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THE PRESIDENTIAL ADDRESS DELIVERED BEFORE THE TWENTY-SECOND ANNUAL MEETING OF THE ONTARIO MEDICAL ASSOCIATION.

By N. A. POWELL, M.D., Toronto.

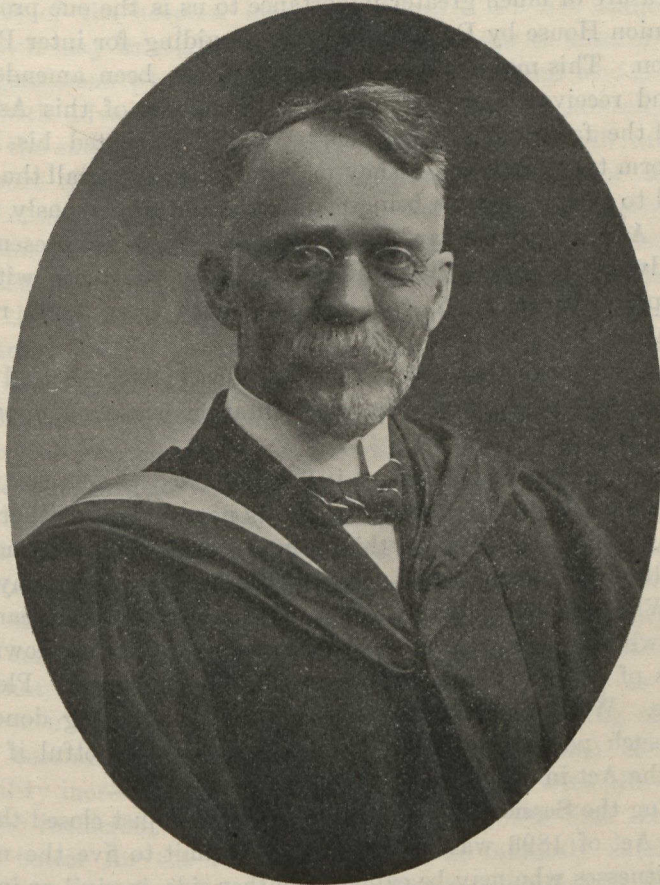
GENTLEMEN,—To utter words of kindly greeting is always a grateful task, and to-day it becomes my pleasant duty to welcome you to the 22nd Annual Meeting of the Ontario Medical Association. To all of you—to our guests, to old friends and to those who are with us for the first time, I offer a greeting which is none the less sincere because it happens to be official.

The Ontario Medical Association may be fairly taken as representative of what is best and most progressive in the profession of this Province. This being so, I would be an ingrate indeed if I did not, first before all else, thank you for the evidence of good-will shown in your having bestowed upon me for this year the office of President. Being deeply sensible of this kindness, the selection of a topic to which I might with advantage invite your attention, has weighed heavily upon me. If one could have been found the intrinsic interest of which would more than have atoned for my own imperfect presentation of it, then indeed I should have felt a measure of contentment. I can claim no marked success in the quest for a subject such as this, but a number of topics seem to have sufficient interest to justify their discussion in your presence. The first of these has to do with the bearing of recent and of pending legislation, Dominion or Provincial, upon the welfare, the rights and the prospects of Ontario physicians. Before entering upon any consideration of these matters it is just as well that we should put aside the modesty with which we have for a long time been tongue-tied and claim boldly that in regard to the regulating of the study and practice of medicine by legislation, this province has been and still is in advance of any other province or state on this continent. More than this, our methods of conducting examinations by a Board representing all the interests concerned and having the sole power to confer licenses for practice, while it has served as a model for the organization of many State Boards, is still better than any other. Our examinations have been and are more exacting and searching and our standards are higher than those of any other

State or Province. The influence for good which has thus been exerted cannot easily be computed. It is quite true that *upon paper* examinations have been set which would appear to present greater difficulties for students, but the percentage required for a pass and the proportion of candidates rejected have uniformly been lower than has obtained with us. Numberless students who, after being graduated here, have passed some one or more of the better class of State examinations in the United States, or have taken degrees in our own Mother Country, testify to this fact. Their uniform report is that our examinations present greater difficulties than any other. The net result of the operation of the Ontario Medical Act of 1869, and of amendments thereto, has been that there is to-day, in this Province, a profession of which we can justly feel proud; and that, scattered over the world, are countless progressive and successful physicians who, having been trained here, owe no small measure of their success to the fact that, for more than thirty years, the Medical Colleges of this Province have had to teach up to the requirements of a rigid State examination. We are proud of this record as a record, but what has been done is of importance mainly as indicating what better results may still be attained. Where we stand on any question or what we have done, is of less importance than the direction in which we are moving. In medicine we are facing a wonderful to-morrow! The measureless growth of its sciences within recent years, impose upon us grave responsibility, and we cannot afford to "mark time," while other and even less favored states or provinces are progressing.

Claiming all that I have for the Ontario Medical Act and for its influence upon the profession here, I am far from claiming that it is incapable of improvement, or that its provisions have always been wisely and judiciously administered. A long series of indictments could be laid against successive Medical Councils. If I were to undertake even an enumeration of the mistakes, the shortcomings and the follies of these bodies, I should have no time to discuss them. It is the part of wisdom to learn from the mistakes of others, and, recognizing such mistakes, let us try for the future rather to avoid and correct them than to waste time in harping up them. During the past winter, a Bill to amend the Ontario Medical Act was introduced into our Provincial Legislative by Dr. Jessop. In brief, this Bill asked that the Medical Council should be composed entirely of the Territorial representatives, and that the Universities, the Medical Colleges and the Homeopathic faction should no longer have direct representation. Although without mandate from you upon the matter, I felt called upon to oppose this Bill for reasons with most of which I need not trouble you just now.

Admitting, for the sake of argument, that the Homeopaths are over-represented, we still must remember that when our Act was passed, a direct bargain was made with these gentlemen and that it should be carried out in good faith till changed by mutual agreement. Those who trade on the name of Hahnemann, or who, at a greater or less distance, follow his vagaries, are diminishing in number and in influence and for



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PRESIDENT ONTARIO MEDICAL ASSOCIATION.

us to drive them into making application for separate incorporation and into the position of an oppressed minority, would be foolish in the extreme. As to the right of representation of the Universities, actually engaged in the educational work of the country, and of the Medical Colleges, there can be no question. It does seem to me, however, that the members of the Medical Council who represent charters in abeyance, or Universities having no direct interest in medical education, should no

longer have the right to appear at the Council Meetings and that our Act should be amended so as to reduce the membership and expense to this extent.

Dr. Jessop's Bill was thrown out with, I believe, a strong feeling on the part of the House Committee which dealt with it, that some such provision as this should become operative in the near future.

A measure of much greater importance to us is the one promoted in the Dominion House by Dr. Roddick, and providing for inter-Provincial registration. This measure has passed the House, been amended in the Senate and received vice-regal sanction. Members of this Association will recall the fact that Dr. Roddick strongly advocated his Bill from this platform two years ago. They may not as easily recall the fact that I objected to the measure as being manifestly and disastrously unfair to Ontario. As then put forward, the Bill gave as large a representation to Prince Edward Island, to Alberta and to other provinces with a few score of practitioners as to this province with over 3,000 registered practitioners.

I am glad to say that the protest we raised was effectual and that the Bill was re-drawn with the representation arranged upon a more equitable basis.

An examination of the bill, as it finally passed the Senate, leads me to fear that it has been emasculated, and is now potent, neither for good nor harm. I may be wrong in this estimate; and, since the main object of the bill is such a desirable one, I should be glad to find myself mistaken. What we, in Ontario, must guard with jealous care, is the standard which we now have. There must be no leveling down to meet the needs of schools in any other part of the Dominion. Pledges will not suffice. We must have the power to prevent its being done; and, if we have such power and use it, I am exceedingly doubtful if we shall ever see the Act in operation.

During the Session of the House of Commons just closed the Canada Evidence Act of 1893 was amended so as to limit to five the number of expert witnesses who may be called, on either side, in civil or in criminal cases when the consent of the judge for the calling of a larger number has not been asked for and obtained, before beginning the examination of the first witness to give opinion evidence. This, in my judgment, is a sensible enactment, tending to lessen but not competent to remove certain abuses which His Honor Judge McDougall may touch upon in his address before you to-night. It will have some tendency to lessen the advantage which always goes with a long purse in litigation, but it appears to run counter to the statement which we have from the very highest of authorities that "in the multitude of councillors there is safety."

The development and extension of Cottage Hospitals in very many of the cities and larger towns of Ontario is a movement in the right direction, and a natural outcome of the more complete and practical training which our students are now receiving. It has greatly increased the number of positions as house surgeon, now available, and these positions become year by year a more important factor in medical education. The status of the hospital interne in Ontario is a live subject, and, in order that it may be studied from a view-point new to most of us, I have asked a gentleman who is still a hospital resident, and who is filling his position with advantage to his hospital and credit to himself, to read a paper on the subject at this meeting. I hope that he will take up the appointment of graduates in medicine, who, on account of our fifth or so-called clinical year, are still without the license to practise, that he will discuss the relation of these gentlemen to the administration of anæsthetics, and, most important of all, that he will consider the advisability of the appointment of a certain proportion of the house surgeons of our larger institutions every six months, with a graded service of eighteen months, instead of our present unsatisfactory plan of appointing all together once a year, and for one year only. In a recent visit to some of the surgical centres of the neighboring Republic I was impressed by the fact that no surgeon whom I saw at work was doing better operative surgery than is being done here from day to day, but that the assistance given and the "team" work, if I may borrow a term from the campus, was far and away better than anything we see here. We have as good or better men to select from, but the present plans of appointment and terms of service do not give them half the chance they should have. Besides that, every operator is handicapped by having as his chief assistants men who have just been appointed, and by losing them when they are becoming trustworthy and helpful. A graded course, with responsibility increased as experience is gained, and with the men who are lazy or inefficient weeded out at the end of the first six months, would be better for the residents themselves, infinitely safer for the patients, and would help the surgeons who are operating to obtain the results they individually strive for. The first six months of such service would naturally be spent in performing the less responsible duties of the position, and during this time, in my opinion, the administration of anæsthetics should be placed in other hands.

In another respect we appear to be falling behind the procession. While here in Toronto as I know, and in Kingston and London as I fully believe, excellent teaching is given to undergraduates in medicine, we have so far failed to make adequate provision for post-graduate instructions. As a consequence, gentlemen desiring review courses have been

going in large numbers to Manhattan Island and to certain large towns in Pennsylvania, Maryland and Illinois. We have the men, the hospitals and the material to meet all needs but they are not utilized as they might be. In the past professional jealousy was so keen and controversy so bitter that success would have been hardly a possibility. Now *Laus Deo* we know each other better and out of mutual respect can come united and successful action. True, we are given to criticizing each other a good deal; but, with rare exception, this is in the spirit of rivals rather than of antagonists. Old animosities are dying out and are not being replaced.

"The teeming future
Glorious with visions of a full success."

Holds for us a grand, united and splendidly equipped school of medicine doing for the students of a coming time what in an imperfect and patchy way we are striving to accomplish now.

I have faith in that future and in the men who shall sway its destinies and believe that with absolute fairness to all real interests the wisest course can be found and followed.

The reaper whose name is death, has not been idle in the year that has passed since we last met. Your Committee on Necrology will present the names of certain of our members who rest from their labors and whose memories we honor. Permit me to refer to two only of the number: Dr. John Coventry was President of this Association in 1899 and well and worthily did he perform the duties of his office. He died from the disease which cuts off, in the midst of their greatest usefulness, so large a number of physicians,—from an acute pneumonia. Leslie M. Sweetnam, in the full tide of professional success and with an ever widening circle of patients and of friends who appreciated his sterling worth and who loved him for what he *was* as well as for what he *did*, fell a victim to blood poisoning received in operation—I had almost said to a wound received in action.

In one of the songs which Homer chanted when the world was young we hear Idomeneus crying to Hestor:

"Worth many a life is his
The skillful leech, who knows with practiced hand
To extract the shaft and healing drugs apply."

If this were true when men were wild and when human resources were few, how shall we estimate the value to the communities in which they practice, of wise and prudent physicians, honest to their own consciences and armed with all the aids which advancing science has placed in their hands. Looking further afield we have to regret the death of a man, who, with the possible exception of the elder Gross, did more for the development of surgical pathology, than any other surgeon in the new world. Christian Fenger was your guest three years ago and those who

met him only at that time will join with all who knew him more intimately in the belief that he has made a lasting impression upon surgical science. Recalling the fact that surgical pathology has progressed more rapidly than any other department of medicine—that, as has been truthfully stated, it has made more progress in the last thirty years than in the previous thirty centuries, we can appreciate the splendid work which this great investigator and teacher was able to crowd into thirty-five years of professional life. His work and the work of others like him will live. Their best knowledge will continue to be utilized for the benefit of mankind.

“Were a star quenched on high,
For ages would its light
Still travelling downward from the sky
Shine on our mortal sight.

So when a good man dies,
For years beyond our ken
The light he leaves behind him lies
Upon the paths of men.”

The interest you have always shown in the Ontario Medical Library and the financial aid you have from year to year given towards the up-building of a working library for all the physicians of this Province, leads me to mention that after the death of Dr. L. M. Sweetnam, his friend and our friend Dr. Howard A. Kelly, of Baltimore, authorized me to select from Dr. Sweetnam's extensive library every book not already in the Ontario Medical Library and these, to the number of about three hundred, he purchased and presented to us. He did this in order that the collection should be kept together and should form in some degree a Memorial Library. Dr. Kelly's action was a pleasant surprise to many who did not know him—all who have the pleasure of knowing him intimately recognized it as just another large-hearted generous act such as he is continually doing. Dr. Osler's establishment of the Bovell Memorial Library in honour of an old teacher of his, was along the same line and may have prompted this later gift. I am glad to be able to tell you that through the generosity of the President of the Library Association, Dr. J. F. W. Ross, a catalogue of the principal works now upon our shelves is being printed and copies will shortly be sent to members of this Association. They will then be enabled to see what an extensive library has been accumulated and should remember that these books are at all times available to them without expense.

The continued presence of smallpox in Ontario, the large number of reported cases and their wide distribution are causes of regret, of alarm and of humiliation. Of regret on account of the loss of life, the direct expense and the indirect interruption of bread-winning involved; of alarm, because the end of the outbreak does not seem to be as yet in

sight, and of humiliation, because we appear to have taught the public, less faithfully than our fathers did, the demonstrated fact that this disease can be controlled, and in times of epidemic can only be controlled, by vaccination and re-vaccination. Two of the factors which increase the difficulty of stamping out smallpox undoubtedly are humbug vaccination and a failure to make the differential diagnosis between this disease and chicken-pox. In regard to the first, let me cite the case of a girl, exposed to so-called chicken-pox occurring in a man who had come here from Cleveland. This man lied to his physician about his symptoms. I cannot use Browning's euphemism and say "He fell from truth in climbing toward it." He knew that he had been exposed to smallpox and that he had the symptoms of that disease, but to avoid being placed in quarantine, he lied, and as a result his physician took smallpox and died from it. The girl referred to and one other member of a large family had certificates of vaccination but no scars and both took the disease. Both had been "vaccinated" by a physician who did not believe in Jenner's discovery and who had used the uncharged ends of ivory points in performing the operation. Justice fails when a man who spreads smallpox is not made to atone, so far as he can for his offence, by serving a long term in the penitentiary. May I here raise the question of the necessity for a standard certificate of vaccination, stating the result obtained in each case, and may I in this connection also ask if the time has not arrived for placing chicken-pox on the list of diseases which must be reported to our medical health officers.

It is a matter for mutual gratulation that we have, now available in our gloriously health-giving Muskoka region, a hospital for the free treatment of 50 patients with incipient Phthisis. If my own connection with this and with its sister institution, the Muskoka Cottage Sanatorium had been less intimate, I might have been tempted to say more regarding them. Old men are said to talk of what they have done, children of what they are doing and fools of what they are going to do. As I am no longer a child, have not as yet begun to grow old and cannot believe you would have placed one of the third class in the chief office of this Association, I am precluded from entering into any detailed statement at present. Instead let me be content with extending, on behalf of the Board of Trustees of the National Sanatorium Association and of my associates of its Medical Staff a cordial invitation to each one of you to visit Gravenhurst at your earliest convenience and to see for yourselves just what is being done. Let me assure you that the "latch strings" there always hang outside for the members of this Association.

Perhaps from a professional standpoint the most regrettable incident of the year was the simultaneous publication in all of the Toronto daily

papers as advertisements of the so-called "Ramage process" for the cure of Phthisis as "demonstrated" as a private hospital here. The hospital in question is conducted by two of the members of this Association and the advertisements to which I refer appear to set at defiance the code of ethics which we have adopted and by which we profess to be governed. I would gladly have passed over, in silence and in sorrow, these publications if it were not for the conviction that by so doing I would have shewn a cowardly dereliction of duty. The medical men to whom I have referred are engaged in active practice and reputed to be wealthy. By their direct connection with flagrant advertisements of this character, they appear to have established a *prima facie* case against themselves. If they are right in what they have done and are doing, they should be given an opportunity of proving it and of removing the stigma that now rests upon them. The matter is one for consideration by our Committee of Ethics, and to this body I now officially transfer it in the full belief that it will be dealt with fairly, courageously and in a spirit of professional self-respect.

Before closing it is only right that I should express my deep sense of obligation to the gentlemen who have labored so earnestly to make this meeting a success. In a time of political excitement like this I may refer to them as my Cabinet, Dr. Parsons being Secretary of State; Dr. Fotheringham, Minister of Education; Dr. J. M. Cotton, Minister of Public Works and Dr. A. R. Gordon, Chancellor of the Exchequer. How efficiently they have labored will never be known, because they are far too modest to speak of it themselves and much too prudent to let the real facts escape lest I should lose all credit for the results attained.

I am sure gentlemen that we have all watched with keenest interest the movements of the armies of our Empire which in Southern Africa have been making history. We have felt an honest pride in the bravery and fighting skill of the thousands who have gone from Canada to aid the Mother Land. Only a few days ago we were thrilled with the story of how Canadian surgeons at Hart's River for a whole day long and under a withering fire of shot and shell went on with the work of caring for the wounded. While we unite in profoundest thankfulness to Almighty God that the end of this bitter struggle has come, we exult in the part taken by our own country in conquering a peace. We have fought a good fight! we have kept the faith! what has been gained?

"Do you not see your Greater Britain's soul
Has come to birth!
Do you not hear above the sighs—the song
From all those outland hearts which peace kept dumb;
"There is no fight too fierce, no trail too long
When love cries 'Come'".

AN IMPORTANT MALPRACTICE DECISION.

WE have much pleasure in submitting to our readers the able judgment of Justice Falconbridge on the case of *Town v. Drs. D. and A. Archer*. This is, perhaps, the most exhaustive and important medico-legal decision that has ever been handed out in this country. We trust it may be of much service in settling the questions of what a medical practitioner is supposed to know and do. We commend its careful perusal to our readers.

