some time ago as one in which we believed an attempt would be made to reinstate him by special legislation, and in which the activity and alertness of the medical men who are members of the Legislature prevented it. I regret to say that the legal adviser of this man is none other than the Attorney-General of the Province. The attempt to reinstate failed, but an amendment to the Act passed, giving power to anyone whose name had been erased from the Register to appeal within three months to a Judge of the Supreme Court. So that we have not heard the last of this case. In England the repeated decision of Judges places the final decision of what is "infamous conduct in a professional respect" in the hands of the Council.

As to the difficulty of securing convictions against irregular practitioners, I may mention the case of a clergyman no great distance from Halifax, who practises among the people of his neighborhood, and against whom we have failed to secure a conviction, even although the words "for hire, gain or hope or reward" have been struck from the section dealing with such cases.

And lastly, how humiliating it is that the ignoble question of money should play so large a part in our lives. I may say at once that the Provincial Medical Board of Nova Scotia has no income, save that derived from registration and examination fees, and that our exchequer is sometimes perilously low. At one time indeed, it was exhausted, and two or three members of the Board, the late Dr. Parker, Dr. J. F. Black, and the Registrar, Dr. Lindsay, had to keep a note going until money came in. Nova Scotia is the only province in Canada in which the Pro-

fession makes no direct contribution to the expenses of the Board.

In Quebec and Ontario two dollars per annum is levied on each practitioner.

In British Columbia the fee is "not less than two dollars and a half or more than ten"; in Manitoba, "not less than two or more than five."

In our sister province of New Brunswick the annual fee is "not less than one dollar or more than two," and this is regarded as a debt recoverable with costs.

In Prince Edward Island "the Council may levy an annual fee."

In Newfoundland each practitioner takes out his license annually and pays the prescribed fee.

I submit that the consideration of an annual contribution to the working expenses of the Board from each registered practitioner is a question which should engage the attention of this Society and the various County Societies in the Province.



# SOCIETY MEETINGS.

## NEW BRUNSWICK MEDICAL SOCIETY.

THE twenty-eighth annual meeting of the New Brunswick Medical Society was held at St. Stephen on July 21st and 22nd, 1908.

The meeting was called to order at 10 a.m. by the President, Dr. J. M. Deacon, of Milltown, N. B. The minutes of the 27th annual meeting were read and approved.

The President in his opening address spoke of the men in the profession who have passed away, referring particularly to Drs. Wm. Bayard, J. H. Scammell and C. E. Swan.

It was then moved that a committee be appointed to draw up letters of condolence to be sent to the families of deceased members. Committee: M. L. Young, W. H. Irvine and J. H. Gray.

Dr. J. M. Deacon read the report of the insurance committee as follows:

At the last meeting of the Medical Society he had reported that there were twenty-three who had not signed the agreement to hold the fee for examination of candidates for insurance at \$5.00 each.

Before your committee met in December, 1907, Mr. Weston, representing twenty insurance companies, offered a fee of \$4.00. Then at a meeting held in St. John in December, 1907, it was decided to submit Mr. Weston's offer to the Medical Society. It was moved by Dr. Skinner and seconded by Dr. Gray that the discussion of this report be postponed until the afternoon session; carried.

Dr. Skinner then read the report of the Council of Physicians and Sur-

geons of New Brunswick. It is as follows:

Saint Stephen, N. B.,  
July 20th, 1908

Mr. President and Members of  
The New Brunswick  
Medical Society:—

I beg to submit the Annual Report of the Council of Physicians and Surgeons of New Brunswick for the year 1907-08.

The Council—finding that the examination and registration fees (\$20.00) were not sufficiently high to cover the expenses of the examination, and that they were much below the majority of the other Provinces of the Dominion, *e.g.*, Ontario, \$100.00; British Columbia, \$100.00; Alberta, \$102.00; Saskatchewan, \$102.00; Manitoba, \$75.00; Québec, \$40.00. Nova Scotia, \$60.00; Prince Edward Island, \$20.00—have taken steps to have the fees for examination and registration in New Brunswick increased to \$60.00; *i.e.*, for examination \$20.00, and for registration, \$40.00. The object in making the fee for registration double that for examination is that when reciprocal registration will be established with Great Britain, the increase will go a long way towards making up the deficiency in the receipts of the Council.