Editor LANCET.

IN THE HIGH COURT OF JUSTICE.

TOWN v. D. ARCHER AND R. ARCHER,

Tried at Toronto non-jury Sittings.

N. F. Paterson, K.C., and Sharpe, for plaintiff.

Aylesworth, K.C., J. H. Moss and W. H. Harris, for defendants.

Judgment delivered by Hon. W. G. Falconbridge, Chief Justice of the King's Bench, Province of Ontario.

This is an action brought by the plaintiff, who is the wife of a farmer residing in the County of Ontario, against the defendants, who are physicians and surgeons residing and practising, in partnership, at the Village of Port Perry, in the same county.

In the month of May, 1899, the plaintiff fell and sustained injuries in her left ankle and foot, and the defendants were retained as surgeons, for reward in that behalf, for the purpose of treating the plaintiff for such injuries.

The plaintiff charges that the defendants negligently, improperly and unskilfully treated the plaintiff for such injuries, in consequence whereof the plaintiff has been suffering, and still suffers, pain, and her foot has become distorted and twisted so that she has been rendered permanently lame, and her health has become otherwise impaired thereby.

The defendants plead, in their statement of defence, that they are both duly registered members of the College of Physicians and Surgeons of Ontario; that the defendants were not retained to treat the plaintiff, as alleged, but that defendant D. Archer was called in after the accident to the plaintiff, as a surgeon to set the plaintiff's ankle, and, with the assistance of another surgeon, did set the same in a proper and skilful manner, and that said defendant D. Archer was thereupon discharged by the plaintiff from any further attendance in the case. They also plead that the injury complained of by plaintiff was not caused by any negligence of the defendants, or either of them, but is due solely to the negli-

gent manner in which the plaintiff's injuries were treated by herself, subsequently to the treatment of her ankle by the defendant D. Archer. And the defendants further set up as a defence, that the plaintiff's ankle was set by defendant D. Archer more than a year before the commencement of this action, and that the plaintiff's claim, if any, is barred by R. S. O. ch. 176, section 41.

The case was tried before me on the 18th, 19th, 20th and 21st of February last, and argued on the 27th of the same month. I have deferred judgment until now, not because I had any doubt as to what the disposition of the issues ought to be, but because the importance of the case to the medical profession, and to the community at large, seemed to require that I should make a more formal and deliberate deliverance of my opinion than would be conveyed by an off-hand judgment pronounced at the trial.

The condition of the plaintiff, who is a woman of sixty years of age, at the time of the trial is fully set out in the report of the surgeon appointed by Order of the Court to make a physical examination. It is as follows: "Report on the Physical Examination of Mrs. Narcissa A. Town of Saintfield, Ont."

"She states that she sustained an injury of the left ankle on May 17th, 1899. Examination by Order of the Court, Sept. 28th, 1901. Condition on examination:

Length of Tibia, same on both sides.

Length of Fibula, same on both sides.

Circumference of the left leg, 1 inch less in calf than that of right.

Circumference above knee, equal.

The distance from the external Malleolus to the ground is increased, and that from the internal to the ground slightly diminished. This causes the foot to be turned inwards, so that in the erect position the left side of the sole of the foot reaches the ground, while the inner side is raised about an inch. This is more marked at the toe than at the heel.

There is a marked prominence of bony character in front and to the outer side of the ankle joint. This is clearly the head of the Astragalus. The body of the Astragalus can be felt distinctly behind this, somewhat in front, and to the outer side of its normal position.

The patient complains of pain on pressure over this part and also at the inner side of the foot below the malleolus (ankle).

There is but little thickening of the soft parts.

No other injuries are present.

Conclusions:

(1) There has been, and still is, a dislocation of the Astragalus, forwards and outwards.

(2) There is no sign at present of there ever having been fracture either of the Tibia or Fibula.

(3) Result: the pain will perhaps become less on using the foot, and the displaced parts will gradually become accustomed to their altered relations; but the deformity resulting from the dislocation will be permanent.

(Signed) "GEORGE A. PETERS, M.B., F.R.C.S., Eng."

The question then for trial, is whether the condition of the plaintiff to-day is due to the want of care and skill of the defendants; or, (2) whether the plaintiff's own want of care has resulted in the injury, or whether she has by her own conduct aggravated her injuries; or, (3) whether her present condition is a result which might reasonably be looked for, and which has come to pass having regard to her age and to the nature of the injury, even with the best degree of care and skill of a medical attendant, and the best degree of care and obedience to the doctor's orders on the part of the patient and of those in attendance on her in her own household.

Although I consider it due to all the parties concerned, to pass upon the merits of the case, yet I am bound to give an opinion upon the defence which has been raised under the Statute, of the limitation of the action by reason of the lapse of time. The Statute R.S.O. ch. 176, (The Ontario Medical Act, section 41), is as follows: "No duly registered member of the College of Physicians and Surgeons of Ontario shall be liable to any action for negligence or malpractice by reason of professional services requested or rendered unless such action be commenced within one year from the date, when, in the matter complained of, such professional services terminated."

The writ herein was issued on the 21st day of December, 1900. If, therefore, the defendants' professional services continued up to the 21st day of December, 1899, the statute is not a good defence. The defendants contend that their professional services terminated with the visit of the 12th June, 1899, and that any visits paid by them after that date were friendly visits and not professional ones. Plaintiff contends that she called, as a patient, on defendants at their office on the 21st December, 1899, and on the 11th January, 1900; and that the defendants' professional services did not terminate until the last mentioned date. There is a conflict of testimony between the plaintiff and defendants as to the real date of the last visit but one; the defendants contending that it was not on the 21st December, but on the 21st November, and backing up their statement by evidence of their different professional engagements and journeys on that day, and on the day preceding. However that may be, I

am decidedly of opinion that when the plaintiff went to see the defendants on the last two occasions she did not go as continuing the relation of patient and medical men, but as a person who had a grievance and who was dealing with the defendants more or less at arm's length. She had called in another doctor (Parke of Saintfield) to look at the foot, on the 13th December, 1899; and she consulted a solicitor during the same month. Consulting another surgeon, in the absence of, and without notice to or leave of the surgeon in charge, is an indication of want of confidence in the latter, and would of course be treated by him, when he came to know of it, as tantamount to a dismissal of him by the patient. I am clearly, therefore, of the opinion that the defendants can claim the benefit of the Statute and that on this ground alone the action fails.

But, as I said before, I deem it incumbent upon me to dispose of the other issues in the case.

The defendants are practising in partnership, but David Archer was the partner who was in charge of the case, and it is his alleged negligence which is in question here. But where physicians or surgeons engage in practice as partners all are liable for malpractice by any member of the firm.

Malpractice (*Mala praxis*) is bad or unskilful practice by a physician or surgeon, whereby the health of the patient is injured. Negligent malpractice means gross negligence and lack of the attention which the situation of the patient requires; as if a physician while in a state of intoxication should administer improper medicines; that is not charged here, but what is charged is ignorant malpractice, namely, a course of treatment which was calculated to do injury, which has done harm, and which a well educated and scientific surgeon ought to know was not proper in the case.

In 1697 the Court of King's Bench, (Temp. Chief Justice Holt) resolved in Doctor Groenvelt's case, which Lord Raymond reports at page 214 in the quaint language of the day, "That mala praxis is a great misdemeanour and offence at common law (whether it be for curiosity and experiment or by neglect) because it breaks the trust which the party has placed in the physician, tending directly to his destruction."

The burthen of proof is upon the plaintiff in an action of this character, to shew that there was a want of due care, skill, and diligence on the part of the defendant, and also that the injury was the result of such want of care, skill and diligence. The general rule of skill required of a medical practitioner was thus ably summed up by Chief Justice Erle, in *Rich v. Pierpont*, 1862, 3 F. & F., at page 40; "A medical man was certainly not answerable merely because some other practitioner

might possibly have shown greater skill and knowledge; but he was bound to have that degree of skill which could not be defined, but which in the opinion of the jury was a competent degree of skill and knowledge. What that was the jury were to judge."

"It was not enough to make the defendant liable, that some medical men of far greater experience or ability might have used a greater degree of skill, nor that even he might possibly have used some greater degree of care. The question was, whether there had been a want of competent care and skill to such an extent as to lead to the bad result."

Chief Justice Tindal, in *Lamphier v. Phipos*, 1838, 8 C. & P., at page 479, charged the jury in the following clear and succinct terms: "What you will have to say is this, whether you are satisfied that the injury sustained is attributable to the want of a reasonable and proper degree of care and skill in the defendant's treatment. Every person who enters into a learned profession undertakes to bring to the exercise of it a reasonable degree of care and skill. He does not undertake, if he is an attorney, that at all events you shall gain your case, nor does a surgeon undertake that he will perform a cure; nor does he undertake to use the highest possible degree of skill. There may be persons who have higher education and greater advantages than he has, but he undertakes to bring a fair, reasonable and competent degree of skill; and you will say whether in this case the injury was occasioned by the want of such skill in the defendant."

It has been held in some American cases that a locality in which a medical man practises is to be taken into account, and that a man practising in a small village or rural district is not to be expected to exercise the high degree of skill of one having the opportunities afforded by a large city; and that he is bound to exercise the average degree of skill possessed by the profession in such localities generally. I should hesitate to lay down the law in that way; all the men practising in a given locality might be equally ignorant and behind the times, and regard must be had to the present advanced state of the profession and to the easy means of communication with, and access to, the large centres of education and science. For example, Port Perry is a two hours' journey from a city of a quarter of a million inhabitants, with three medical colleges and numerous hospitals.

There is no implied warranty on the part of a physician or surgeon that he will effect a cure. He can be treated as an insurer or guarantor of success only if there be an express agreement to that effect.

If a surgeon treat a patient improperly, he is liable to an action even though he undertook *gratis* to attend to the patient.

If a patient by his own conduct, or disobedience of orders, has

aggravated his injuries to an extent that will account for the mischief complained of, he cannot recover damages from the medical man, having regard to the general law of contributory negligence. The burthen of proof to shew contributory negligence is, of course, on the defendant in an action for malpractice.

The failure on the part of a medical man to give a patient proper instructions as to the care and use of an injured limb is negligence for which the medical man is liable for injury resulting therefrom.

These are the principal propositions of law involved in the consideration of the present case.

In addition to the cases cited above, I refer to Slater v. Baker, 1767, 2 Wilson, 359; Carpenter v. Blake, 60 Barbour, 488; same case, 50 N.Y. 696; Beven, Negligence 2nd Ed. page 1390 *et seq.*; Smith on Negligence, Blackstone ed.* 195 *et seq.*; American & English Encyc. of law, 1st ed., vol. 14, page 76 *et seq.*; Bouvier Law Dictionary, *sub tit.* Physician.

Actions of this kind were, as a matter of course, formerly tried, both here and in England, by a jury; and it was the almost inevitable result that juries, perhaps innocently and unconsciously, looked more favourably upon the case presented by the patient than on that presented by the physician or surgeon. To remedy this condition of affairs, and not to leave doctors entirely at the mercy of juries, the courts in this country early became astute to lay down limitations and restrictions on the actions of the Twelve; or, rather as to what matters ought to be left to them to deal with. For example, in 1869 the Court of Queen's Bench held in Jackson v. Hyde, 28 U.C.R. 294, that in an action against a surgeon for negligent malpractice, where the evidence is as consistent with the absence as with the existence of negligence, the case should not be left to the jury.

In Fields v. Rutherford, 1878, 29 C.P. 113, although there was professional evidence that a different course of treatment might preferably have been pursued, but the weight of evidence showed that the course of treatment pursued by the defendant was such as would have been adopted by medical men of competent skill and good standing in the profession; it was held that there was no evidence of negligence to be submitted to the jury, and a non-suit was entered. These cases were followed in McQuay v. Eastwood, 1886, 12 O.R. 402. The *ratio decidendi* of these cases was, that a medical man ought not to be placed in peril with a jury where their decision would involve the consideration of difficult questions in the region of scientific enquiry.

The next step in the practice was the suggestion by the courts that this class of cases ought more properly to be tried by a judge without a jury. This was the corollary or natural logical sequence of the cases

which I have cited, and was first made in *Kempfer v. Conerty*, 1901, 2 O.L.R., page 658 (note); and the same intimation was given in *McNulty v. Morris*, 1901, 2 O.L.R. 656. In both these cases it was stated in the judgment that this intimation was not intended to fetter the discretion of the trial judge in this regard. And so it comes about that this case is tried by me without a jury, the parties having practically consented to my so doing.

The injury which the plaintiff sustained, namely, dislocation of the astragalus, is one which is admittedly not of frequent occurrence; difficult to diagnose, especially when there is swelling of the parts; and one in which perfect restoration is not, at the plaintiff's time of life, to be expected. I was strongly pressed by counsel in the argument to find as a fact that David Archer and Dr. Windell did not make a correct diagnosis, or recognize the dislocation of the astragalus at all. Much stress was laid upon the somewhat different accounts given by these two, of the extent and position of the alleged fracture of the fibula. I think that the comments on this subject were somewhat hypercritical; and I fail to see their cogency in this regard. Technically speaking, the breaking or carrying away of portions of the periosteum constitutes a fracture; and I find, on the preponderance of the evidence, that such a fracture cannot be expected to be disclosed after the lapse of two years by the aid of the X-ray or sciagraph. The sciagraph is not a photograph; it is a shadow, and it is, in the present state of the science, not an infallible guide in fractures, to this extent, at least, that it will not always disclose the line of fracture; and the possibility is that the bony covering being reunited might not show at all. I, therefore, attach much less importance to what is now claimed to be shewn by the sciagraph than the plaintiff's counsel wishes me to do. On the whole case, and having regard to the burthen of proof, I find myself unable to determine this point in plaintiff's favour.

The next point in the case is, assuming the diagnosis to have been correct, whether the treatment adopted was in accordance with good surgery. Two medical men were called to say that it was not. Having already been examined as witnesses they were recalled at the very end of the plaintiff's case to criticize the treatment that was adopted. One of them was, apparently, a very respectable country practitioner of eighteen years' standing; the other was the gentleman who produced the sciagraph and gave evidence based thereon. These two witnesses found fault with the treatment in this respect that, in their opinion, the particular injury in question having been diagnosed, a bandage should have been applied with some form of angular splint before putting the leg in a box; and they said that the treatment actually adopted, namely

the wooden box splint with cotton batting packed about the limb, and a bandage outside the box, was not good surgery. I find that this position is not sustained by the preponderance of expert evidence. Dr. George A. Bingham says that what the defendant did was good surgery, and that the treatment suggested by the two witnesses of whom I have spoken would be practically "criminal." Mr. I. H. Cameron is equally pointed and incisive in his statement; he says that the box splint is quite good practice, and that the bandage next the skin and the rest of the treatment suggested by plaintiff's witnesses "would be the most undesirable that could be conceived." Dr. Herbert A. Bruce says that the splint box and bandaging adopted were perfectly suitable, and that the angular splint and the bandage next the skin would be very detrimental.

To what, then, if I find, as I am bound to do upon the preponderance of evidence, that the case was properly diagnosed, and that the proper treatment was adopted, is the present unfortunate result to be attributed? If it came down to a question between negligence or malpractice on the part of defendants, on the one hand; and the extreme improbability, even under favourable conditions, of perfect or even approximate restoration, I think the doctor in charge ought to have the benefit of the doubt.

But I am of the opinion that there is abundant evidence to show that the present unfortunate condition of the plaintiff is due to her own conduct

I may premise by saying that it is clearly proven that it is impossible to say now whether the present dislocation is initial or is a dislocation subsequent to the injury of the 17th May, and the setting or reduction thereof on the same day. It is further to be observed that Mr. Cameron says that the X-rays show that the astragalus is still in its mortise; *i.e.*, in place as regards the tibia and fibula, but that there is a rotation of the joint, and a displacement of the head of the astragalus outwards. I think I understood Dr. Bruce to say that this condition of affairs was evidence that there had been a reduction of the original dislocation. Be this as it may, Dr. Windell swears that having diagnosed and set and reduced the injury with David Archer on the 17th May, he visited the patient on the 19th May and found her condition satisfactory, and again on the 22nd. He paid a visit on the 3d June, alone, and found that the bandages had been disturbed, and he asked her about it and she admitted that she had had the bandages loosened and had a nice sleep. That he then found a partial dislocation of the astragalus and that he replaced it, put the limb back in the splint and repacked it; that he could not tell what was the extent of that dislocation, but that he does not think that there was any dislocation except at the head. He

attributes this partial dislocation to her having fallen asleep and turned over. The three medical experts called by the defence agree in saying that there was very grave danger in a box splint if the patient relaxed the bandages; that it would be impossible to say that there was no disturbance, even if the patient lay perfectly still; that there would be room for spasmodic action of the muscles which might occur involuntarily or during sleep, and which might be attended with grave results; that it would not be possible, even with an effort, to keep the limb rigid for more than a minute or two; and, moreover, that the result of this disturbance might not be discernible until after the patient began to use the foot, when a gradual inversion of the foot might be looked for as the patient commenced to walk.

I am asked to disbelieve the statement of Dr. Windell, upon the mere ground that while he is not a defendant in the case, his professional reputation is at stake. I find myself unable to do this, especially as his evidence is strongly corroborated. The plaintiff admits having gone to sleep once, while the bandage was loosened; this, however, was after the leg was placed in the plaster of paris splint and cut open on the 12th June; but Mrs. Asling, an apparently independent and creditable witness, says that she went in one time and the bandage was loose, and the plaintiff was working at the cotton batting, and witness asked plaintiff not to do it, and cited the case of a relative of her own whose tampering with bandages had been attended with disastrous results. Witness saw it loose on one other occasion afterwards. Both these times were while it was in the box splint; it was unbound when the witness came in and she helped the plaintiff to do it up. She says Mrs. Gibson was there on that last occasion. Mrs. Asling also says that she saw the plaster of paris bandages taken off and the leg laid bare, and the plaintiff wanted the witness to get it done up in a hurry before Mrs. Baird, plaintiff's daughter, should come in. Mrs. Gibson corroborates this statement, saying that she was at the plaintiff's house with Mrs. Asling one evening that the bandage was loose, and it was bound up while she was there. As far as she can remember it was while in the box splint; it was right out of the splint and that they replaced it in the splint and bound it up in the bandages.

If this evidence were much less clear and convincing than it is, in other words if the case were much more evenly balanced, I should feel obliged to give the defendants the benefit of the doubt; but, as I have indicated before I am decidedly of opinion that the plaintiff has failed to make out a case of negligent malpractice, and that the action must be dismissed.

PRACTICAL POINTS IN LIFE INSURANCE EXAMINATIONS.*

BY S. M. HAY, M.D.

OF late years, Life Insurance has assumed vast proportions. During the last century it rose from a mere gamble in human lives to a science, which is claiming the talent and attention of some of our very brightest intellects.