The question of reciprocal registration with Great Britain has been thoroughly discussed by the Council. An application is being made in proper form to have the Province of New Brunswick declared a separate British possession under the British Medical Act. This is a necessary legal procedure to be taken before re-



reciprocity with the Mother Country can be established. This Act is already in force in Quebec and Nova Scotia.

The Council have advised that in the interest of medical science, and for the betterment of the profession throughout the Province, a short post-graduate course be carried on at the General Public Hospital, St. John, at a time suitable to the authorities of the Institution.

In accordance with a resolution passed by the New Brunswick Medical Society, "That the matter of allowing the Osteopaths to practice be brought before the Council for their consideration," a suit was brought against A. L. Spangler, Osteopath, in the St. John Police Court in March last, resulting in an adverse decision being given. The Council have the matter still under consideration.

The Council is taking steps to proceed against Dr. T. W. Griffin, of Woodstock, who is practising medicine illegally, his name not appearing on the Medical Register.

It has been decided to make the fiscal year of the Council end the last day of February, in order that the Treasurer's and Registrar's accounts may be closed on the same day.

A committee has been appointed to take the Medical Act into consideration and submit any amendments they think fit at the next meeting of the Council.

The number of names on the Medical Register this year is two hundred and fifty-five.

The following graduates in medicine have passed the professional examination:

Dr. W. L. Tracy, Dr. W. M. Jenkins, Dr. W. E. Gray, Dr. J. M. P. Allaire, Dr. W. P. Kirby, Dr. J. F. London, Dr. B. Lang, Dr. Hugh P. O'Neil, Dr. E. J. Ryan, Dr. J. A. Gaudet.

Mr. E. Roy Hicks has passed in the primary subjects.

STEWART SKINNER, M. B.  
*Registrar.*

THOMAS WALKER, M. D., *Treasurer,*

*In account with THE COUNCIL OF  
PHYSICIANS AND SURGEONS  
OF NEW BRUNSWICK.*

*Receipts from March 22, 1907,  
to May 1, 1908:*

Bal. on hand Mar. 22, 1907,	\$1,008.48
Received from the Regst'r.	718.00
Int. on Savings Bank Dp't.	77.37
	<hr/>
	\$ 1,803.85

*Expended from March 22, 1907,  
to May 1, 1908:*

Salary of Registrar.....	\$ 225.00
Travelling Expenses .....	94.00
Examiners' Fees .....	151.00
Publn'g Medical Register	72.55
Printing and Advertising..	16.14
Expenses of Examination (cleaning room) .....	3.00
	<hr/>
	\$ 561.69
Balance on hand ....	1,242.16
	<hr/>
	\$ 1,803.85

Respectfully submitted,  
THOMAS WALKER, M. D.  
*Treasurer.*

Examined and found correct,  
May 16th, 1908.

H. GEO. ADDY,  
J. P. MCINERNEY,  
*Auditors.*

STEWART SKINNER, M. B., *Registrar,*

*In account with THE COUNCIL OF  
PHYSICIANS AND SURGEONS  
OF NEW BRUNSWICK.*

*Receipts from March 22, 1907,  
to May 14, 1908:*

Annual Fees .....	\$ 334.00
Matriculation Fees .....	15.00
Examination Fees .....	100.00
Registration Fees .....	140.00
	<hr/>
Total .....	\$ 589.00

Expended from March 22, 1907,  
to May 14, 1908:

July 16. Paid Treasurer...	\$ 195.00
Dec. 2. " " ...	42.00
Jan. 17 " " ...	179.00
Mar. 18 " " ...	55.00
May 4 " " ...	118.00
	<hr/>
Total .....	\$ 589.00

Respectfully submitted,  
STEWART SKINNER, M. B.,  
*Registrar.*

Examined and found correct,  
May 16th, 1908.  
(Sgd.) H. GEO. ADDY, M. D.,  
(Sgd.) J. P. MCINERNEY, M. D.,  
*Auditors.*

MEMBERS OF COUNCIL:—J. M. Deacon, M. D., Milltown; \*J. H. Gray, M. D. Fairville; J. P. McInerney, M. D., St. John; \*G. M. Duncan, M. D., Bathurst; R. P. Inches, M. D., St. John; \*C. T. Purdy, M. D., Moncton; E. T. Gaudet, M. D., Memramcook; Murray MacLaren, M. D., St. John; \*Thos. Walker, M. D., St. John.