All sound, progressive companies now *select* the lives offered them. This was not always so; and the great responsibility of this selection rests with the medical profession.

All Life Insurance calculations are based on the expectation of Life, that is the average after-lifetime of all persons at that age.

The laws of mortality are as fixed as the laws of gravitation. Babbage says, "Nothing is more uncertain than the duration of life, when the maxim is applied to the individual; but there are few things less subject to fluctuation than the duration of human life in a multitude of individuals." We cannot tell how long any given person shall live—whether a few days or many years. Expectation has no significance as to the individual life, but only to the lives in the aggregate. However, if we take one thousand, or better still, ten thousand persons of the same age, we can predict with almost mathematical precision the number who will die within a given period. This is the principle of annuities, endowments, limited payments, etc., in insurance.

Nearly all application forms now have an expectation table printed on them; but, if they have not, you can easily find the expectation of an applicant by deducting his age from eighty and taking two-thirds of the remainder. This will be approximately correct. It will be inaccurate when applied to very young, or very old lives. Between 25 and 75 it is fairly correct.

Now, if you remember that healthy men seek insurance with considerable deliberation, and that unhealthy ones rush after it when they think they have a chance of passing the examination, you can plainly see what a great responsibility rests with the local examiner. There should always be the closest harmony, and strictest confidence, between the local examiner and the referee of the company. An entire medical department, thus working harmoniously, ever on the alert to prevent bad lives creeping in, constitutes the greatest safety-valve the Company can possibly have. I am glad to belong to a profession of which a large majority are highly honorable men, and who could not be induced to betray a trust. Experience compels me to say, however, that some local

* Read at Toronto Medical Society, May 15.

examiners, though receiving their appointment from the medical department of the company, being responsible only to that department, receiving their remuneration from the same source, and having promised, in their application for appointment, to be uninfluenced by either agent, or applicant, and, in case of doubt, to give the company the benefit of the doubt, constitute themselves, apparently unconsciously, solicitors for the applicant; and are thus untrue to the interests of the company, employing and trusting them.

The above conclusion has been arrived at after careful observation and close investigation. Let me give you examples of carelessness, as I hope it was not the intention of the examiner to discriminate against the company, and in favor of the applicant. I have seen application after application come in from the same examiner with the pulse rate given, sitting and standing, respectively as 68—72, 68—72, 68—72; and respirations as 15—15—15. Becoming suspicious, I have asked the clerks to bring me a bundle of that examiner's work, and, on reviewing them, have found the pulse rate, in nearly all his examinations, the very same. Some will put the pulse rate higher sitting than standing, and the inspiration measurement less than that of expiration. This is generally a mere mistake—carelessness. Still, the application cannot be disposed of till that is made right, there is a delay for correspondence, and the risk of losing the business.

Occasionally an examiner will write a letter to the referee, which is always gladly received and confidentially regarded, but his letter may come in two or three days after the examination, and when the policy has been issued—unpardonable delay.

I have known an examiner give an agent a "Prospect," and arrange for a part of the commission from an agent. This is contemptible and very short lived for both examiner and agent when discovered. It is practically the same thing as the agent examining his own applicants. How many would he reject? I have also known an examiner, when interested in the commission, merely mention a heart murmur to emphasize its insignificance. Later I saw the applicant, and found he became short of breath on slight exertion, and, without exaggeration, the murmur could be distinctly heard through his ordinary clothing and an overcoat.

A prominent busy doctor in one of our western towns has been making examinations for life insurance by telephone, or on the street, or in a place of business, without removing any clothing. Suspicion arose. A referee interviewed some of those examined, or supposed to have been examined, and discovered the character of the work. The doctor acknowledged his guilt and was very much humiliated. The information

passed from one company to another, and it is scarcely necessary to say that his insurance business has not, since then, been very exacting on his time. Many examiners, considered honorable in their locality and profession, put no conscience into their life insurance work; and act as though their appointment and trust were nothing more than a mere idle form. I believe that the day is not far distant when the work of the local examiner will be carefully and regularly inspected, at least until he becomes thoroughly established in the confidence of the company. I shall now take up some of the important points in personal examination.

Inspection :—Did you ever pause to think how much we can learn from a look at an applicant, and how large a part of our examination is made by inspection? In this day of mechanical aids—the stethoscope, clinical thermometer, microscope, etc.—have we not fallen far behind our forefathers in observation and touch for example? Green says: “The skilled physician begins his examination at the very instant that his glance falls upon the applicant, and is carrying it on even while the formal phrases of an introduction are falling from the agent’s lips.” First impressions are often important, but should not bias the examiner. Note the gait and attitude of the applicant. Look for indications of drug and alcoholic habits, also for incipient mania, or paresis. Note general appearance and bodily conformation. Hippocrates tells us “that persons of a fine contexture, tender, and who have a small shrill voice, thin clear skin, a long neck, narrow breast, depressed or straight chest and whose shoulder blades stick out, are of all others most subject to consumption;” and that “consumptive people are quick, full of spirit, hasty, and of sharp, ready wit.” That ancient description is fairly applicable to-day. Beauty and health are not as closely related as some would have us believe. Who has not observed the full soft melting eyes, beautiful sweeping lashes and exquisite coloring of those predisposed to tuberculosis.

By inspection the examiner must learn to read correctly the marks of bad habits, and of incipient disease, even before they are well marked. Compare carefully the apparent age with the age given. Does the applicant appear older, or younger, than the age given? This is very important. Baldness and early grayness are not significant when taken alone. Rapid aging is very important, and reduces by, perhaps, one half the usual expectation.

With regard to syphilis, observe the saddle nose, condition of the throat and teeth, skin lesions, muddy complexion, or hair gray in patches. These applicants frequently protest against a close inspection of skin and mouth. The more resistance offered, the more determination is required on the part of the examiner. Just now

I recall a case where a lady applicant declined having her chest examined. I insisted, and found that one breast had been removed for supposed cancer; and arrangements were already made for the removal of the other. Brights Disease cannot often be detected by inspection till far advanced. Then puffy eyelids, especially in the morning, giving way to a wrinkled condition in the evenings, is suggestive unless the party be advanced in years. The color of the skin varies from that of exaggerated health to a dough-white. The appearance of the alcoholic condition is so sadly familiar as to require no special comment. Heart disease may, or may not, be apparent on inspection according to the degree. Aortic regurgitation may leave its victim pale, thin and nervous; and you may also notice pulsating carotids and throbbing temporals. Drug habits may be very hard to detect. The victim here—as in alcoholism—is usually untruthful. You may observe frequent rubbing of the nose, and contracted pupils, if morphine has been recently taken. When suspicious, always look for hypodermic marks.

Cocain closely resembles morphia in its action, but the circulation is more likely to be weak and the pupils dilated.

The merry, happy, bright, laughing eye of the innocent child, in contrast with the shifting, evasive glance of the hardened criminal, is familiar to all. But the eye is more than the window of the soul. In it we find the indication of many diseases. Note the condition of pupils, the ocular conjuction, the presence of old opacities, an exophthalmos, evidence of paralysis, or brain tumor, meningitis, or hemorrhage. It will be seen from the foregoing that inspection is a very important part of the examination for Life insurance, as it is in disease.

Let us now review some of the questions usually asked in an examination form. Occupation is frequently answered in a very indefinite and unsatisfactory manner for example, "Traveler" may mean for dry goods or liquors, "Clerk" may mean in a bank, or a saloon and pool room. A man might be a "Foreman" in a furniture or a dynamite factory. "Electriction" might signify employment at the office desk, or climbing poles.

Married men are generally considered better risks than single men, and some go so far as to say that bachelors never attain a very advanced age. Length of life is not increased, however, by marriage late in life, especially if the mate selected be quite young. Is the residence healthful or otherwise? Is the home in a malarial district, or at the mouth of some open sewer? An important question now on some application forms is, "Has any member of your family, or household, died of tuberculosis

within one year?" A death in a home sometimes induces other members to insure. It is important to know the cause of such death; and, if from tuberculosis, to ascertain whether efficient means of disinfection have been employed. "Does the applicant assert that he is now in good health and of sound constitution?" The applicant may manage to evade many of the questions; but this is so pointed that it puts him on his honor, and generally brings a truthful answer. As to "appendicitis," if an applicant has had "stoppage of bowels," "bowel trouble," "inflammation of bowels," "constipation," "colic," "peritonitis," or "acute indigestion," be on the look out for this disease. "Peritonitis" generally means disease of the female pelvic organs, or appendicitis. The examiner should always get a detailed account of these attacks. If an operation was performed, what was accomplished? Was the appendix removed; or an abscess merely opened and drained? Examine the wound for probable hernia. Cases of acute, non-suppurative appendicitis, without operation, are insurable after two years of complete immunity. If the appendix has been successfully removed, one year of immunity is sufficient. If an appendicular abscess has been opened and drainage employed, three to five years should elapse before the person is safely insurable. In chronic relapsing cases, a period of from three to five years should be allowed, dating from last symptom of last attack. Asthmatics should be looked on with suspicion, and examined with care. Many consumptives consider their trouble asthma.

Chest Measurement.—Note the amount of expansion. Do the sub-clavian regions expand freely and fully? The chest expansion should be one-tenth of the maximum chest measurement. The chest capacity, in inches, should be one-half the height of the applicant, for example, a man five feet ten inches in height should have a chest measurement of at least 35 inches. Athletes and many consumptives have good expansion—the former from training, and the latter from teaching. Athletes are usually not first-class risks; and the consumptive, of course, not insurable. The waist measurement, in well proportioned men, is slightly less than that of the chest.

Colic.—This indefinite term always requires explanation. It may mean gallstones, floating kidney, colitis, abdominal aneurism, neuralgia, indigestion, hernia, lead colic, renal colic, appendicitis, ulcer of stomach, etc.

Liquor Habit.—All insurance companies regard intemperance with disfavor. "Do you use spirits, wines, or malt liquors, etc.?" It is frequently more difficult to get a truthful answer to this than to any other question in the form. When questioned regarding the quantity a com-

mon answer is, "a glass occasionally," and the referee is left to guess whether it means a glass occasionally each hour, or occasionally each month, "A glass when I meet a friend," or "A drink when I feel like it." may mean forty times a day. These answers, and others like them, are altogether too indefinite to be of any service in deciding a case. The examiner should in every case give the daily, weekly, or monthly average number of drinks, or average quantity consumed.

"*Ke'e'y Graduates.*"—These are mostly rejected, although some companies accept them after five years of total abstinence have elapsed.

Fearing I have already exceeded the time allotted for this paper, I hasten to conclude, fully recognizing the fact that many points, for example, rheumatism, kidney disease, etc., of equal importance to those taken up have been necessarily omitted.

A CASE OF ACUTE NEPHRITIS.

JOHN HUNTER, M.B.,

Physician to Toronto Western Hospital.

THE patient, A. W., was a female, single, aged 35, with good family history, she had had scarlatina, with some renal complication, in childhood. The recovery was complete, and her health ever since has been excellent. About Feb. 5th she began to complain of slight chills, fever, headache and nausea, but was not aware of any kidney troubles. She took bromo-quinine, and continued about the same until 9th, with the exception that her clothes and shoes seemed to be a somewhat tighter fit, she began to menstruate on 9th, and, on 10th, helped to wash and hang out clothes. The ground was covered with soft snow. Her feet and skirts became wet and cold. That evening, she complained of more severe chills, fever, and a greater tendency to vomit. She had to urinate rather frequently, though the quantity of urine was small. I saw her about 10 p. m., when her temperature was 100, with the symptoms above noted. There were no cardiac or pulmonary symptoms. She said that she had been taking some medicine for la grippe and that she had caught more cold, putting out the clothes, but would be all right in the morning. I prescribed a saline purgative with drinks of hot lemonade, I was hurriedly sent for on the morning of 12th, as the patient had become greatly alarmed at her condition. There was considerable dyspnoea, and she had to be propped up with pillows. The eyes were almost closed on account of the oedema of the face

The abdomen presented the appearance of a seventh or eighth month's pregnancy. The hands, feet, and limbs were about double their natural size. The temperature was 101, and the pulse was rapid and tense. The œdema of the chest walls made it very difficult to ascertain, with any degree of accuracy, the pulmonary or cardiac conditions; but there was evidently pleuritic effusion of considerable amount. A small quantity of high colored, acid urine was obtained, which, on being boiled, coagulated into an almost solid mass. I prescribed saline cathartics, sufficient to keep up free purgation, and a solution of potass. bitart. to drink, also heat by means of hot water bottles to promote abundant perspiration. These measures reduced the general œdema some, but the dyspnoea, increased. On 13th, I inserted a hypodermic needle, between the 6th and 7th ribs, in the mid-axillary line, on the right side. The syringe was immediately filled with serum. I introduced the needle of the aspirator at the same puncture, and slowly drew off between two and three quarts of a clear, amber colored serous fluid. This relieved her breathing and she was able to lie down. On 14th the kidneys began to act more freely, the œdema slowly passed away, the patient making an uninterrupted recovery. The last examination of the urine was as follows:—Sp. gr. 1020, clear, and no albumin, sugar, or casts. The pulmonary and cardiac conditions were normal, but the patient was still very anæmic.

A case like this presents several interesting factors, e. g., etiology, pathology, albuminuria, anasarca, prognosis and treatment. The purport of this paper is to briefly outline these, leaving the fuller discussion to the hands of this association.

ETIOLOGY. Acute Nephritis, unassociated with any other morbid condition is a rather rare disease.

The chief exciting causes are cold and dampness, irritants passing from either the vascular or lymph channels, obstruction or traumatism. The predisposing ones are extremely varied and numerous. The functions of the kidneys make them vulnerable to bacteria, toxins, or, in brief, to the noxious products of disease, in every fluid, tissue, or organ of the body. The toxins of some of the acute infectious diseases, such as scarlatina and diphtheria, seem to exert a peculiarly irritating effect upon some of the renal tissues. The fact that albuminuria is a very frequent complication in diphtheria, seems to be rather overlooked, for some time ago, on giving a rather unfavorable prognosis in a case of this kind, an older physician with a larger experience, who saw this case, expressed surprise, and said he thought it must be a rare occurrence.

The **PATHOLOGY** of acute nephritis has to do more particularly with the morbid effects produced on the epithelial lining of the malpighian

tufts, and the tubules. Exfoliation of epithelium and changes in the vascular walls permit of direct transudation of the albuminous fluid, from the vascular and lymph channels, into the tubules. The other factors are increased blood pressure and chemical changes in the blood, due to bacteria, toxines, etc.

The chief morbid element in albuminuria is serum albumin. If urine, containing this substance, be boiled in a test tube, and a few drops of dilute acetic or nitric acid be added, a cloudiness, numerous flakes, or a more or less dense coagulum is formed, according to the quantity of serum albumin present. The serum albumin present in albuminuria is derived from the blood and lymph. A small quantity may be present, as the product of suppurative processes, anywhere in the urinary tract. Several theories have been advanced to account for the presence of albumin in the urine. 1st hæmatogenous changes, which are supposed to render the albumin more readily diffusible; 2nd vascular changes, on account of which the vascular walls become more permeable; 3rd, Pressure changes, where cardiac, or vaso-motor influences increase or diminish the blood pressure.

The œdema, anasarca, or dropsy, is caused by a serous fluid, which has the following composition: 950-990 parts of water in a thousand, the remainder consisting of albumin and salts. The fluid occupies the lymph spaces of the subcutaneous, cellular tissue. It may also be found in the serous cavities, cerebral, pulmonary, cardiac, and peritoneal. In health, serum is constantly passing into the lymph spaces from the capillaries; and, as quickly, removed by the venous and lymphatic radicles. Œdema is the result of either an excessive flow of serum into the lymph spaces, or of impairment of the functions of the venous and lymph radicles. The equilibrium may be disturbed by vascular, or vaso-motor changes, the former influencing the chemical constitution of the blood, the latter the blood pressure.

PROGNOSIS. Clinical evidence and pathological research have greatly modified the grave views held by the illustrious Bright, and by physicians generally, until quite recently, in regard to the presence of albuminuria. This term, and Bright's disease, long stood for certain severe morbid lesions of the kidney. It is a well established fact now that albumin may be present in the urine without at least the gross renal lesions incident to Bright's disease. Albumen, in greater or less quantity, may be present in the urine, constantly or at intervals, in association with cardiac or vaso-motor disturbances, rheumatism, gout, lithæmia pregnancy, or during the ingestion of certain drugs. It is frequently present during the period of adolescence. Acute nephritis, apart from

any serious complication, usually terminates favorably in a few days.

TREATMENT. If we accept, and I think we can, the views now held regarding the presence of albuminuria, we at once recognize the importance of having a very general and thorough examination made, not only of the kidneys and renal secretion, but of every other condition, function and organ of the body, of patients presenting themselves with renal trouble. In acute nephritis, as in every other form of renal disease, we must bear in mind the special function of the kidney, viz., the elimination of effete and noxious products from the system. In the form of disease under discussion, this function is seriously impaired. The great object of treatment is to relieve the disabled kidneys of a large portion of their work, by securing the elimination of waste products by other channels. The skin should be kept very active by means of vapor baths of 15 or 20 minutes duration. Such a bath can be quickly extemporized by means of a wooden seated chair, a spirit lamp, and a blanket. Hot water bags, or bottles, packed round the patient are very serviceable. Saline cathartics, such as Epsom, or Rochelle salts, bitartrate of potash, etc, are generally more useful than the drastic purgatives. Small quantities of milk is the best diet. Where the amount of œdema, or effusion into the serous cavities is excessive, only a limited amount of water should be allowed as a drink. There is no drug, so far, at least, as I have had any experience, that can be safely given to lessen the amount of albumin. Such drugs as digitalis, strophanthus, caffeine, sparteine, and iron, should be withheld, or, at least, very carefully watched, as they are known to increase the amount of albumin in acute nephritis. I am satisfied the coal tar preparations should be placed in the above list. When the function of the kidneys has been re-established, the dietary may include farinaceous articles, fruit, and vegetables, and, later, the nitrogenous food. Particular directions must be given regarding the clothing. Woollens should be worn to preserve a more uniform temperature. In addition to abundance of fresh air and sunshine, ferruginous tonics may be useful in restoring the blood. Surgical means for removal of fluid from the cavities may be required.

ACUTE INSANITY FROM DENTAL IRRITATION AND TOXEMIA.

By ERNEST HALL, M.D., Victoria, B.C.