\*Government appointees.

The following are the officers appointed at the last Annual Meeting:  
President, Dr. Murray MacLaren  
Treasurer, Dr. Thos. Walker  
Registrar, Dr. Stewart Skinner

Audit Committee:—Dr. J. P. McInerney, Dr. H. G. Addy.

Registration Committee: — Dr. Thos. Walker, Dr. H. G. Addy.

Examination Committee:—Dr.

Murray MacLaren, Dr. J. P. McInerney, Dr. Thos. Walker.

Laws Committee:—Dr. Thos. Walker, Dr. Murray MacLaren, Dr. J. P. McInerney.

Prosecuting Committee:—Dr. J. P. McInerney, Dr. Thos. Walker, Dr. Murray MacLaren.

Professional Examiners:—Dr. A. B. Atherton, Dr. P. R. Inches, Dr. J. W. Daniel, Dr. G. A. B. Addy, Dr. T. D. Walker, Dr. Stewart Skinner.

Matriculation Examiners:—Dr. H. S. Bridges, Dr. G. U. Hay.

On motion the Registrar's report was adopted and ordered to be placed on the minutes.

The committee appointed to draw up letters of condolence to be sent to the families of deceased members brought in the following report:

Whereas, it has pleased Almighty God to call home Dr. William Bayard, one who has always stood for those things that had for their culmination all that is highest and best among men, more particularly men of our profession, and in the language of one who knew him well, was ever characterized by the strictest honour and sterling integrity, ever foremost in every movement intended to promote the private and public welfare of his professional brethren. He occupied the distinguished position of being the oldest active practitioner in Canada, and was recognized by his Alma Mater for his scholastic and professional attainments. He was also regarded as the Father of the Profession in New Brunswick, and it can be said that few are left that can hope to succeed him,

And, Whereas, it has also pleased Almighty God to remove Dr. J. H. Scammell, one young among us, who at an early age had achieved distinction in our profession and was active-

ly employed as well in benevolent and religious work.

And, *Whereas*, it has pleased Almighty God to call to his reward, Dr. C. E. Swan, the oldest practitioner in Maine, and intimately identified with the social, religious and business life of the St. Croix River, through an active period of such length as is granted to few men.

*Resolved*: That this body expresses its sense of loss and conveys to the families of the deceased its sympathy in their bereavement.

*Further Resolved*: That these resolutions be spread upon our minutes and copies of the same forwarded to the families of the deceased members.

Respectfully submitted,

M. L. YOUNG,  
W. H. IRVINE,  
J. H. GRAY,

*Committee.*

St. Stephen, N. B.

July 22, 1908.

READING OF PAPERS.

Dr. Murray McLaren read his paper on "Ovarian Hernia." He described the different organs which may be found in the perineal sac, as ovaries, bladder, etc. This paper was discussed by Drs. Deacon, Lawson and Crockett.

Dr. Butler read his paper on "Glandular Disease," relating a number of cases in which there was smallness of glands in neck, axilla and groin.

Paper discussed by Drs. Irvine, Young, T. Walker, McLaren, McInerney, Skinner.

The next paper was read by Dr. J. M. Deacon. He reported cases of (1) Prostatectomy. (2) Two large abdominal tumours. (3) Gallstone in biliary duct. In first case operation was done by the suprapubic method, with recovery of patient. The ab-

dominal tumours were 1st, retaining cyst weighing 100 lbs. 2nd, ovarian cyst. The third was gallstone in common duct. The stone was removed and patient made good recovery.

Paper discussed by Dr. McLaren.

Meeting adjourned till 2.30 p.m.

Afternoon session opened at 3 p.m. with Dr. McIntosh, V. P. in chair, and Dr. W. H. Irvine, Acting-Secretary.

The Mayor of St. Stephen was introduced to the meeting and gave an address of welcome. He was followed by Hon. W. G. H. Grimmer, Surveyor-General, who gave a most excellent and forceful address.

At this session, Mr. Weston, who represented a number of insurance companies, was permitted to address the meeting on life insurance fees. He made an offer of \$4.00 for medical fee for examining candidates for insurance.

A motion was made to accept this fee, but when put to meeting was lost. It was then moved and seconded that the fee be \$5.00 and that this action of the Medical Society be brought into effect on Oct. 1, 1908. Carried.

It was moved by Dr. J. H. Gray, seconded by Dr. Murray, that the next place of meeting be at St. John. Carried.

Moved by Dr. Skinner, seconded by Dr. Gray, that meeting proceed to election of officers.

The following were elected:

President:—Dr. McIntosh.

1st. Vice-President:—Dr. C. T. Purdy.

2nd. Vice-President:—Dr. A. J. Murray.

Treasurer:—Dr. Geo. G. Melvin.

Corresponding Secretary:—Dr. J. V. Anglin.

Secretary:—Dr. Corbett.

Trustees:—Drs. M. L. Young, Geo. McNally, Deinstadt.

Committee of Arrangements to be appointed by President.

The following were elected Council of Physicians and Surgeons of New Brunswick:

Drs. McLaren, J. P. McInerney, E. T. Gaudet, J. M. Deacon, P. R. Inches.

It was moved by Dr. Alexander Murray, seconded by Dr. Day, that a committee be appointed to take into consideration fees paid by fraternal societies, to obtain the views of members of the profession and report thereon at the next annual meeting. Carried.

The committee is Drs. Murray, Day and Corbett.

Dr. McInerney read a paper on "Is the medical profession making good in its own behalf?" The writer treated of Dominion Registration; of the need of a sanatorium for New Brunswick; of compulsory vaccination; of illegal practitioners of medicine

The paper was listened to with close attention, and on motion a committee was appointed to consider the paper and make recommendations.

The committee appointed were Dr. McLaren, Gray and Gaudet, and they reported as follows:—

MR. PRESIDENT AND GENTLEMEN:—

Your committee appointed to consider Dr. McInerney's paper, beg leave to make the following recommendations: 1st. That this Society recommend the Council to continue their efforts to secure Dominion Registration. 2nd, Your committee would ask that a committee be appointed to wait on the Government to point out the necessity of a sanatorium for the treatment of tuberculosis. 3rd, Your committee would recommend that this Society memorialize the Government in reference

to the necessity of compulsory vaccination of all children attending school. 4th, Your Committee approve of the efforts of the council in their prosecution of illegal practitioners, and would recommend that they continue their efforts in that direction.

(Sgd.) MURRAY McLAREN,

E. T. GAUDET,

J. H. GRAY,

*Committee.*

On motion it was ordered that this report be placed on minutes and recommendations contained in it be carried out by incoming President.

Meeting adjourned.

On evening of July 21st the Society had a sail down the St. Croix, which was enjoyed by all present.

JULY 22ND, 10 A. M.

Meeting called to order by the President. The Treasurer's report was read by the Secretary and showed a balance of \$159.55. The accounts were audited by Drs. Butler and Irvine, and declared correct.

Dr. W. J. Gilbert read his paper on "The Eye as a Factor in Diagnosis and Prognosis of Bright's Disease and Diabetes."

He was followed by Dr. W. H. Irvine, who reported a case of Twin Labour complicated with pleurisy with large pleural effusion and pneumonia and recovery of patient.

This paper was discussed by Drs. Young, Gray and Corbett.

Dr. Corbett's paper was on "Craniotomy," and he discussed the subject from moral and scientific points of view. Paper discussed by Drs. Webber, Atherton, Butler and Deacon.

Dr. Webber, of Calais, read a paper on "Abdominal Pain in Thoracic Disease." He reported cases having abdominal pain as a symptom and

followed by pneumonia. The paper was discussed by Dr. Young, Atherton and Deacon.

Dr. Anglin read a paper on "Suicide," which was listened to with close attention, and discussed by Drs. Gray, Murray, Atherton and Irvine.

Dr. Bennett's paper on "Pelvic Abscess" was read by Dr. Webber.

Dr. Atherton reported a case of Cancer of Cæcum. He showed interesting specimens of dermoid cyst of testicle, and one of gallstone.

A vote of thanks was passed to the Masonic Society, and one to the President for his efforts in connection with insurance work.

The usual honorarium of \$25 was granted the Secretary.

A notice of motion was given to change the matriculation examination.

The meeting then adjourned.