INSANITY is present in a given case when the normal harmony of the cortical intercellular metabolism is disturbed by abnormally intensified irritations, the result of the contact of nerve terminals with diseased conditions, or, metaphorically, insanity exists when the dominating and

controlling ego is subjugated and controlled by the intensity of the irritation from diseased structures. As physical disease manifests variations of intensity, often beyond our ability to explain, so will variability be characteristic of the psychic disturbance. In this connection, we may call insanity the psychic product of physical abnormality, which product is yet unknown to us, except in name and crude classification. We can approximately determine the character of the psychic phenomena, caused by some of the vegetable poisons; but we have not been as successful in similar efforts to classify the psychic expressions of the animal ptomaines. Here is a field for the expert in pathological psychology—the determination of the pathological index of abnormal cortical metabolism, in other words to evolve the psychology of the various diseases. The following case exhibits some of the psychic phenomena referred to:

Mrs. X., aged 23, married four months, excellent heredity, menstruation scanty but regular, presented a swelling over the ascending ramus of the inferior maxilla, from which an abscess had discharged into the mouth a few days previously. The teeth were badly decayed, the mouth offensively foul, temperature 103, considerable emaciation, and general sepsis. The accompanying mental symptoms were interesting, inasmuch as there was constant acute delirium. Sedatives and forced feeding were advised; and the opinion given that the cause of the trouble lay in the diseased condition of the teeth. I returned the following day along with a dentist. The condition of the patient was unchanged, the delirium having been continuous. Chloroform was administered, and the decayed molars removed. The pelvis was also examined with negative results. Upon recovering from the anæsthetic, the patient was rational, for the first time in weeks. After six hours, the delirium returned, but disappeared under forced sleep, reappearing for a few hours on each of four successive days. In fact, the mind became normal with the healing of the gums. The medical treatment consisted in stimulants, tonics, ample food, and anti-streptococcic serum. The history of the case, previous to my visit, is better given in the words of one of the attendants as follows: "Mrs. X. caught cold on the 2nd, causing an abscess of the face. On the 14th, she awoke in the night, and asked her husband not to leave her, and to protect her. On the same day, she used these words, 'I am so happy the end of the world has come,' and ran out on the street shouting. A physician was consulted, who ordered her to bed, 'saying there was an abscess of the face' During the following week, she spent the nights singing and clapping her hands, and was very restless. On the 23rd she ran to her sister's residence, over half a mile away, shouting and saying, 'someone was trying to hypnotize her and kill her sister.' The next day

she was worse and wished her husband to kill her. She would continually get out of bed, saying 'there was someone under the bed.' On the night of the 24th, she fought with everyone, tearing her hair and pulling herself to pieces generally. Two physicians then advised removal to the asylum as soon as possible, there being no other hopes for her, and made out the necessary papers for her commitment." The report of Dr. Clements, who removed the teeth, is as follows: "A number of teeth were decayed below the gum margin, with inflammation of the gums and destruction of the vitality of the pulp and nerve. In the case of the third lower molar, the inflammation had passed down through the canal at the apex, infecting the alveolar process and other contiguous tissues, causing an abscess at its root. The wide distribution of the impulse, in irritation of the inferior dental nerve, is shown by its connections with the other branches of the fifth nerve and with the sympathetic, through the submaxillary and gasserian ganglia."

Three years ago, with an experience of twenty-three cases of mental disease, I wrote the following: "Wherever from external causes outside the body, or from local physical causes, the nerve fibre is affected, sensation occurs, and there the Self is, for the time being, conscious of experience. But if the local sensation be exceedingly painful and long continued, as in a severe toothache, the harmony of the Self may be disturbed until the tooth is removed. The loss of the organ and the impairment of the function of mastication is incomparable to the benefit given to the organism and the harmony of the Self obtained by the relief from pain. With the knowledge of slight psychic disturbance, caused by brief irritations of a sensory nerve, we can easily conceive that a continuous irritation of a sympathetic nerve, though devoid of sensitive fibres, could not but act prejudicially upon the local functions and produce correspondingly disastrous results upon the Ego, without even the manifestation of a painful sensation."

To-day, with a list of ninety-five cases of mental abnormality, it is satisfactory to find not only a practical confirmation of my main contentions, but also, as in the case above reported, a verification of the theory illustrated by the hypothetical toothache.

The rarity of dental irritation, as a primary cause of insanity, is shown by the fact that I have been able to find only two other cases in my limited literature at hand. These are given by T. Lauder Brunton, who, speaking of dental irritation causing disorders of motion and sensation, goes on to say: "even the cerebral faculties themselves may also suffer from a similar cause. One or two very interesting cases of this sort are recorded by Dr. Savage in the *Practitioner* for June, 1876. The

first of these was that of a farmer, aged twenty-two, with a strong tendency to insanity. In May, 1875, he suddenly took to riding madly about the country without his coat and waistcoat. From May until November he was exceedingly noisy, destructive, untidy, almost constantly excited, and, if for a day or two he was exhausted, he was sullen and more dangerous. In the middle of November he complained of a very severe toothache that caused him to be sleepless. He bore this for two or three days, after which the stump was removed. There was suppuration at the root of the fang. From the time that the stump was extracted the patient steadily improved, and by the middle of December was quite well. Another case was that of a woman, aged thirty-four, who had a brother insane, and had herself been intemperate. She was admitted in September, 1875, suffering from acute mania. She was noisy, violent, and obscene. She continued to be so until January 20th, 1876, when she complained of great pain, with swelling and redness of her right lower maxilla. She had some bad teeth, but did not complain of toothache. The pain and swelling increased, and, at the same time, she became quiet and reasonable. She said she could not remember much of her state of excitement. The swelling of her face subsided, and she remained quite well. This case, however, was not so convincing as the first one recorded, because here there was a second cause of recovery, as she was pregnant, and said she felt quickening about ten days before her recovery. The recovery, however, was coincident with the pain and swelling of the face, and seemed, rather than the quickening, to be the cause of recovery." It is hardly necessary to comment upon the haste which too frequently characterizes asylum commitments, as this case speaks for itself. This matter will be dealt with in a future contribution.

THE SURGICAL TREATMENT OF EMPYEMA.*

BY J. L. TURNBULL, M.D., Clinton, Ont.

I DO not propose to-day to give you any lengthy dissertation on the subject "The Surgical Aspects of Empyema," as empyema is being also taken up on the medical side, and I presume all that pertains to the history, the etiology, the pathology and the treatment of the disease will be dealt with there. I will therefore take the case only from the time it falls into the hands of the surgeon. I might be allowed to state, however, that this disease, or collection of pus, often comes on insidiously, especially in children. A child may have typhoid fever, measles, whooping cough, scarlet fever or any of the diseases common in childhood; the illness,

* Read before the Huron Medical Association.

perhaps runs an ordinary course, but afterwards the child does not do well, it begins to lose flesh, looks pale, there is poor appetite, languor, some fever, sweats, and it is altogether miserable. These cases should be examined very closely for a collection of pus; and, by a careful examination of the chest, you may run across an empyema. The diagnosis of empyema belongs perhaps to medicine, but in any suspected case it does no harm, if strict antiseptic precautions are taken, to put in an aspirating needle and remove some of the fluid. When the presence of pus is determined, it should be evacuated at once, as there is always the danger of the abscess bursting into the chest, or through the chest wall, or even through the diaphragm, causing peritonitis. I saw one case where it had been left so long that there was quite extensive necrosis of two ribs, and the pus was pointing on the chest wall. That, I think showed gross carelessness, as it ought never to have been allowed to reach that stage. Now, whenever the diagnosis is clearly established, we must get rid of the pus, and this may be done by aspiration, by simple incision between the ribs, or by incision and the removal of a portion of bone; and, in nine cases out of ten, the last is the correct method.

Aspiration is performed in the way that is too well known to require any description. The only point to remember is not to remove the fluid too rapidly, in order to obviate the danger of pulmonary irritation or hemorrhage from the rupture of a vessel.

Aspiration in these cases very often fails, because the pus usually collects again; or, being often curdy, it will not pass through the needle. The second way is by incision. Now, in opening an ordinary abscess, one usually tries to get at the lowest, or most dependent part, to secure free drainage. This obviously would not do in an empyema, because it would call for the opening as far back and as low down as possible, which is not the best place. If too low down behind, the chest falls in and the viscera rise up, stopping the hole. The opening must be at least two or three inches above the lowest point of the pleural cavity. There is danger of wounding, or puncturing, the diaphragm if the incision is too low down. It is not necessary to have it so low, as we can get perfect drainage higher up. I saw one case where the surgeon, in trying to get as near as possible to the lower part of the cavity, cut into the diaphragm, opening both into the chest and the abdominal cavities. Peritonitis ensued and the child died, whereas its life would surely have been saved had the opening been higher up. The points usually chosen are the space between the fifth and sixth ribs, an inch and a half in front of the mid-axillary line, or the eighth or ninth intercostal space, just anterior to angle of the capula. The operation is a simple one. The parts are made perfectly

aseptic, the patient is put under an anæsthetic, an incision is made through the skin and muscles, and then through the pleura, or a director may be thrust through the pleura, dressing forceps being passed along the director and widely opened.

The preferable method and the one which I always adopt, after the diagnosis of pus is made, is to remove a portion of a rib. In this operation an incision is made directly down on the rib. A horizontal and two transverse incisions are made through the periosteum, which is raised with a rugine and a piece, say an inch and a half, of the rib is cut out, either with the saw, the preferable plan, or with the bone forceps. Strict antiseptic precautions must be taken in this operation. After removal of the rib, the portion of periosteum should be cut out, then a drainage tube, or double tube, inserted, with side openings only in the outflow tube. The cavity is washed out with sterile water. Washing out should be done every day, if the pus is offensive, and the tubes gradually shortened, until they can be removed altogether. There are a few cases where a cavity and sinus remain after the above operation, the lung not expanding sufficiently to meet the infalling ribs. The sinus may become closed, and there is the formation of a second empyema. In these cases we should at once do either Estländer's operation, or a modification of it. One of the best methods is to carefully locate the size and boundaries of the cavity with a probe, then to dissect up a flap of skin over the whole extent of the cavity, removing portions of third, fourth, fifth and sixth ribs—the length of the pieces removed and their number depending on the size of the cavity. The only thing is, be sure to remove enough. There is in these cases always a quantity of hard, fibrous tissue beneath the ribs, and partly filling the space. This must all be very thoroughly removed, the whole cavity mopped out with pure carbolic acid, then with alcohol, to prevent carbolic acid poisoning, and finally with pure sterilized water. The cavity is carefully dried. The skin flap is fitted over the surface of the pleura and stretched around the edge, and a drainage tube put in the most dependent part.

HYSTERESTOMY FOR UTERINE FIBROIDS.

By N. E. MacKAY, M.D., M.R.C.S., Eng.

Senior Surgeon Victoria General Hospital, Halifax; Professor of Surgery, Halifax Medical College.

R F. C., single, age 30, was admitted to the V.G. Hospital on June the 25th, 1901, suffering from uterine Myomata (fibroids).

History.—Born in Lunenburg Co. She had all the ordinary diseases of childhood, worked on the farm in summer and made shoes in winter, and

had always been healthy with exception of present illness. She began to menstruate at 17, and was always regular. Had no pain with her sickness till 2 years ago.

The present trouble began 4 years ago, when she noticed a lump the size of a hens egg, which was quite moveable, on the left side of the abdomen. Also she began to have bearing down feelings, like weight in front of the abdomen; menstruation kept regular and without much pain for 2 years. The tumor kept slowly increasing in size till four months ago when it took on a more rapid growth. At the end of two years her menstrual periods became painful but not irregular.

Patient's general health is good. Respiratory and circulatory systems normal. Urine normal. She has some frequency of micturition.

Examination of the Abdomen.—There is a solid tumor about the size of the patient's head in the mid line in the lower part of the abdomen, more moveable to the left than to the right. It is quite free and not nodular. It extends a little more to the right than to the left of the middle line. The colon can be traced above but not over it. The flanks are tympanitic. There is no glandular enlargement. Menstruation is regular every four weeks, lasts for 6 days and is very painful for 4 days before, and 2 days after menstruation is established; always has an inter-menstrual discharge of a creamy character.

Exam. in G. O. Room.—Cervix very thin and drawn up beyond reach of the finger and pushed to the right by a tumour to the left of the vaginal wall. Two tumours are present. The upper, the larger, is slightly moveable over the lower which is fixed and extends downwards $\frac{2}{3}$ the length of the vagina. It is about the size of a cocoa-nut. The former is in the body of the uterus and the latter apparently in the cervix. The sound passes into the uterus 3 inches and its point is easily felt through the abdominal wall, right side.

July 4th. Operation: Hysterectomy. Patient prepared as usual. Vagina douched with bichloride 1-1,000, and iodoform tampon inserted. The abdomen sterilized in usual manner. Ether the anæsthetic used. An incision 5 or 6 inches long was made in the median line and the abdomen opened. The tumour which was pinkish in colour presented itself. The upper and larger part of the growth was above the pelvic brim, the lower and smaller within the pelvis. The tumour was now pressed out through the abdominal incision and the ovarian arteries and round ligaments were secured by double ligatures and divided. The broad ligaments were separated and the right uterine artery tied. The peritoneum on the anterior and posterior surfaces of the uterus was gently peeled off on a level with the internal os. The larger growth

which embraced the uterus was now lifted up and the lower one which involved the cervix, was carefully dissected from its position in the pelvic cavity. This done the cervix was divided on a level with the internal os and the tumour removed. The left uterine artery was now secured. Patient lost very little blood, not more than an ounce or two. The cervical canal was then swabbed with pure carbolic acid and alcohol, and a narrow strip of gauze inserted for drainage. All bleeding points being well secured and the abdominal cavity freed of blood, the pelvic peritoneum was stiched over the cervical stump. The abdominal incision was closed with 3 rows of sutures. The ligatures used were sterilized silk except in closing the skin incision. Here silk worm gut was used. Dressed the wound aseptically and sent patient to ward 65 in very good condition. Time, one hour.

After progress, uneventful. No vomiting after anæsthetic. Highest temp. 100°, quickest pulse 96. This was at 6 p.m., day of operation. After this temperature did not go over 99, nor pulse over 78. Was fed exclusively per rectum for the first 24 hours. For the next two days she was given soft diet. Bowels moved on 2nd day with calomel and enema. After the third day she was allowed to return gradually to solid food. Changed dressing.

Spread of Typhoid Fever.

Dr. W. H. Corfield, in his Milroy Lectures on typhoid fever, adduces evidence to show that the disease may be spread by foods and drinks, as oysters, mussels, cockles, fish, ice-cream, milk, water, ginger beer made from polluted water, raw vegetables washed with polluted water or from homes with typhoid. Then sewer air may be a direct cause of the infection. Outbreaks of the disease have been traced to conditions where the sewer air makes its way into the houses. Other sources for the infection had been carefully sought for and never found, except the sewer air entering the dwellings. With regard to personal infection, strong evidence is collected to show that typhoid fever may be communicated from the patient to those in close contact with him. This view is contrary to much of the present-day teaching, but the lecturer advances cogent reasons for its acceptance. Another source of infection, revealed by the study of the disease in South Africa, is the fly. During the cold months, when flies do not abound, the disease abates, and spreads again in the hot months. The cold in itself does not affect the bacillus.

CURRENT MEDICAL LITERATURE.

Conducted by A. J. MacKESZIE, B.A., M.B.

TINNITUS AURIUM.

IN the March Laryngoscope, Harris in discussing the therapeutic treatment of Tinnitus Aurium, places the drugs in the following order of merit, Strychnine, Iodide of Potash, Nitro-glycerine, Tinc. Gelsemium, Bromide of Potash, Tinc. Digitalis. Strychnine was given in one-sixtieth grain doses before meals. Relief more or less temporary was obtained in 41 per cent of the cases. Nitro-glycerine was prescribed in doses as high as 20 minims per day, in cases marked by a high tension of the arterioles. Aconite, Atropine, and Arsenic gave negative results, and Bromide of Potash, and Hydrobromic Acid were without a single exception disappointing.

DR S. LEDUC, of Nantes, has introduced a specially constructed glass tube for the inhalation of powders into the larynx, which consists of a glass tube of about six inches in length, bent at one end into a crook of about half an inch, while 2½ inches of the other extremity are bent downwards at an obtuse angle. The short crook, lying downwards, is pushed by the patient to the back wall of the pharynx, and the opposite extremity is allowed to dip into a small quantity of light powder in a watch-glass or plate; the patient then closes his lips and draws in his breath rapidly through the tube so as to inspire some of the powder. This, following the inspiratory blast, finds its way, according to the inventor of the method, into the larynx. It is a method of great simplicity, and has the advantage that it can be carried out by the patient himself under the direction of his medical adviser.

ACQUIRED DEAF MUTISM.—DUE TO IMPACTED CERUMEN.

AN interesting case of this was presented before the British Laryngological Association in January. The child, female, aged nine, had a virulent attack of measles at the age of three without any ear symptom. This was followed by signs of deafness, and with the increasing deafness power of uttering intelligible sounds had diminished, until the vocabulary was limited to a few sounds such as "Mummy," "More," "Pese." Unless the child was previously looking at the ques-

tioner it was necessary to touch her before interest could be aroused. The board school had refused her admission. The family history and the appearance of the child afforded no clue. On being spoken to in a loud voice she answered no questions, and did not utter a sound. Noises made behind her had no effect. The appearance of the ear and throat was normal, but the auditory canal was rather long, and unusual in its curve, making it difficult to obtain a view of the membrane tympani. In each ear in contact with the membrane there was found a hard, inspissated mass of cerumen of old standing, which was removed with difficulty, and the membrane itself proved to be retracted, somewhat opaque, but otherwise healthy. The improvement in hearing and speech which gradually followed was quite marked, and the prognosis was excellent.

LINGUAL VARIX.

MR. LENNOX BROWNE presented this subject, and showed five cases before the British Laryngological Association in January. Most of these complained of some cough of an irritating character, with occasional traces of blood, or with a taste of blood in the mouth on waking. In four cases either rectal hæmorrhoids or obstinate constipation were present, and in the fifth the patient had varicose veins of the foot and ankle. Most of the patients suffering from the disease are somewhat neurotic, especially those of the female sex, but only a small proportion will get well of themselves; and, if treatment be neglected and their sufferings ignored, there is apt to be generated a certain amount of melancholia and hypochondria, with a development to reflexes of apparently impossible relationship. In this connection Mr. Mayo Collier referred to a case of severe dyspnoea, with emaciation and loss of strength, where the cauterization of a varicose and enlarged condition of the veins at the root of the tongue and a marked fullness of the lingual tonsil had afforded complete relief. The patient had become a source of great anxiety to her friends, and had consulted many physicians in vain. Lingual Varix is often overlooked and its importance unduly minimized, but it may be a source of great discomfort, and may tend to grave pathological conditions in the upper air passages.

INTESTINAL OBSTRUCTION TREATED WITH QUICKSILVER.

The *British Medical Journal* for April 26th, has a report of two cases of intestinal obstruction treated successfully by J. M. Harrison, by means of quicksilver. The first case was in a man 60 years of age, in

whom the symptoms followed a fall and increased in spite of all medical assistance for a week, the friends refusing surgical interference, until as a final resort Dr. Harrison administered $\frac{1}{2}$ -lb. of quicksilver, accompanied by opium. The following morning the patient felt better, was able to take and retain some nourishment, the distension disappeared and the bowels which had been quite obstinate were moved. The mercury came away ten days after administration. The second case was in a man over 80 years of age, in which the diagnosis was made on the symptoms pain, fever, distension, vomiting, obstinate constipation. There was no possibility of an operation, and so on the fourth day $\frac{1}{2}$ -lb. of quicksilver was given, the bowels moved about twelve hours after, the distension was reduced and he was able to take nourishment. Twelve days after the mercury was passed, and he made an uninterrupted recovery.

In neither case was there the slightest symptom of mercurialism, nor increase of abdominal pain. The writer had no hesitation with regard to his diagnosis, and is strongly of the opinion that in cases such as described that the treatment is worthy of trial.

DEFLECTION OF THE SEPTUM.

IN the March Laryngoscope, Chevalier Jackson, in discussing the causes of the frequent failure of corrective operations, advances a somewhat remarkable theory, and an equally remarkable line of treatment. According to this theory, the inferior turbinated body on the concave side of the deflection swells up during sleep, and pushes the straightened septum over to the opposite side, thus restoring the statu quo. The offending turbinal is one which during the day time, or when under observation is apparently of small size and incapable of any such surreptitious design upon the good work effected by the surgeon. Dr. Jackson traces however, upon the septum a species of facet formed by the intermittent pressure of this turbinal and has surprised if often in flagrante delicto, his experience being that such a turbinal having had its own way so long owing to the curvature of the septum is capable of developing great strength and size and pressure power. Were it not for this action the septum being once replaced it would become quite unnecessary to support it by means of a splint, or even of packing to hold it in its new position. The remedy proposed by Dr. Jackson is to say the least radical, for to use his own words, "we must prevent the failure of our corrective operations by preceding every operation for deviation by a turbinectomy or a very radical turbinotomy of the inferior turbinal on the concave side."

The experience of those who are constantly performing one or other

of the many operations for deflected septum will hardly bear out Dr. Jackson's sweeping assertions, or be favourable to so drastic a treatment. Certainly care should be taken to keep the concave side quite patent and any obstruction must be freely removed, but when we have said this we have said all. Surely it is wiser to await the after results of operation and to take the measures then required, rather than to offer so large a discount in advance, as is involved by a turbinectomy. The term failure would seemingly require definition. An absolutely straight septum is perhaps seldom obtained, but is nevertheless seldom required, so long as all obstruction to perfect nasal breathing, and the performance of the nasal functions is removed.

The above sweeping statement of Dr. Jackson would seem to be of the mischievous variety.

SADDLE NOSE.—TREATED BY SUBCUTANEOUS INJECTION OF VASELINE.

THIS ingenious treatment of a disfiguring condition which causes so much annoyance and is so difficult of remedy, was first prescribed by Gersuny, of Vienna, and cases illustrating its usefulness were recently presented before the Laryngological Society of London by Dr. Bronner and by Dr. Scanes Spicer, whose portrait, by the by, has been so strikingly reproduced by Vanity Fair among its cartoons of prominent men. The patient of Dr. Spicer had a well-marked, tip-tilted saddle nose, and stunting of the nasal framework, with crescentic wrinkles from eye to eye over the bridge of the nose. The paraffin used was a mixture of hard and soft paraffin made to meet at 40° C., previously sterilized. The syringe and needle were boiled in the sterilizer, which at the same time acted as a water-bath to heat the paraffin. The syringe, an ordinary hypodermic, was removed from the socket in the needle for refilling, which once in situ was allowed to remain there until it was judged that enough vaseline had been injected at that spot. Some ten or twelve syringefuls were injected in various directions into the depressed gap, and the injected matter moulded by the fingers, so that the part became shaped before setting occurred. There was no pain or reaction at the time, but after a few days some oedema of the upper eyelids appeared in the one case, and some inflammation of the nose in the other, in neither case, however, attended by any evil results. In Dr. Spicer's case, the patient's mother was "proud of her in her altered condition," and the skin over the bony bridge of the nose being bolstered up, presented a very respectable organ. In Dr. Bronner's case, the nose was very much

harder than in the one above referred to, but equally satisfactory. Care evidently requires to be exercised to prevent the paraffin forcing its way into adjacent tissues, as the eyelid, and for this purpose it has been recommended to exercise firm pressure upon the root of the nose, by means of a piece of lead sheeting applied to it and the parts adjacent. This pressure being kept up for some time afterwards, as the action of the muscles, such as the pyramidalis nasi, requires to be controlled. No anaesthetic is needed, but cocaine may be injected if the patient is nervous. The obstacle most difficult to overcome in this connection is the rapidity with which "setting" occurs, the small amount of paraffin required conducing to this. If by some means this can be prevented until the nose be moulded into the exact shape desired, this new "plastic" operation has almost unlimited possibilities before it, and the ancestral nose can be brought forth with as great ease as the genealogical tree with which it must go.

THE ETHIOLOGY OF CANCER.

THE April number of the Journal of Medical Research contains the Second Annual Report of the Cancer Committee to the Surgical Department of the Harvard Medical School, under six headings, as follows.

I. Coccidium infection of the Rabbit's Liver, by E. E. Tyzzer: the results of this investigation briefly is as follows:

1. Associated with certain lesions of the liver in the rabbit are found parasites, of varying form and character.

2. The various forms represent the life cycle of a definite species of sporozoon, *Coccidium oviforme*. The necessary stages of the life cycle are traceable

3. In only one stage does the parasite resemble the cell-inclusion of cancer. Even this stage presents a definite and constant morphology.

4. The immediate effect of the parasite upon the host is to produce degeneration and destruction of the epithelial cells of the bile-ducts. Further results are seen in proliferation and cirrhosis.

5. Repair is effected through the walling off of the process by connective tissue, by the destruction of the remaining parasites, and finally by cicatrisation.

On the whole the changes are those of a chronic inflammatory nature and do not indicate any relation to the cell inclusions of cancer.

The second paper is on the subject of *Molluscum Contagiosum* by Charles J. White and W. H. Robey, Jr. It has been held by some observers that this skin lesion was due to a protozoon, but the conclusion here arrived at is that it has not been demonstrated that there is any

parasitic growth in the body and that the change is not a colloid or hyalin degeneration, but rather a metamorphosis of rete cells into keratin; and is not analagous to the lesion seen in cancer.

The third paper is entitled "Culture experiments with Malignant Tumors, by Oscar Richardson, in which the results of twenty-four inoculations, variously distributed among eighteen different media, are tabulated, and not a single case of growth of culture is found, being a strong argument against the existence of a specific infecting organism.

The fourth paper deals with four pathogenic *Torulæ*, which represent the most common species of these forms of plant growth, and which were examined by Joseph D. Weiss, in order to ascertain if any of them had characteristics suggesting the forms found in cancer. These were the organisms isolated by Sanfelice and Klein and which according to their theory were the cause of cancer.

These were found on examination to be *torulæ* and *saccharomycetes*; and as *torulæ* are to be found everywhere in the air and earth it is not surprising that they should be found associated with cancer.

In the fifth paper, Edward H. Nicholls examines the relation of *blastomycetes* to cancer, and as this is the most important of the investigations at least from the practical standpoint we give the conclusions more fully.

1. Certain *blastomycetes* can live and multiply in human and animal tissues, produce local lesions and metastases in the internal organs, *i.e.*, they are pathogenic.

2. The lesions produced in animals by spontaneous infection with *blastomycetes* are acute inflammations, abscesses or nodules of peculiar granulation tissue, and are not in the least analagous to cancer?

3. The lesions produced in human beings in cases of spontaneous infection with *blastomycetes* are acute inflammation (abscesses or ulcers) or proliferation of endothelium and connective tissue. At times a proliferation of the epithelium does occur but it is not due to the action of the *blastomycetes*, but is secondary to the chronic inflammation of the underlying corium. This proliferation of epidermis is not analagous to the proliferation of epithelium seen in cancers, since no epithelial metastases occur.

4. *Blastomycosis* in human tissues is very rare.

5. The lesions produced in animals by experimental inoculation with *blastomycetes* are, with the exception of Sanfelice's successful cases, inflammations or nodules of peculiar granulation tissue. Sanfelice's cases are not conclusive in themselves, are in direct opposition to the results obtained by all other observers, and, even if true, are logically explained as coincidences and not as results.

6. Blastomycetes, as a rule, cause marked proliferation of tissue, and little infiltration with leucocytes; *i.e.*, their toxic powers are small.

7. Blastomycetes primarily extend along lymphatic clefts and vessels.

8. Rarely in human beings, more frequently in spontaneously infected animals, blastomycetes may be taken into the blood vessels, disseminated throughout the body, and produce a general infection and metastases.

9. The secondary nodules have the same character as the original nodules, *i.e.*, formation of granulation tissue.

10. The morphology of the so-called cancer bodies is not the same as that of the blastomycetes.

11. Blastomycetes are not constantly present in human malignant tumors and cancers.

12. Even if blastomycetes do occur in human cancers, they are not present in such numbers and in such a relation to the anatomical lesion as to justify the belief that they are the cause of the disease.

In the sixth paper, R. B. Greenough discusses "cell-inclusions," and gives the weight of his opinion derived from a careful investigation, to the support of the theory that these bodies are due to secretion, and not to degeneration, or to metamorphosis of the protoplasm.

On the whole, the report represents much careful and intelligent work, and, if it does not solve the vexed problem, it at least assists in clearing the way for further investigation.

Parasitic Origin of Cancer.

At the recent German Surgical Congress, held in Berlin, Professors Gussenbauer and Kahlden discussed the nature of cancer. Prof. Gussenbauer said that he was convinced of the parasitic origin of cancer. This view explained its local nature at first: the constitutional symptoms at a later stage; and the tendency to return, some parasitic infection being left. On this subject it may be appropriate to quote the words of John E. Erichsen in the seventh edition of his "Surgery," 1877: "Cancer appears to be a disease favored by, if not actually dependent on, the aggregation of individuals under the influence of an advanced civilization. Amongst savage tribes, as amongst wild animals, it is unknown. In the great centres of civilization, as amongst domesticated animals, it abounds. This circumstance points certainly to the possibility of there being a parasitic origin for the disease—to the possibility, in fact, of its being originally an organism that has entered the body from without. Of this, however, we possess as yet no evidence." It will be seen that twenty-five years ago, on clinical grounds, Erichsen was anticipating the work of to-day.

PROVINCE OF QUEBEC NEWS.

Conducted by MALCOLM MacKAY, B.A., M.D., Montreal.

THE tenth regular meeting of the Montreal Medical Society was held on May 16th. Dr. James Stewart brought forward a living case of cerebellar ataxia. This patient, a male aet. 15, had always been a delicate child but exhibited no definite symptoms of the disease until about two years ago, when he began to have difficulty in walking. This difficulty was first noticed when attempting to run, but very soon the patient had to leave school because he was unable to walk any distance. He managed to do light work for about a year but about two months ago found that he could not go upstairs without losing his balance and from that time has been under a physician's care. The family history showed nothing pointing to a predisposing factor, no other member of the family having suffered from any nervous disorder. It may be mentioned that the patient has a brother and sister younger than himself who are in perfect health. The general appearance of the patient gave one the impression that he was rather deficient in intellect, but on questioning him his memory proved to be good and he was certainly quick at figures. His gait was the characteristic staggering progression of cerebellar disease and he could only walk for a short distance without support. His feet showed a marked condition of 'pescavis.' Both knee jerks were increased and Babinski's sign was present together with ankle clonus on the right side. Sensation was normal throughout, and although there was a marked weakness of the right external rectus muscle, the pupils reacted to light and accommodation. Dr. Stewart considered the case to be one of Friedrich's ataxia of the so-called cerebellar type.

Dr. Finley then read a report of a case of myasthenia gravis. The pharynx and tongue were the portions chiefly involved. A lively discussion followed the reading of these case reports.

Dr. Robertson followed with a paper on the use of hyoscine before the administration of ether. He considered that it was of great value in diminishing the mucus secretion and preventing subsequent vomiting. He had only used it in a limited number of cases and did not think that general conclusions could be drawn from his experiments, but from his experience he thought the drug worthy at least of a trial and asked the members present to bring forward cases in order that a larger series might be made up by which he might check his results. Dr. C. G. Camp-

bell stated that he had used a number of drugs in this connection with varying success but that he had never thought of hyoscine and he did not see how any of its properties would enable it to attain the desired end.

Dr. Cushing gave a summary of a number of cases of pulmonary œdema which had been noted at the Royal Victoria Hospital. The treatment was discussed and he stated that although morphine was considered by some to be contraindicated, the only recorded cases of recovery in his series were those in which this drug had been used. Dr. Lafleur advocated the use of morphine, and illustrated the effects following its administration by citing several cases occurring in his wards at the Montreal General Hospital.

At the meeting of the Society on June 6th, Dr. Hutchison showed an enterolith, which had been the cause of obstruction in the sigmoid flexure of a female patient. About eight years ago this patient had a severe attack of biliary colic in which there was no jaundice but extreme pain. From that time until February, 1902, the patient continued to be in good health, when suddenly she was seized with severe abdominal pain. Purgatives did not relieve the condition and the abdomen became distended. Rectal examination revealed nothing, but it was found that a rectal tube met an obstruction in the sigmoid flexure. Bimanual manipulation eventually dislodged the enterolith and with it came away another smaller stone together with a quantity of blood and mucus. Examination proved that the stones were undoubtedly of biliary origin. In discussing the case Dr. Finley, who had been called in for consultation, thought it probable that the stones had ulcerated directly into the large intestine, for otherwise there would likely have been symptoms pointing to partial obstruction, at least, had they passed through the whole length of the small intestine, and again the absence of jaundice rather favored this conclusion.

Dr. Deeks read a short report of a case of angioneurotic œdema which affected the tongue as well as the parotid and submaxillary glands. On being called to see the patient he found her in a most alarming condition. Her eyes fairly bulged out of her head and the cyanosis was extreme. The patient was gasping for breath and appeared to be *in extremis*. A hypodermic of morphine and atrophine gave almost immediate relief, and within fifteen minutes the patient was quite comfortable. The past history of the patient showed that she was subject to attacks of asthma with coincident urticaria. Dr. Bickett mentioned a case in which the nasal mucous membrane became engorged and the breathing labored. A laryngeal examination showed that there was no œdema above the

cords, but that the tracheal mucous membrane was intensely injected, to such an extent indeed, that the breathing was of a distinctly croupy character. In this case also an injection of morphine gave almost immediate relief. Dr. Shines then read the report of a case of probable hæmorrhage into the grey matter of the right anterior horns, in the sixth and seventh cervical segments, followed by symptoms of Brown-Sequard's paralysis. The paralysis followed a febrile attack of some three weeks' duration which was supposed to be typhoid fever, although no widal reaction was present. The paralysis was right-sided and the sensory disturbances were confined to the left side. All the deep reflexes were increased, thus showing that the upper motor neurons were involved, and again, the reaction of degeneration was found in several individual muscles paralyzed side pointing to a lower motor neuron degeneration. Dr. Shirres accounted for the symptoms by a hæmorrhage in the anterior horn extending to the lateral descending tract of the same side. Dr. Finley thought that an inflammation extending over the same area would also account for the condition, and pointed out that the febrile process preceding the nervous symptoms would make this diagnosis still more probable.

The fifty-eighth annual meeting of the American Medico-Psychological Association is to be held in the Windsor Hotel, Montreal, on June 17th, 18th, 19th and 20th. Dr. J. R. Preston will deliver the presidential address on the morning of Tuesday the seventeenth, the evening session beginning at 8 p.m., when the first series of papers will be read. On Wednesday morning the report of the council will be received and this will be followed by the election of officers and other necessary business. McGill University will be visited in the afternoon and an informal luncheon will be served in the medical building by the members of the Montreal Medico-Chirurgical Society. At 8 p.m. the annual address will be delivered by Dr. Wesley Mills of McGill University. Thursday morning and afternoon will be devoted to the reading of papers, while in the evening a reception will be held for the visiting delegates by the board of management of the Protestant Hospital for the Insane. Friday will be given up to business and memorial notices. Between the regular sessions numerous entertainments for the delegates have been arranged for by the various medical societies of the city.

Another important meeting which is to be held this month is that of the French Association at Quebec, on June 25th, 26th and 27th. This recently formed society will meet in the buildings of the University of

Laval, where papers will be read and discussed under four headings: Surgery and specialties; Medicine, including mental diseases; Gynæcology and obstetrics; Hygiene and professional interests. The whole of the proceedings will be conducted in the French language.

The annual report of the Royal Victoria Hospital has just been completed. It shows that there were 2,879 patients admitted to the wards and 3,651 treated in the out patient department. The death rate for the year is 4.42 per cent., or deducting those dying within 48 hours of admission, 3.54 per cent. The report draws attention to the X-Ray Department which has been equipped with a very complete installation, also to the isolation pavilion which has been so designed as to afford accommodation for four different diseases being treated at the same time without danger of intercommunication. A detailed statement of the cases treated in the various departments follows the superintendent's report, and the records of the pathological department are also published, including a succinct account of each autopsy performed.

Interstate Licenses.

In the United States there is much discontent with the present system of licensing medical practitioners. A license from one state is no good in another. It is urged in some quarters that the general government should take the matter in hand. It is argued that this would be an interference with state rights. Dr. W. L. Rodman, of Philadelphia, is urging the formation of "a Voluntary Board of National Examiners." The certificates from this Board would be of such a high standard as would command the respect of the several states, and enable the holder of such certificate to register and practice. The same trouble exists in Canada. Each province has power to regulate its own educational affairs. A qualification, no matter from what body, does not entitle the holder to practice in another province. This condition has caused much inconvenience in the past. During the last session of the Federal Parliament, Dr. Roddick, of Montreal, introduced a bill to overcome these difficulties. It was passed by both the House of Commons and the Senate. As soon as the several provinces agree to the bill, there will be a common standard for the entire Dominion. It is hoped this will not be long delayed by any of the provinces declining to accept the terms of the bill.

MARITIME TOPICS AND NEWS.

Conducted by W. D. FORBES, M.D., Can., L.R. C.P. Lond., M., R. C. S. Eng., B.Sc. Halifax.

THE Board of Governors of Dalhousie University on the recommendation of the Medical Faculty have appointed Dr. Murdoch Chisholm, of Halifax, Examiner in Clinical Surgery. Dr. Norman F. Cunningham, of Dartmouth, Examiner in Clinical Medicine, and Dr. Hector H. McKay, of New Glasgow, Examiner in Materia Medica and Therapeutics, the latter to fill the vacancy made by the death of Dr. William S. Muir, of Truro.

The corner stone of the new Halifax Infirmary was laid by His Grace the Archbishop of Halifax on April 30th. The building is of pressed brick with granite facings, and when completed will be an ornament to the city. It is to be fitted up with all the modern improvements, and will be up to date in every particular. The operating room is to be built and equipped, as a memorial to the late Dr. Edward Farrell, who was always deeply interested in the welfare of this institution.