R. W. DAY,

Secretary

## MARITIME BRANCH OF THE ASSOCIATION OF MEDICAL OFFICERS OF THE MILITIA.

A MEETING was called at Aldershot by Lieut. - Colonel Sponagle, A.M.O., during the recent training, on the 15th inst., to consider the advisability of forming a branch of the Association of Medical Officers of Militia. After remarks by Col. Sponagle on the advantages of a local branch, holding an annual meeting during Camp, where any matter of interest to the medical service might be discussed—perhaps in the way of a "kickers" meeting like that of the Rifle Association, Colonel G. C. Jones, the Director-General, spoke of the advantages of such a branch and of some proposed changes in the by-laws of the general association, *i. e.*, to hold the annual meeting at Ottawa during military week in February, and to add Dental Surgeons as members.

It was moved by Major Morse, 69th Regiment, that a Maritime Branch be established. Seconded by Lieut. Ford, A.M.C., and carried.

The following officers and executives were elected.

President:—Lieut. Colonel M. A. Curry, 66th Regiment.

Vice-President:—Major D. McDonald, 94th Regiment.

Secretary:—Major L. R. Morse, 69th Regiment.

Executive Committee:—Lieut.-Colonel Foster, P.A.M.C.; Lieut.-Colonel J. A. Sponagle, A.M.C.; Major H. V. Kent, 78th Regiment; President and Secretary, *ex officio*.

Unanimously moved that Colonel G. C. Jones, D.G.M.S., and the Minister of Militia be honorary members.

Members present at the meeting:—

Colonel Jones, D.G.M.S.

Major Brousseau, P.M.O., Quebec

Lieut.-Col. Curry, 66th Regiment.

Lieut.-Col. Sponagle, A.M.C.

Major Ross, A.M.C.

Major Vaux, P.A.M.C.

Major J. Feindal, 75th Regiment.

Major McDonald, 94th Regiment.

Major Morse, 69th Regiment.

Lieut. C. H. Morris, A.M.C.

" Moore, A.M.C.

" Ford, A.M.C.

" Beckwith, D.S.

" Dickey, 63rd Regiment.

Major Brousseau, P.M.O., Quebec, was introduced by Colonel Jones. He made some interesting remarks suggesting that Halifax be made a training depot for officers of the whole Canadian Militia.

Meeting adjourned.

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to the toxin; of the apparently healthy cases that reacted it is to be assumed that foci of disease undiscoverable by clinical methods exist in them, which assumption is strengthened by the history of long exposure to infection given in these cases. The final conclusion of the authors is that the old method of using tuberculin is more accurate in cases where the general susceptibility to tuberculin is slight; the ophthalmo-reaction, however, possesses the great advantage of simplicity over the old method; moreover, it may be used in acute febrile conditions, where the presence of fever prevents the use of tuberculin subcutaneously.

In another publication (*Journal of Experimental Medicine*, No. 2, Vol. X) McCampbell and White give the results of applying the Calmette test to the diagnosis of tuberculosis in

cattle. Calmette's tuberculin preparation produced no results, and special tuberculin procured from the United States Department of Agriculture had to be employed. A quarter of a cubic centimetre of this was used, in full strength, and the characteristic reaction was obtained in a sufficient number of cases to show that the method will probably be of value. Findings parallel to those discussed above were again noticed: the previous use of tuberculin subcutaneously interfered with the ophthalmo-reaction and advanced cases reacted less intensely than incipient ones. The authors are continuing with their investigations, and promise to give further data in the near future. Such work will be followed with great interest. The question of bovine tuberculosis and its relation to the human disease is still a debatable one, and

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Faculty of Medicine, Seventy-Seventh Session, 1908-1909

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THERE IS, IN ADDITION TO THE ABOVE, A STAFF OF 65 LECTURERS, DEMONSTRATORS AND ASSISTANT DEMONSTRATORS.

The Collegiate Course of the Faculty of McGill University begins on September 15th, 1908.

**MATRICULATION.**—The Matriculation Examinations for Entrance to Arts and Medicine are held in June and September of each year. The entrance examinations of the various Canadian Medical Boards are accepted.

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**RECIPROCITY.**—Reciprocity has been established between the General Medical Council of Great Britain and the Province of Quebec Licensing Board. A McGill graduate in Medicine who has a Quebec licence may register in Great Britain, South Africa, India, Australia and the West Indies without further examination.

For information and the annual announcement, apply to

F. J. SHEPHERD, M. D., LL. D., Dean, JNO. W. SCANE, M. D., Registrar,  
McGill Medical Faculty.

the observations of the ophtho-mo-reaction in cattle with the use of various tuberculins may throw additional light upon this vexing problem.