Halifax N. S. has recently been called upon to mourn the loss of one of its most prominent citizens Mr. James T. Hamilton. Up to a few weeks before his death Mr. Hamilton was mayor of the city—a position which he filled with credit to himself and to the satisfaction of the citizens—on three different occasions. Mr. Hamilton's death at the early age of 51 was due to malignant disease of the throat and during the last few weeks of his life his sufferings were, we are informed, intense. His will—made several days before his demise—is one which wealthy men in the Maritime Provinces might well take cognizance of. The concluding paragraph of the will is as follows.

“And whereas, I am desirous of helping to alleviate the sickness and suffering of deserving poor in the city of Halifax, I hereby will and direct that the said executors and trustees of this my will, after the decease of my mother, and after paying in full all the legacies and sums of money herein before in this my will provided to be paid, shall pay the residue or remainder of my estate to the Halifax Visiting Dispensary, said residue or remainder to be applied by said Dispensary with special attention to the relief of malignant diseases of the poor and the purchase of scientific apparatus and medicines to assist in the alleviation of same and in the curing of said malignant diseases.”

The 34th annual meeting of the Nova Scotia Medical Society will be held at New Glasgow on July 2nd and 3rd. The president of the Society is Dr. John McKay, of New Glasgow—the secretary Dr. John Stewart of Halifax.

The address in Medicine is to be given by Prof. F. G. Finlay, of McGill University, that in Surgery by Prof. Armstrong of the same institution.

Besides the above there will be a Discussion on Vaccination in which Drs. A. P. Reid, A. Halliday and M. Chisholm will take part.

Dr. H. H. MacKay, of New Glasgow will read a paper on Insomnia, with some suggestions for treatment. Dr. Farrell, of Halifax will give a report on cases of Supra-pubic cystotomy and abscess of the Lung.

Many other papers have been promised some of which are as follows:

The treatment of Puerperal Sepsis, Ernest Kendall, M.D., Sydney. Mental Disturbances during the Puerperium, W.H. Hattie, M.D., Halifax. A short report on two unusual cases, J. N. Mack, M. D., Halifax. Gall Stone Diseases, M. A. B. Smith, M. D., Halifax. Notes on Smallpox, W. B. Moore, M. D., Kentville. Some indications for the use of Arsenic and Sodium Benzoate, E. Kennedy, M.D., New Glasgow. Senile Peritonæal Tuberculosis, A Birt, M. D., Berwick. Albuminuric retinitis, Geo. Cox, M.D., New Glasgow. Notes on treatment of Enuresis, D. A. Campbell, M.D., Halifax. Examination of Water, chemical and bacteriological, A. Halliday, M.D., Halifax.

Previous to this year, the Nova Scotia Medical Board required of men wishing to practice medicine in the province, a certificate that they held a diploma from a recognized University or Medical School. Four years ago a bill passed the Provincial Legislature, making it compulsory for these gentlemen to pass an examination set by the Medical Board. This law comes into force on July 1st.

The examiners appointed under the Act for 1901 and 1902 are : S. A. Morton, M.A., Halifax, Karl Weatherbe, Windsor, Examiners in Physics ; G. T. Kennedy, Windsor, E. McKay, Ph. D., Halifax, Examiners in Physics ; F. W. Anderson, M.D., Halifax, J. G. McDougall, M.D., Amherst, Examiners in Anatomy ; H. H. Mackay, M.D., New Glasgow, L. M. Silver, M.B., Halifax, Examiners in Physiology ; W. B. Moore, M. D., Kentville, M. A. B. Smith, M.D., Halifax, Examiners in Materia Medica and Therapeutics ; C. E. McMillan, M. D., Whyteogate, C.B., A. P. Reid, M. D., Kentville, Examiners in Medical Jurisprudence ; W. H. Hattie, M. D., Halifax, J. A. M. Hemmson, M.D., Bridgewater, Examiners in Pathology ; M. A. Curry, M. D., Halifax, W. S. Muir, M. D., Truro, Examiners in Obstetrics and Diseases of Women ; N. F. Cunningham, M.D., Halifax, A. J.

Cowie, M.D., Halifax, Examiners in Medicine; J. F. Black, M.D., Halifax, N. E. McKay, M. D., Halifax, Examiners in Surgery; Dr. H. H. Read, Halifax; Homoeopathic Examiner.

PERSONAL.

Dr. M. A. Curry of Halifax, has been appointed to the medical staff of the coronation contingent. He left a few days ago to join it at Quebec.

Dr. John Purcell has been appointed assistant city medical officer of Halifax. This is a new appointment, the work having previously all been done by the one man.

Dr. D. N. Morrison, late of Oxford, N.S., has, owing to ill health, given up practice for a time, and intends spending the summer in Halifax.

Dr. J. G. McDougall of Amherst, who has been confined to his house for some weeks back, is, we are glad to say, able to be about again.

Dr. George Gandier of Picton, was married on June 5th to Miss Annie Dickson of St. John. Dr. Gandier and bride left immediately after the wedding on a tour through Canada.

Dr. L. M. Crosby of Yarmouth, has recently returned from London. While in that city he devoted his attention to the eye, ear, nose and throat. Dr. Crosby intends practising his specialty in Charlottetown, P. E. I.

Safety of Chloroform and Ether.

Drs. Crouch and Corner, in the LANCET for 24th May, enter fully into this interesting subject. They arrive at the conclusion that chloroform is safer than ether as a general anaesthetic. They show that after the administration of ether there is, on an average, one case of respiratory inflammation in every 240 cases of ether anaesthesia. Such is not the case after chloroform. There is one death in 3,000 cases of chloroform anaesthesia. In ether there is one in every 2,400 cases. In chloroform, the death occurs during anaesthesia; whereas in ether it is after the administration. When all the facts are fully considered, ether has no advantages over chloroform.

MILITARY MEDICAL TOPICS AND NEWS.

Conducted by Lt.-Col. Nattress, P.M.O. M.D. No. 2.

The following extracts are taken from a letter received by me a short time ago from Capt. J. A. Roberts, 10th Canadian Field Hospital, Field Forces, South Africa :

IN CAMP AT DRISKINS,
GENERAL KITCHENER'S COLUMN,
April 10th, 1902.

DEAR DOCTOR NATTRESS,—

Nothing of particular interest transpired during the trip, bar the development of four mild cases of small-pox. The daily monotony of sea was occasionally varied by the appearance on the horizon of a sail. Once we saw a whale, but every other denizen of the deep kept in seclusion. We anchored in Table Bay in about twenty-four days from Halifax. My first view of South Africa was the city of Cape Town, with Table Mountain in the background, and I must say I was very favorably impressed. During the course of the morning the local health officer and P. M. O. came out to us, and our sick—including the four small-pox cases—were taken ashore. Then every man on the vessel was vaccinated, and you can imagine how busy we were for a few days. Toward evening orders came for us to proceed to Durban, and we started at once. During the next four days we were within sight of the shore most of the day, and sometimes we were quite close in. Through the glasses we could distinguish everything of interest, so this extension of our trip lacked monotony. About February 28th we reached Durban, to find the bay full of transports, mule vessels, etc. The real harbor has a very narrow entrance and until the opening of this war was considered impassible for large vessels. Recently the British Government have kept two beautiful dredges at work on the bar, and have extended the piers until now almost any vessel can with care be taken in. At 6 a.m. the pilot came out to us and by 8 a.m. we were moored alongside our dock. The railway spur runs to the side of the ship, so we had not far to go, and the work of unloading the horses and equipment began at once. As soon as each squadron was disembarked it was loaded into a train and sent up country; the destination being Newcastle. We were the last to be unloaded, and as usual the transport trucks were insufficient to carry our equipment, so it remained behind in charge of our Quartermaster Tre-

mayne. If anyone ever tells you that the railroads of this country consider the comfort of the travelling public they are either trying to talk of something with which they are not familiar, or they are kidding. The train which we drew consisted of an engine about the size of a Daisy furnace, and closely resembling one. At any rate, I am sure it would prove as great a success as a heating apparatus as it did as a traction engine. Without exaggeration I am sure it travelled at the tremendous rate of four miles per hour most of the day, and the remainder of the time it positively refused to move at all. It has one great advantage, that it enabled us to see the country, and we did want to see this section. During this trip we passed through the country so closely associated with the early operations of the war under General Buller. Colenso, Dundee, Glencoe, Talana Hill, Ladysmith, etc., need only to be mentioned. In about three days we reached Newcastle, the advanced depot of Natal, and were placed in a quarantine camp for two weeks. This was rather slow, but enabled the men and horses to change sea legs for land ones. The second day in camp Lord Kitchener, commander-in-chief, visited us, and spoke very nicely to our officers.

Of course the R. A. M. C. men of the vicinity rushed in to inspect our equipment, and the usual board met on us. Everyone seemed delighted with what we had, and wanted to get some parts of it. Finally we were ordered to trek to Volksrust, the border town of the Transvaal, and the change was hailed with much pleasure. Again we were most fortunate, as the trail led us to Ingogo the first night, then along the base of Majuba, and over Laing's Nek on the second day. After a rest of a day we were again loaded into trucks, our ambulances put on flat cars, and we started across country for this locality, our destination being Klerksdorp.

In three days an order came for a part of the hospital to be sent to join the column under General Kitchener, so Major Jones, myself, ten orderlies and four transport men with four ambulances were detailed for the work. It was to last for seven days, but we have been out for three weeks and it now begins to look like a permanent affair. During the first week or so we treked about from place to place, usually at night, and had one tremendous march of twenty-three hours, covering 90 miles, It was a drive which resulted in the capture of 150 Boers, roughly speaking. After this march I had my first experience with gun shot wounds.

Again began a series of apparently useless trips, and they were growing monotonous until an event took place on Easter Monday which added considerable zest to the game. On Sunday evening I received orders to proceed with three empty ambulances to Col. Cookston's column.

About 12.30 p.m. the scouts and advance guard came into contact with the enemy in force, and an engagement at once began, and we had seven casualties. As soon as firing began I hustled my ambulances forward and reached the front in time to see the enemy retiring over a rise ahead. I picked up the wounded, and had just finished the primary dressings when the main body came up. The commanders at once held a conference and decided to go into a defensive position at once. The wagons were laagered and a good position taken up. The arrangements had just been completed, and I was in the act of doing my dressing, and attending to my wounded when a 15 lb. shell came screaming over the camp. I looked up and saw that the Boers had three big guns and a pom-pom in position, while on every side we were surrounded by their riflemen. Then it became very warm. The first two or three shells pitched over the camp, but then they got the range perfectly, and every one dropped somewhere in the camp confines. The guns used against us were those taken from Lord Methuen recently. Fortunately they did not fully understand timing the shells, and the greater part of them burst too high in the air, or not until they had struck into the ground. Our men took up their various positions around the camp and lying down, opened fire on the enemy. The action began about 1.30 p.m. and was sustained with great vigor and determination for two and one-half hours, and that was about the busiest time I have ever experienced. From the first moment of the fight wounded men began to pour into our hands. The doctors of the column had collected at my ambulances, so all the wounded came to us. By an hour's time we had almost every available inch of space covered with wounded, and still they came in. How we handled them I don't know, but we did. Unfortunately our position was the most exposed one in the camp. Twenty yards to our front was a spruit half full of water, and the bank was lined with riflemen, some 75 yards in our rear and firing over our heads, were two pom-poms. The Royal Horse Artillery had three guns in action some thirty yards to our left, while the horses some 1500 in number, belonging to C.M.R. Damant's Horse, M. I., etc., were in a big bunch some forty yards to our right. The rifle fire was severe on all sides of the camp, and our position was such that it converged on us from three directions. The artillery in our immediate vicinity drew the fire of the enemy's guns, hence it is not at all surprising that a score of the shells dropped in our hospital lines. A score of wounded men were hit as they lay about our ambulances, and some were killed. It looked as though the fire was directed on the ambulances, but I think this was due to our proximity to the artillery and pom-poms. At any rate we had a decidedly warm corner. I was so busy, that I really never thought of being shot

myself, and I went about doing my work as best I could, soon became accustomed to the screaming of the shells and the zip, zip of the rifle bullets. Only once did I stop to think that possibly I might also be the billet of one of these invisible projectiles, and that was when Gunn, one of my orderlies, was shot. I was dressing a man shot through the chest, and I had asked Gunn to raise his shoulders from the ground while I put on the bandage. He leaned forward, raised the man and I proceeded to pass the bandage around the chest. Had made two or three turns when I heard zip and a thud in quick succession. Poor Gunn collapsed and I knew he was hit. An examination showed that the ball had entered over the left scapula passing downward diagonally across the body, the exit being in right lumbar region about two inches from median line. How I escaped is a miracle as my head was resting on his left shoulder at the instant he was hit. Poor chap was afraid the ball had passed through my head before hitting him. He is doing nicely and will be fit for duty again in a few weeks.

As soon as the enemy were driven off, I went out into their lines under a red cross flag, and saw Generals Van Zyl and Kemp, and oh! great caesar, what a bunch of Boers there were.

Then work began. Several cases required instant operation, and we amputated a leg and two arms. I wish you could have seen those operations. All the aseptic and antiseptic teachings of surgery had to be thrown to the winds. We had only one basin of dirty water, a big knife, two or three pairs of surgery forceps and some needles and sutures. The operating room was an old bell tent with six dying men in it. The operating table was a dirty stretcher, and yet the results were good. No suppuration to date. After finishing these and several minor operations, such as cutting out bullets, I had to pitch in and look after my wounded men, most of whom were in great distress. This kept me busy until about 3 a.m., and then I turned to and assisted in digging a trench, in which we placed our wounded to protect them from the rifle fire, for we certainly expected an attack with the dawn. To make matters worse it began to rain. Really, one could not look at those poor suffering fellows without having all one's sympathy go out to them. I forgot my own discomforts, and was thankful that my lot was not theirs. Morning at last came, but no Boer attack; and when it became sufficiently light we saw that they had drawn away during the night. Then we went out over the surrounding ground and picked up the dead and wounded. By 9 a.m. our hospital resembled a——I cannot think of any fitting comparison. Thirty or so dead lay in a row, and we had loaded the wounded into ambulances, buck-waggon, Cape carts, in fact anything we could utilize as a conveyance. The various corps "told off" burying

parties, and it was a sad sight to see them winding the dead in blankets and carrying them off for burial.

I had a hard day after my return as there were fully a hundred men to attend to, but finally everything was done, and I at once went to sleep, and I think I worked Morpheus for all he was worth. Next day we did two major operations on chaps shot in the face by shell fire. Since then there has been an operation almost every day. Yesterday I elevated a depressed fracture of the temporal region, and in an hour the chap spoke the first word since he was shot. I had hoped for experience of this nature, but my fondest hopes have been more than realized.

All of the military men say that our camp sustained as hot, if not one of the hottest, shell and rifle fires on record during the present war. Not having been in any other, I cannot institute a comparison, but it certainly was warm enough to suit me. In all probability I will not have another opportunity of enjoying such an experience again, but I am still anxious to see further fighting. There is something very fascinating about the suppressed excitement of an action. We ran into a sort of jack-pot, it seems. Six commandos under Delarey, De Wet, Kemp, Van Zyl, and the other leaders I forget, had met to discuss the further plans of campaign. We ran into them as they were holding the conference, and so met 2,500 of the best fighting men at present in the field.

There is only one thing further to tell you about this fight at Bosch-bolt, and that is the sad side. We had twenty-six killed and one hundred and thirty-nine wounded. Of these, some eleven Canadians are dead and thirty-six wounded. I had nine horses and six mules tied to the poles of my ambulance, and I lost eight horses and four mules (shot). Had to borrow transport before I could move. Two companies of C.M.R. under Carruthers, of Kingston, behaved very well, indeed, and sustained heavy loss. Among the dead is Kinsely, the first man examined by you in Toronto.

In another letter I will try to tell you something of the hospital arrangements of the army so far as I have seen them, but I am deferring it, hoping that I may have an opportunity of going through them thoroughly. We find our light ambulances a great success, but they require four transport horses or six mules. We find the hospital tents a great success, and they will stand anything. Had them up in as severe a storm of wind and rain as one could imagine, and they stood the test admirably.

We learn from late reports that for his gallant work that day Captain Roberts was "mentioned in despatches."

AMONG THE SOCIETIES.

The American Urological Association.

The first annual meeting of the American Urological Association was held in Sarotoga, N.Y., June 13th and 14th, under the Presidency of Dr. Ramón Guiteras. The object of the Association is the study of the male and female urinary tract in health and disease.

The Canadian Tuberculosis Association.

This association held its annual meeting at Ottawa on 17th and 18th April. Sir James Grant, of Ottawa, presided. The meeting was a representative and influential one. His Excellency, Lord Minto, delivered an address. There were valuable papers read. It was agreed to establish a central organization at Ottawa, with a paid secretary. The Federal and Provincial Governments are to be asked for aid, as there are 40 000 consumptives in Canada, with an annual death-rate of 9,000. Some check should also be placed against the introduction of consumptives into the country. It was thought that all hospitals receiving public aid should make provision for tubercular cases. W. C. Edwards, Esq., M.P., was elected president, and H. B. Small, M.D., secretary.

The Canada Medical Association.

The Canada Medical Association will meet in Montreal on 16th, 17th and 18th of September, under the presidency of Dr. F. J. Shepherd of that city. Dr. George Elliott, of Toronto, is the general secretary, and Dr. Martin, of Montreal, the local secretary. Information can be obtained from either of these gentlemen. Dr. Osler, of Baltimore, will deliver the address in medicine, and Dr. Stewart, of Halifax, the address in surgery. Efforts are being made to make the meeting one of much interest and value. It is hoped the profession of Canada will give the association their support by a large attendance, the reading of papers, the presentation of cases, and taking part in the various discussions.

Below will be found a list of papers already promised for the annual Meeting at Montreal in September next. Members and others contemplating contributing to the success of this meeting should notify the General Secretary at an early date of their intention. Arrangements as to Railroad and Steamship rates, Entertainments, Clinics, etc. will be announced in due time. The following have been promised so far:—Professor Osler, Baltimore, the address in Medicine; John Stewart, Halifax, N. S., the address in Surgery; Dr. Corlett, Cleveland, Ohio, Lantern Demonstrations on the Exanthemata; James Stewart, Montreal, Some points in

Cerebral Localization with Cases and Specimens ; J. R. Couston, Huntingdon, Que, the Country Practitioner of to-day ; A. H. Ferguson, Chicago, the Pathologic Prostrate and its Removal through the Perineum ; Casey A. Wood, Chicago, Empyema of the Frontal Sinus ; J. F. Macdonald, Hopewell, N.S., on Tuberculosis ; A. R. Robinson, New York, X-Ray in Cancer ; David A. Shirres, Montreal, on Degeneration of the Spinal Cord, Anæmia, Malnutrition with Microscopic Specimens ; Papers are also promised by D. Campbell Meyers, Toronto ; G. S. Ryerson, Toronto ; A. Laphorn Smith, Montreal ; F. A. L. Lockhart, Montreal ; G. A. Peters, Toronto ; P. Coote, Quebec ; Geo. E. Armstrong, Montreal ; and Ingersoll Olmstead, Hamilton.

Toronto Medical Society.

The President, Dr. F. N. G. Starr, in the chair.

Dr. Hay moved that visitors be extended the privileges of the Society and be asked to take part in the discussion. Carried.

Dr. S. M. Hay read his paper "Some Important Points to be noted in Life Insurance Examinations." See page 679.

Discussion: Dr. Oldright said it was a question how far we were justified in taking statements of applicants. Urinary analysis is now required by all companies. Applicants were not told this by the agents. The urine should not be brought to the office in a bottle, but should be voided in the presence of the examiner. Association with tubercular people is just as important as heredity. Heredity on one or both sides is important, also any history of straight infection. A single instance of straight infection being much more favorable to the applicant than a case of hereditary taint on one side or the other. He said the remuneration to the examiner was too small for the amount of work and running round required of him. He also spoke of the protection of the examiner, stating that companies too often changed their local examiner to please an agent. This should not be as long as one man is giving satisfaction and doing good work. Preventive medicine was a subject not taken up by insurance companies. Cases of appendicitis, operated upon, he considered better risks, even earlier than Dr. Hay had said, than cases cured without operation even after six years.

Dr. John Ferguson said: Applicants were often first-class in one part of the examination, fair in another, and poor or bad in another. As for instance, personal history may be first-class, family history bad, physical examination good or first class, or all these first-class and the moral and social elements bad. These must all be considered carefully before recommending an applicant. A very important point was the difficulty of making an examination in the applicant's office or place of

business. The urine should always be voided so that the examiner knew no substitution or alteration was possible. It was not always possible to get a sample. An examiner should always be on the outlook for first impressions gained from a general inspection and view of the applicant. A family history showing early deaths indicated a general lack of vitality in the family. He fully agreed with Dr. Oldright re cured cases of appendicitis. Some diseases were an advantage as typhoid, smallpox, etc. He divided alcohol users into three classes: 1st, Spree class—a drunk with friends, a jollification. 2nd. Dypsomaniacs—periodical outbreaks, ending in delirium tremens. 3rd. Dram drinkers. Classes two and three were rejectable lives. Occupation was important, and indefinite answers should never be taken as clerk, traveller, etc. The following points of the examination should always be carefully considered: 1, Heredity—the whole family history; 2, Personal record; 3, Proportionate height, weight, expansion and measurements; 4, Occupation, social habits, and moral condition.

Dr. W. J. Wilson said, in a large proportion of middle aged persons, no albumin would be found until after repeated examinations. The urine may be of low sp. gr., but granular casts were frequently demonstrable, without albumin being shown by chemical tests. The arterial condition should be considered, as to there being evidence of sclerosis in the radial or temporal arteries. A velvety condition of the skin, or spotting, were important, and should put the examiner on his guard. The heart sounds should be proportionate.

Dr. Clouse said medical students should receive a special course in insurance examinations. He thought the supreme examiner often made mistakes by laying too much stress upon proportions. It was sometimes very hard to put down for the head office, the answers received, so as to give correct and proper information. Urinalysis was very important. He thought sugar may be occasionally found in perfectly good risks. Some individuals were very prone to meet with accidents and were therefore not first class, because of some visual defect, or nervous condition, which of itself did not amount to much, only in its bearing upon the safety of the applicant. The moral element mentioned by Dr. Ferguson he considered very important. Having had contagious diseases indicated a condition of lowered vitality.

Dr. Ashton Fletcher said that he did not agree with Dr. Hay that tall men were usually better risks. Short men, he said, usually had greater lung capacity. That the difference between expiration and inspiration was usually greater in short men than in tall men. Therefore Dr. Hay's rule that the mean chest measurement should be half the height was not sound. Short men were less liable to accidents, being

more agile and sure footed. He noticed some companies were beginning to wake up to the importance of preventive medicine. One company was asking the questions: How long after the death of a consumptive did you occupy the same house or room? Have you been closely associated with a consumptive? Another company asks: Have you used patent medicines? If so, what for.

The president said, "Do not write normal." State the facts. A question that should be on every form is, "Does applicant in illness use a qualified regular medical man"? It was hard to get a correct family history. Was death at child birth, during labor, or a week, or six weeks after? were questions hard to answer and meant much to the chief examiner. He knew cases of hernia cured by the injection method accepted by companies, though he considered them unsafe, as he had seen at post mortem a knuckle of intestine attached to the sac, by adhesions which formed a stoppage, causing death. Underweight men were prone to tuberculosis. The pulse should be taken with three fingers.

Reply. Dr. Hay said the referee was not justified in accepting cases with sugar in the urine where found frequently. But many cases might have been accepted, who were rejected. The applicant must be examined thoroughly, even if the local examiner is sure he would not pass. He made the same reply re albuminuria as re sugar. A very important point was the question: "How long have you known the applicant"? He would consider much more favorably the recommendation of the local examiner if he had known the applicant some years. Short men with large chests were out of proportion and usually too fat.

The treasurer's report and the recording secretary's report were read and adopted, showing the society financially strong and doing good work. The membership had been increased by eleven during the year, the average attendance being twenty-five.

The officers elected for the ensuing year were:—President, S. M. Hay; First Vice-President, G. Silverthorn; Second Vice-President, J. Hunter; Corresponding Secretary, —. Beatty; Recording Secretary, Ashton Fletcher; Treasurer, G. H. Carveth; Committee, F. N. G. Starr, Hooper, Fisher.

The Ontario Medical Association.

The twenty-second annual meeting of the Ontario Medical Association has come and gone. Of the now long list of these gatherings, this year's one was particularly successful. It reflected much credit upon those who had been entrusted with the arrangements. It is no sinecure to plan and carry out successfully such an event.

The papers and discussions did credit to the profession of this

Province. To one who has watched closely these annual meetings it is at once apparent that the medical profession is becoming steadily more advanced in its views of medical science. There is a full appreciation of the responsibilities that rest upon it, as a learned profession; and as full a determination to discharge its duty in the interests of the public weal.

An important feature of the recent meeting was the exhibition of a considerable number of interesting cases. Much benefit is often to be derived from the study of such cases by a number of members of the profession, as in this way different aspects of these cases are brought out.

THE PRESIDENTIAL ADDRESS.—Dr. N. A. Powell delivered an able and timely address. He touched upon a number of very important topics. It is hoped that careful attention will be given to these matters, and that some effort will be made to carry some of the suggestions into effect. Among these subjects may be mentioned his remarks on the Dominion Medical Council Act, the house-surgeon, vaccination, improper advertising, and the maintenance of a high standard of medical education.

JUDGE McDougall's ADDRESS.—A feature of the meeting this year was an address from his honor Judge McDougall, on medical testimony, and especially expert evidence. He pointed out that medical men might give evidence as to facts; or give their opinion on these facts, or any set of facts. This latter was expert evidence. Thus, if asked in what condition he found a person, he would only be relating facts; but if asked what would cause the condition, the answer was opinion evidence, or expert testimony. Evidence must be authenticated; or, in other words, taken under oath, by proper declaration, or as an *antimortem* statement. Evidence might be direct, or what the witness saw, or heard, or what was within his own knowledge, or observation. On the other hand, indirect evidence was circumstantial, or inferential.

Expert evidence is of much value. Juries, and often Judges, do not understand the scientific meaning of many things in medical and surgical experience. The medical witness could explain these; or, in other words, give opinion evidence on the facts. This enabled the jury to understand the case much better. Thus a child might be seriously burned, and opium given for the relief of its pain. On the death of the child it might arise as to whether the child died of the burn or the opium. Here the expert could throw much light on the case. With regard to the difference of opinion among experts, it ought to be remembered that there must always be some difference. This difference might be quite honest opinion, or it might be due to ignorance.

Before opinion evidence is given, all the facts should be understood

and considered by the witness. He should hear all the other evidence bearing on the case. An expert witness should avoid appearing to be an advocate. This was likely to discredit his evidence. In, say, a will case, it is not the duty of the expert to decide testamentary capacity, but merely to show whether the person was of sound mind or not, and to what extent the unsound state of mind existed. It was for the Court to then determine the capacity to make a will.

When there is much divergence of opinion, the Judge may direct the jury to reject the expert evidence, as the jury is not bound to hear expert opinion. The cause for so much difference of opinion is to be found in the present method of selecting experts. Those are chosen who are known to be favorable to a certain view of the case. It is natural for the witness to see the side succeed that employs him. This tends to influence the witness, and make him appear an advocate. It is very difficult to resist this sort of thing. A railway surgeon may not wish to see the company which employs him heavily mulcted.

Cross examination is conducted too often in such a manner as to show that the opinions already given are not true, or that they are ridiculous. This is a studied effort to conceal the truth and not to elicit it from the witness. This goes on on both sides. No wonder that a bad opinion is often created regarding the expert.

The remedy is to be sought in a new method of appointing or selecting the expert. He should be chosen by the Court, or Government; but not by the litigants. The expert should be an impartial assistant to the Court. His opinion should be taken by the trial judge. In this way he would not be partizan. He would give the Court a scientific or technical explanation of points of the case as it progressed. His fee should not come from the litigants, but from some fund provided for such a purpose.

A very important matter in giving expert evidence is always to avoid technical terms. As far as possible use simple language.

Dr. S. A. Knopf—A very pleasant surprise to the members of the association was the unexpected visit of Dr. S. A. Knopf, of New York, who is known to every physician to have paid great attention to the question of tuberculosis. He spoke in no uncertain manner against the attempt to regard consumption as an acute infectious disease. Such teaching is calculated to do a vast amount of harm to the crusade against the disease. It was undoubtedly a communicable disease, but, in pulmonary tuberculosis, the danger lay in the sputum. Proper destruction of this did away with the risk of infection. He pointed out that it was unnecessary to place difficulties in the way of either the patient or the physician. This new fear he called phthisiophobia. He held that, with

proper safeguards, there was no danger. He argued strongly for the spread of the view that tuberculosis was a preventable disease and that the great efforts of medical men should be along this line. The public should be roused to take this view, and to furnish sufficient and efficient means of dealing with this disease.

He took strong ground that consumption, especially in the incipient stage, was a curable disease. Many got well without treatment. He deprecated too much drug treatment in these cases, and advised against the administration of the coal-tar products. He said that many stomachs had been injured by creosote, and that it should never be given so as to irritate this organ. But, on the whole, the less drugs the better.

The treatment consisted in air, food, and water. With regard to air, this meant abundance. Night and day the patient should be in fresh air. Consumption was not only a communicable disease, but it was a social disease, arising out of crowding and bad sanitary conditions. With regard to food, the rule was plenty good nourishment. No special dietary had any advantage. He encouraged the use of cold water. The patient is sponged for a few days with alcohol; then for a few days or a week with half alcohol and water; and then with cold water and well rubbed. Everything was in the proper employment of simple means.

Dr. Knopf urged that it was the duty of the general practitioner to be on the alert for early cases, and to give efficient directions for the management of these. In this way, many cases would be cured, and much prevention attained. Reporting cases was favored. This did not mean that the cases were to be isolated, or placarded, nor interfered with by the health officer, as to treatment or directions, but merely that the physician in charge might have suitable instructions, or printed matter sent to him to give these cases. It would be of value, too, from a statistical point. In all our efforts, as little fear should be created as possible, as it might deter the consumptive from seeking advice, for fear of losing his situation, or being shunned.

Dr. Park's Address—Dr. Roswell Park spoke on some aspects of gall bladder surgery. He advocated the removal of the gall bladder in cases of acute infection inflammation and chronic disease, with recurrent attacks. These latter he spoke of as "growling cases." He compared the gall bladder and the appendix; and stated that the treatment was largely the same, namely removal. When the gall bladder is exposed, it is opened. This admits the fingers as guides to the operator. When the gall bladder is freed from its attachments it is removed. In the cases where he had performed this operation he had had no call to regret the procedure. There were many examples of disease in the gall bladder that could only be successfully treated in this way.

The meeting this year was a very busy one indeed. There was a long list of papers, and many very interesting cases. Some thirty-five papers were read, fifteen cases were shown, and number of interesting preparations and specimens, and two very excellent lantern demonstrations, by Dr. McCallum, of London, on nervous diseases, and Dr. Hodgetts, of Toronto, on cases of smallpox. These were highly appreciated by those present.

The luncheon, in the gymnasium of the Normal School, was well attended, and as well enjoyed. Short and bright speeches were made by Drs. W. B. Geikie, R. A. Reeve, Roswell Park, of Buffalo, J. A. Temple, J. C. Mitchell, G. A. Bingham, A. R. Robinson, of New York, and Harrison. The success of the luncheon reflected much credit on those who had the matter in charge.

The Committee on Public Health, through its chairman, Dr. Hoig, strongly recommended that a provincial health officer be appointed. The present system of having local, and unpaid medical health officers, was not satisfactory. The local medical health officer was often called upon to perform an unpleasant duty, that might give rise to difficulty with a neighbor practitioner. All this could be avoided and the law more strictly enforced by the plan advocated in the report of the Committee. The report was unanimously adopted.

The report of the Committee on Publication contained a very important recommendation, namely that the proceedings be issued this year in book form. This seemed to meet with much favor, and was adopted, power being given the Committee to proceed with the work of publication. To assist in this, notice was given that next year, the rules of the Association be amended so as to require all members to pay their annual fee, whether present at the meeting or not.

The officers elected for next year were:—President, J. C. Mitchell, Enniskillen; first Vice-President, G. A. Bingham, Toronto; second Vice-President, W. G. Anglin, Kingston; third Vice-President, J. W. T. McCullough, Alliston; fourth Vice-President, J. D. Meekle, Mount Forest; Secretary, H. C. Parsons, Toronto; Treasurer, A. R. Gordon, Toronto.

Should the proceedings not be published, it was agreed to grant the Ontario Medical Library Association \$100.

To Build Sanitarium.

As a result of the recent tuberculosis conference, two gentlemen have offered to build sanatoria at their own expense. One is Sir Wm. Macdonald of Montreal, who will build one probably in the neighborhood of Montreal. The other is Mr. W. C. Edwards, M.P., whose sanitarium will be in the neighborhood of Ottawa.

UNIVERSITY AND COLLEGE NEWS.

The University of Toronto has passed the following for the degree of M.B.: Miss E. L. Anderson, A. E. Archer, G. H. L. Armstrong, G. M. Atkin, W. J. Bell, A. Brown, J. L. Campbell, W. J. Chambers, Miss E. Conor, W. S. Dakin, J. E. Davey, G. C. Draeseke, H. R. Elliott, J. Esler, A. Fisher, G. W. Fletcher, J. J. Fraser, E. E. Fry, J. E. Godfrey, J. S. Graham, J. N. Gunn, V. E. Henderson, E. T. Hoidge, J. L. Huffman, J. R. Irwin, E. P. James, W. T. Kergin, H. Logan, D. McBane, H. N. McCordic, A. D. McEachern, N. T. Maclaurin, Miss MacLar , W. A. R. Mitchell, A. Moir, C. H. Montgomery, W. G. Montgomery R. G. Mullin, A. Murdock, H. E. Roaf, R. W. Rutherford, P. W. Saunders, F. Short, D. Smith, A. E. Snell, L. L. Stauffer, H. J. Sullivan, W. T. Wallace, O. C. Withrow, A. B. Wright, O. Klotz.

In medicine the medals and scholarships awarded are :—

Medals—Faculty gold medal, H. E. Roaf and P. W. Saunders, aeq.; first faculty silver medal, G. W. Fletcher; second faculty silver medal, A. Moir; third faculty silver medal, A. E. Archer.

Scholarships—First year, 1 W. S. Lemon, 2 R. L. Clark; second year, 1 A. Kinghorn, 2 S. B. Walker.

Fourth year, degree with honors—G. W. Fletcher, P. W. Saunders, H. E. Roaf, E. J. Davey, H. M. McCordic.

CONVOCATION HALL FUNDS.—The report of the University of Toronto Convocation Hall fund for the week ending June 7 shows an increase of \$1,263.50. The subscriptions received so far total \$12,862. The graduates of the various years in arts, law and medicine are responding generously.

NEW MEDICAL BUILDINGS.—The work of erecting the new University medical building will be commenced at once. The building is to be located between the library and the biological buildings. It is expected to be ready for occupation by the beginning of 1903. When completed, the medical and the physiological departments will have laboratories and lecture room of the most modern and approved type.

Trinity University, on 30th May, conferred the degrees of M.D., C. M., on the following persons :—

Adams, William F.; Allin, Edgar W.; Allwood, Stanley G.; Anderson, Archibald H.; Blake, Matthew R.; Boyce, William B.; Brandon, Edgar; Burns, James D.; Campbell, Thomas C.; Carter, John R. C.; Cassidy, Mabel A.; Clancy, Robert W.; Davis, Annie; Gilbert, Francis O.; Harris, William J.; Henderson, James; Hutton, Herbert B.; Imrie, Geo. T.; Irving,

Robert N.; McCauley, William A.; McDougall, Charles H.; McKay, Harvey.; McMaster, Elizabeth.; Morrison, John R.; O'Neill, John H.; Ritchie, Frederick A.; Robertson, William; Ross, Annie; Service, Herbert E.; Seymour, Theodore F.; Smith, William A.; Stenberg, Oscar; Thomson, Isabella M.; Thomson, John; Thomson, John Joseph; Waters, James M.; Waugh, Reuben; Williams, William T.; and Wood, Isabella S.

In the final year, the Gold Medallist was J. J. Thomson; and the Silver Medallist R. W. Irving.

The following Candidates were awarded Certificates of Honour in the Final Examination, J. J. Thomson; R. W. Irving; F. A. Ritchie; W. T. Williams; E. W. Allin; W. A. McCauley; H. B. Hutton; E. Brandon.

The Primary Silver Medallists, were, First G. A. Durnin; and Second R. A. McLurg.

In the Primary Examinations Certificates of Honour were awarded to G. A. Durnin; R. A. McLurg; A. J. Fraleigh; R. J. Manion; H. A. Bray; J. R. Serson; J. A. Brown; and J. F. Adamson.

Trinity Medical College closed its thirty-first session on 31st May. The following medals, fellowships, scholarships and standings were awarded:—

Certificates of honor,—R. W. Irving, J. J. Thomson, E. W. Allin.

First class,—E. Brandon, F. A. Ritchie, S. G. Allwood.

Second class,—W. T. Williams, W. A. McCauley, H. E. Service, J. R. Morrison, R. W. Clancey, J. H. O'Neill, H. B. Hutton, W. B. Boyce, O. Stenberg, J. D. Burns, R. Waugh, J. Thomson, W. J. Harris, A. H. Anderson, T. F. Seymour.