—Editorial *Medical Record*.

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### CORRESPONDENCE SCHOOLS OF NURSING.

There is no objection to schools of nursing giving correspondence instruction and short-term courses, provided their graduates do not set themselves up as trained nurses and charge trained nurses' prices. It cannot be denied that there is a field for women with a little nursing knowledge who will work for ten or fifteen dollars a week. The majority of families can not well afford a trained nurse.

But it is much to be deprecated that some of these schools, which furnish

this curtailed education, encourage their pupils to hold themselves out as being really trained nurses and to charge the fees of trained nurses. This borders on dishonesty.

Some of the magazines carry the advertisement of such a correspondence school which proclaims that "you can be a nurse and make thirty dollars a week." This school announces that its diplomas "are recognize by the leading physicians and hospitals of the United States." Doubtless this is true, but it fails to tell us what happens when they are recognized!—*New York State Journal of Medicine*.

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### INTERNATIONAL MEDICAL CONGRESS.

The Sixteenth International Medical Congress will be held at Budapest, Hungary, under the distinguished patronage of the Emperor of Austria, from the 29th of August to the 4th of September, inclusive, 1909.

A strong Canadian Committee has been formed to represent the medical profession of Canada at this Conference. The following is the Committee—Doctors W. H. B. Aikins, A. H. Garrat, E. E. King, J. S. MacCallum, G. R. McDonagh, A. McPhedran, G. S. Ryerson, and A. H. Wright, of Toronto; Doctors H. S. Birkett, and F. Shepherd, of Mont-



## HALIFAX MEDICAL COLLEGE, HALIFAX, Nova Scotia. FORTIETH SESSION, 1908-1909

The Fortieth Session opened on Tuesday, September 1st, 1908, and continues for the eight months following.

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real; Dr. Courtenay, of Ottawa; Dr. J. Third, of Kingston; Dr. Ingersoll Olmsted, of Hamilton; Dr. J. D. Wilson of London; Dr. Halpenny, of Winnipeg; Dr. S. T. Tunstall of Vancouver, and Dr. O. M. Jones, of Victoria.

The Secretary of the Committee is Dr. W. H. B. Aikins, 50 College Street, Toronto.



### GONORRHOEA.

In the *Journal of the American Medical Association*, Robert H. Herbert summarizes the treatment of fifty-two cases of almost every form of gonococcus infection, by the antigonococcic serum. The conclusions drawn from his report are quite clear. First, the serum has absolutely no effect on acute gonorrhœal infections, whether they exist in the lower urinary tract or in any other part of the body. Second, its value in subacute and chronic cases is very doubtful, although there were a few isolated cases in which the results were somewhat better than we see with local treatment. Third, the value of this serum in the treatment of chronic gonorrhœal joints is without question. In the past, these painful joints

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accompanying and following gonorrhœa have been most resistant to treatment, both local and general, and he feels that we now have a remedy which will give rapid and permanent relief to the sufferers from this common complaint.—*Cleveland Med. Journal.*



### TONSILLITIS.

By Charles J. Drucek, M. D., Chicago, Ill.,  
Professor of Physiology at the Illinois School  
of Dentistry, Lecturer to the Nurses  
of Mercy Hospital.

A local remedy for tonsillitis to be successful must fill two requirements: A detergent antiseptic and a degree of permanency of effect. Many of the remedies are antiseptic, but they are not exosmotic enough to increase the circulation or else their effect is too transient and their use tires the patient. Locally I have grown to use but one remedy and that is Glyco-Thymoline. I prescribe equal parts of Glyco-Thymoline and water to be used in an atomizer. I get better results with this than anything else I have used. I always use it in an atomizer, because gargling is necessarily painful while a spray is not. Glyco-Thymoline promptly relieves

the dry congested condition and by adhering to the tonsil protects it from external irritation. Its anodyne effect is immediate and lasting. I instruct my patient to use it frequently and because it is pleasant and its action prompt, I find that they need no further instruction but use it thoroughly. As Glyco-Thymoline is non-poisonous it makes no difference as to how much is swallowed and its action does not upset the stomach, but tends rather to assist the destruction of any of the plugs that may be swallowed. I find by this method of treatment that my cases are nearly all cured in twenty-four to thirty-six hours, and that I need no other medicament at all because the system does not become clogged with toxines.



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