Passed—H. McKay, J. R. C. Carter, W. A. Smith, C. H. McDougall; G. T. Imrie, L. J. Isaacs, J. Henderson, E. E. Latta.

The winners of the various prizes were:—Special prize in physiology (Dr. Sheard's), for the first year, value \$25—E. J. Hagan. Scholarships—The 1st first year's scholarships, \$50, R. R. Smale; the 2nd first year's scholarship, \$30, G. H. Carlisle; the 3rd first year's scholarship, \$20, T. C. Brereton; the 1st second year's scholarships, \$50, G. A. Durnin; the 2nd second year's scholarship, \$30, R. A. McLurg. The College gold medal, Robert Washington Irving; the first College silver medal, John Joseph Thomson; the second College silver medal, Edgar W. Allin.

Manitoba University at the convocation on June 6th, granted the degree of M.D. to the following persons:—A. F. Anderson, R. H. Brett, B.A., R. J. Cooke, B.A., A. T. Condell, B.A., J. A. Creighton, B.A., A. K. Cranston, A. G. Denmark, D. R. Davies, F. W. Dykes, W. G. Lyall, J. A.

Montgomery, H. McGavin. A. A. Nicholls, W. Z. Peatman, W. Sinclair, P. D. Stewart, W. H. Wardell, H. W. Wadge.

W. S. McDonald was granted an "Ad eundem gradum" to practice in the Province. A. F. Anderson, A. T. Condell and A. A. Allen had also the degree of C.M. conferred upon them. A. A. Nicholls was awarded the University silver medal; A. F. Anderson, the bronze medal, and R. J. Cook, the medal in Sanitary Science. In third year, A. R. Winram obtained the Scholarship of \$80, and L. J. Carter and R. D. Fletcher, \$25. Second year, N. G. Cooper, \$80, and A. M. Campbell, \$50. First year, J. S. Price, \$80, and R. Kippin, \$50.

Sir Wilfrid Laurier on Medical Profession.

Sir Wilfrid Laurier spoke as follows on the third reading of the bill to form a Dominion Medical Council :—" But the laws of the medical profession are the same everywhere. There is no difference in the teaching of medicine and the practice of the profession—and a noble profession it is—between one province and another. Therefore, I think it is conducive to the interest of mankind to have as few as possible of these corporate bodies which have laws against one another. Leaving the technical and theoretical question aside, my hon. friend knows that in this very city of Ottawa there is a rivalry between the practitioner in Hull and the practitioner in Ottawa. The man having a certificate from Ontario would not dare to go to the assistance of a man in Quebec, nor would one having a certificate from Quebec give advice to an unfortunate invalid in Ontario. If argument is needed to justify such a measure as this, I think it can be furnished by the contemplation of such a case—a case that is not merely hypothetical, but a matter of everyday reality. I am moved in this matter by considerations of the expediency of the Bill. But I would not support it without the amendment that has been made providing that the Bill shall come into effect only with the concurrence of the provinces. If even one province does not give its concurrence, then my hon. friend the promoter of the Bill says, the law shall remain inoperative. Under the circumstances, it appears to me that the danger which some of my hon. friends think they see does not really exist."

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EDITORIAL.

THE KING.

IN a few days the Coronation ceremonies will be over. His Majesty King Edward VII. will have been officially vested in all the robes of his august position. No ruler, past or present, ever swayed so mighty a sceptre. His Empire is 12,000,000 square miles in area, contains 400,000,000 souls, and affords trade for ships of a total tonnage of 200,000,000. Notwithstanding the vastness of his Empire, it may be truly said that the King is not unmindful of any portion of his many possessions. It is a matter of much pleasure to know that he takes so much interest in science in general, and medical science in particular. The welfare of all his subjects is his greatest concern. Within the bounds of his Empire, on which the sun never sets, the clash of arms is nowhere heard. *Sic semper sit!* THE CANADA LANCET unites with its many readers in saying, "God Save the King."

ONTARIO MEDICAL COUNCIL, FIFTH YEAR.

THE regulations of the Council of the College of Physicians and Surgeons of Ontario demand that students must spend a period of five years in the study of medical subjects. To this regulation an exception is made in favor of graduates in Arts who have spent two years in the study of physics, chemistry, biology and physiology. These may take their final examination in four years. The regulations also require the fifth year to be devoted to clinical work. Six months of this year may be spent with a registered practitioner of Ontario, or an approved practitioner outside of Ontario. The other six months the student must spend at one or more public hospitals, dispensaries, or laboratories, and must attend at least twenty-five clinical lectures or demonstrations on each of the following, namely, medical cases, surgical cases, obstetrical and gynaecological cases and pathology; and furnish a certificate of six months' hospital attendance. In lieu of the above, a certificate of having acted as house surgeon for one year in a hospital will be accepted.

In making these regulations, the Council was no doubt acting, as it

thought, in the very best interests of the profession. It goes without arguing that the Council acted wisely in requiring a thorough practical training at the hands of the student in medicine before granting him his license to practise. But just here comes in a difficulty. Section 53 of the Ontario Medical Act states: "No person shall be appointed as medical officer, physician or surgeon in any branch of the public service of this Province, or in any hospital or other charitable institution not supported wholly by voluntary contributions, unless he is registered under the provisions of this Act."

A case occurred a short time ago, where a house surgeon had administered an anæsthetic. No fault was found, nor, indeed, could be found, with the manner of administration, yet the coroner and Crown Attorney took the view that house surgeons must be legally qualified practitioners and not fifth year students. This stands seriously in the way of fifth year students securing appointments. Practitioners and hospitals will not care to take such persons as assistants, if there is going to be danger of legal liability for their acts. Further, hospitals may not be willing to incur the cost of housing and boarding fifth year students, if they cannot legally discharge an emergency duty.

Believing, as we do, in the fifth year, it is hoped the Council may find some way whereby these students may be enabled to legally perform the duties usually falling to a house surgeon to perform. There can be no doubt that the intention of sect. 53 is that persons should not hold salaried positions in the provincial asylums, or hospitals, or any branch of the public service, who does not possess a legal qualification to practice. No one would find fault with this. It would never do for the government to appoint unqualified persons to positions of medical and surgical responsibility. It is quite different, however, when the governors of a hospital, or charity, appoint a fifth year student to perform house surgeons' duties, without remuneration, other than board, and under the direction and supervision of the medical staffs and other officers of such institutions. These institutions are conferring a distinct privilege and benefit upon these students, and taking a prominent part in their efficient and practical education. They should not be held liable for so doing. A fifth year student, with his university degree in medicine is quite competent to be a house surgeon. Section 53 should be amended that he may legally hold such positions.

If a medical student is not a graduate in arts he must spend five years in study before he can obtain his license. To take a house-surgeons'hip after obtaining his license would mean that he spends six years in his medical course. Very few of the students can afford to do this.

Those who are licensed and doing house-surgeonship duties are usually graduates in arts, and, as such, are in their fifth year of medical study. Were it not for this, it would be practically impossible for any of the hospitals to secure the services of legally qualified house-surgeons. The student who does not hold a degree in arts is at a distinct disadvantage. The graduate in arts, who obtains his council qualification and M.B. at the end of his fourth year, is of the same academic status as the one who has not an arts degree, but has completed his four years in medical studies, and has obtained his university degree in medicine.

EDITORIAL NOTES.

Alcohol in Colds.

Sir. Lauder Brunton calls attention to the fact that alcohol is bad for one, when taken before he exposes himself to severe cold. If however, one suffers a chill, it is an excellent remedy, as it dilates the surface capillaries and small vessels and thereby relieves the congestion of internal organs.

Hyperemesis Gravidarum.

Dr. Condamin, of Lyon, treats this condition by enemata of artificial serum. He has administered to the patient 12 ounces every two hours by high enema. For eight or ten days the patients are allowed nothing by mouth. If the serum irritates the bowels a few drops of laudanum are added.

Malpractice Suit.

An action was brought against Drs. Hopkins and Clark for damages, at the assizes, held in Cayuga in April last. John Lynburner, the plaintiff, sued the defendants on behalf of the patient, a young girl, who sustained a compound fracture of the arm. It became necessary to perform amputation. Justice Ferguson dismissed the action. We congratulate the doctors in this case in being so completely vindicated. It was shown that they had done everything that could be done for the patient.

Creosotal in Pneumonia.

Carbonate of creosote, or creosotal is highly recommended by Dr. W. H. Thomson, of New York, in *New England Med. Monthly* for May, in the Treatment of labor pneumonia. He gives adults gr. xv every two hours. He remarks that the symptoms of the disease are favorably affected by the drug. This amount may be continued for days. It does seem to irritate the stomach, nor cause depression. Of eighteen cases treated in this way, there was only one death, an alcoholic subject

OBITUARY.

PROF. HANS BUCHNER.

DR. BUCHNER was professor of Hygiene in Munich. He was one of the early investigators in bacteriology, on which subject his writings were numerous and valuable. He died 30th March.

ERVIN ALDEN TUCKER, M.D.

DR. TUCKER died of pneumonia in March last. He was obstetric physician to the Maternity Hospital, Blackwell's Island. He was an active member of a number of societies, and an able contributor to medical literature. He was in his 40th year

JAMES HAYES, M.D.

WE regret to note that Dr. James Hayes, for many years a practising physician in the Town of Simcoe, died suddenly on 1st June. Deceased took an active part in the affairs of the Town. He was for many years chairman of the School Board, and filled many other offices in connection with the working of the town.

E. M. MOORE, M.D., LL.D.

DR. MOORE died in Rochester, March 3rd at the advanced age of 88. Many may remember his visit to the Ontario Medical Association in 1885. On that occasion he spoke on the treatment of puerperal eclampsia, and Colles' fracture. He was a man of great personality. His manner was most cultivated, and his professional learning extensive.

FREDERICK A. CASTLE, M.D.

DR. CASTLE died in New York a short time ago, aged 59 years. When a student he saw active service in the medical cadet corps during the civil war. He also served in the navy. He was an extensive writer in medical journals, and did much editorial work. For a time he lectured on therapeutics at Bellevue. He took a very active interest in the New York Academy of Medicine, and was for a time its treasurer.

WILLIAM MILLER ORD, F.R.C.P.

MANY will regret to learn of the death of Dr. Ord. He was one of the physicians to St. Thomas Hospital; and, as such, not a few Canadians may have met him. His work on myxoedema shall last for

all time. It was so thorough that he left but little for others to add. His studies of the relationship of the thyroid gland to that disease, gave a great impetus to the study of the relationship between ductless glands in general and disease.

THOMAS MORE MADDEN, M.D., M.R.C.P., Etc.

DR. T. M. MADDEN was one of Dublin's best known medical men. He died at the age of 64, after a lingering illness. Dr. Madden served his apprenticeship under Dr. Cusack, Surgeon-in-Ordinary to the Queen in Ireland. He was an extensive contributor to the medical journals; and wrote a number of books of merit. He had had a number of honorary degrees conferred upon him. He devoted his talents to obstetrics and gynaecology. He was master of the Rotunda for some years; and for many years obstetric physician to the Mater Misericordiae Hospital. He filled many positions of honor in connection with his branch of medicine

ALEXANDER WATSON, M.D., R.N.

INSPECTOR-GENERAL WATSON, died at Liverpool 17th April. He had seen very much service in the British Navy. He did good service in the Crimea and the Black Sea. He then filled an important post in the Mediterranean fleet. He was present at the capture of the Peiho forts in 1858. Later on he was wounded and taken prisoner in the attempt to capture Tien Tsin. In 1868 he was present when the attempt was made to assassinate the Duke of Edinburgh near Sydney, Australia, and attended him through the illness following the pistol wound. In 1875 he was the medical officer in charge of the Serapis when the Prince of Wales, now King Edward VII., made his visit to India. He was appointed to the charge of Haslar Hospital in 1879. He had a number of medals and clasps of distinction.

PERSONAL.

Dr. J. T. Duncan spent two weeks out west a short time ago.

L. C. Jordan, of Dutton, sustained a fracture in his foot, by a kick from a horse.

Dr. Tye, of Chatham, has gone to Chicago to take a course in surgery.

Dr. G. S. Ryerson, of Toronto, left for England June 1, and will return about the end of July.

Mrs. Hendrie, of Hamilton, has donated to the hospital of that city a nurses home.

Dr. Edgar will leave the Hamilton Hospital on 1st August to engage in private practice.

Dr. Howey, of Owen Sound, left a short time ago for London to take a post-graduate course.

Dr. Wyatt Johnston has been appointed Professor of Hygiene in the Medical Faculty of McGill.

Dr. W. H. P. Hill has returned from England and begun practice at 145 Metcalfe street, Montreal.

Dr. G. F. Bodington, late Medical Superintendent of the British Columbia Asylum for the Insane, died on May 5th.

Dr. A. W. Mayberry, of Toronto, left a short time ago for Europe, to visit the throat and chest hospitals.

Dr. Frederick Winnett, of Toronto, left for England on 30th May, and intends being absent three months.

We regret to learn of the severe illness of Dr. Peter B. Wood, of Hamilton, but hope he will soon be around again.

Dr. Ralph Huffman was united in marriage to Miss Georgina Jamieson, of Napanee, on May 28th. They intend residing in Wisconsin.

Prof. G. P. Girdwood, who held the Chair of Chemistry in the Medical Faculty of McGill, has resigned, after a long and distinguished career.

Dr. H. A. Beatty and Dr. E. W. Spragge, both of Toronto, have been appointed Chief Surgeon and Physician of the Ontario Division of the C. P. R.

A. Douglas McIntosh, M.A., B.Sc., has been appointed senior demonstrator of chemistry, McGill Medical Faculty, in lieu of Dr. Henderson, who has resigned.

Oakville May 6.—Dr. Porter of North Bay, was accidentally drowned to-day while bathing. It is supposed he took cramps, and before assistance reached him he sank.

Dr. T. R. England, Professor of Surgery in Bishops College, Montreal, has been appointed to a chair, Vermont University at Burlington. He will not require to leave Montreal.

The new Medical Council for British Columbia elected Dr. Jones, President; Dr. R. E. Walker, Vice-president; Dr. C. J. Fagan, Registrar; and Dr. W. J. McGuigan, Treasurer.

Dr and Mrs. Price Brown, of Toronto, spent a few days in Boston and New York. The doctor attended the Laryngological Association in the former city. They returned on June 2nd.

The following doctors passed the British Columbia Medical Council: J. A. Gillespie, R. F. Greer, S. K. Harvie, R. H. Ker, F. P. Patterson, H. P. Rogers, W. H. Sutherland, A. W. Tanner, G. H. Tuthill.

BOOK REVIEWS.

THE NEUROSES OF THE GENITO-URINARY SYSTEM IN THE MALE, WITH STERILITY AND IMPOTENCE.

By Dr. R. Ultzmann, Professor of Genito-Urinary Diseases in the University of Vienna. Second Edition. Revised, with notes and a supplementary article on Nervous Impotence, by the translator, Gardner W. Allen, M. D., Surgeon in the Genito-Urinary Department of the Boston Dispensary; Instructor in Genito-Urinary Surgery in Tuft's Medical College. Illustrated, Pages 198, 12mo. Price, extra cloth, \$1.00, net, delivered. Philadelphia: F. A. Davis Company, Publishers, 1914-16 Cherry Street.

IT is a genuine pleasure to review the classical lectures of Dr. Ultzmann, of Vienna. He was known to be a distinguished Authority on Genito-Urinary diseases. Dr. Allen has done his share well in rendering the original into clear and readable English; and also in adding a chapter on nervous impotence.

MINOR SURGERY AND BANDAGING.

Including the Treatment of Fractures and Dislocations, Amputations, Excisions, Resections, Intestinal Anastomosis, Operations upon Nerves, Tracheotomy, Intubation of the Larynx, etc. By Henry R. Wharton, M.D., Professor of Clinical Surgery in the Woman's Medical College of Pennsylvania, Surgeon to the Presbyterian Hospital, and the Children's Hospital. The Fifth and enlarged edition. Lea Brothers & Co., Philadelphia and New York, 1902. \$3.00.

THE volume before us is a handsome 12mo. one, of 594 pages, and containing 502 engravings. The publishers have given the profession a book in their well-known excellent style of the book-makers art.

The work has now gone through five editions, and has been before the medical profession for some fifteen years. The matter contained in the book is thoroughly up-to-date. The illustrations are numerous and especially good. The work will prove very helpful to students; and, as a ready reference on many points, to practitioners. To all who desire a work on "Minor Surgery" we can cordially recommend Dr. Wharton's manual.

THE PRINCIPLES OF BACTERIOLOGY.

A Practical Manual for Students and Physicians. By A. C. Abbott, M.D., Professor of Hygiene and Physiology in the University of Pennsylvania, Philadelphia. New, Sixth Edition, thoroughly revised in one handsome 12mo. vol. Cloth, \$2.75. Philadelphia and New York: Lea Brothers & Co.

THE sixth edition of Abbott's Principles of Bacteriology, appearing within three years of the fifth and eleven years of the first edition, preserves its original clearness of style and conciseness of arrangement, while presenting some new features of especial interest.

The addition to the Chapter on Tuberculosis of a short treatise on

the pathogenic streptothricas is the more welcome because it is a subject which has not been included in some of the later books on Bacteriology. Recent researches in the pathology and culture of the bacillus dysenteriae and the diplococcus intracellularis meningitis are also given at some length.

The Chapter on Immunity, although it retains its conclusions unaltered, has a fresh interest in the record of later experimental work in that most fascinating field of inquiry.

The make-up of the book in paper, binding, typography, and illustrations, is all that could be desired. We can highly recommend the work.

L. A. D.

SAUNDERS' MEDICAL HAND ATLAS.

Atlas and Epitome of Operative Surgery. By Otto Zuckerkandl, Privat Dozent in the University of Vienna. From the Second Revised and Enlarged German Edition. Edited with additions by J. Chalmers Da Costa, M.D., Professor of the Principles of Surgery and of Clinical Surgery, Jefferson Medical College, Philadelphia. Second edition. Thoroughly revised and greatly enlarged. With 40 colored plates, 278 text illustrations and 410 pages of text. Philadelphia and London: W. B. Saunders & Co., 1902. Cloth, \$3.50 net. Canadian agents, J. A. Carveth & Co., Toronto.

THE second edition of this excellent little work has just come to hand. The lithographic plates and text cuts serve to make it of value to the student in operative surgery as well as to the young surgeon who is just beginning his career. In the first fifty pages the author lays down some general rules to be followed in operating and gives a description of the instruments and methods used in modern surgery together with indications for their employment.

The greater portion of the first part of the volume deals with ligation of arteries—amputations and euucleations.

The conditions which call for these procedures are stated in a clear and concise manner. All the more common amputations are described in detail.

In the second part of the book, regional surgery more particularly is dealt with and, as in the first part, the author gives a description of most of the operations that the surgeon will be called upon to perform, together with the conditions under which they should be undertaken.

The book is well printed and the binding strong and durable.

W. D. F.