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BRITISH MEDICINE IN GREATER BRITAIN.

BY WILLIAM OSLER, M.D., F.R.C.P.
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(Continued from page 702.)

THE character of the men who controlled the profession of the new colony is well shown by the proceedings of the Medical Board which was organized in 1819. Drs. Macaulay and Widmer, both army surgeons, were the chief members. The latter, who has well been termed the father of the profession in Upper Canada, a man of the very highest character, did more than any one else to promote the progress of the profession; and throughout his long career his efforts were always directed to the proper channels. In looking through Canniff's most valuable work one is much impressed by the sterling worth and mettle of the old army surgeons who in the early days formed the larger part of the profession. The

minutes of the Medical Board indicate with what military discipline the candidates were examined, and the percentage of rejections has probably never been higher in the history of the province than it was in the first twenty years of the existence of the Board.

One picture on the canvas of those early days lingers in the memory, illustrating all the most attractive features of a race which has done much to make this country what it is to-day. Widmer was the type of the dignified old army surgeon, scrupulously punctilious and in every detail regardful of the proprieties of life. "Tiger" Dunlop may be taken as the very incarnation of that restless, roving spirit which has driven the Scotch broadcast upon the world. After fighting with the Connaught Rangers in the war of 1812, campaigning in India, clearing the Sangur of tigers—hence his soubriquet, "Tiger"—lecturing on medical jurisprudence in Edinburgh, writing for Blackwood, editing the *British Press* and the *Telescope*, introducing Beck's Medical Jurisprudence to English readers, and figuring as director and promoter of various companies, this extraordinary character appears in the young colony as "Warden of the Black Forest" in the employ of the Canada Company. His life in the backwoods at Gairbraid, his *Noctes Ambrosianæ Canadensis*, his famous "Twelve apostles," as he called his mahogany liquor stand (each bottle a full quart), his active political life, his remarkable household, his many eccentricities—are they not all portrayed to the life in the recently issued *In the days of the Canada Company!*

Turning now to the second period, we may remark in passing that the 19th century did not open very auspiciously for British medicine. Hunter had left no successor, and powerful as had been his influence it was too weak to stem the tide of abstract speculation with which Cullen, Brown and others flooded the profession. No more sterile period exists than the early decades of this century. Willan (a great naturalist in skin diseases), with a few others saved it from utter oblivion. The methods of Hippocrates, of Sydenham, and of Hunter had not yet been made available in everyday work.

The awakening came in France, and such an awakening! It can be compared with nothing but the renaissance in the 16th and 17th centuries, which gave us Vesalius and Harvey. "Citizen" Bichât and Broussais led the way, but Lænnec really created clinical medicine as we know it to-day. The discovery of auscultation was only an incident, of vast moment it is true, in a systematic study of the correlation of symptoms with anatomical changes. Louis, Andral and Cheomel extended the reputation of the French school which was maintained to the full until the sixth decade, when the brilliant

Trouseau ended for a time a long line of Paris teachers, whose audience had been world-wide. The revival of medicine in Great Britain was directly due to the French. Bright and Addison, Graves and Stokes, Forbes and Marshall Hall, Latham and Bennett were profoundly affected by the new movement. In the United States Anglican influence did not wane until after 1820. Translations of the works of Bichat appeared as early as 1802, and there were reprints in subsequent years, but it was not until 1823 that the first translation (a reprint of Forbes' edition) of Lænnec was issued. Broussais' works became very popular in translations after 1830, and in the journals from this time on the change of allegiance became very evident. But men rather than books diverted the trend of professional thought. After 1825 American students no longer went to Edinburgh and London, but to Paris, and we can say that between 1830 and 1860 every teacher and writer of note passed under the Gallic yoke. The translations of Louis' works and the extraordinary success of his American pupils, a band of the ablest young men the country had ever seen, added force to the movement. And yet this was a period in which American medical literature was made up largely of printed English books, and the systems, encyclopædias and libraries, chiefly reprints, testify to the zeal of the publishers. Stokes, Graves, Watson, Todd, Bennett and Williams furnished Anglican pap to the sucklings, as well as strong meat to the full grown. In spite of the powerful French influence, the text books of the schools were almost exclusively English.

In Canada, the period from 1820 to 1860 saw the establishment of the English universities and medical schools. In Montreal the agencies at work were wholly Scotch. The McGill Medical School was organized by Scotchmen, and from its inception has followed closely Edinburgh methods. The Paris influence, less personal, was exerted chiefly through English and Scotch channels. The Upper Canada schools were organized by men with English affiliations, and the traditions of Guy's, St. Bartholomew's, St. Thomas', St. George's, and of the London Hospital, rather than those of Edinburgh, have prevailed in Toronto and Kingston.

The local French influence on British medicine in Canada has been very slight. In the early decades of the century, when the cities were smaller, and the intercourse between the French and English somewhat closer, the reciprocal action was more marked. At that period English methods became somewhat the vogue among the French; several very prominent French Canadians were Edinburgh graduates. Attempts were made in the medical journals to

have communications in both languages, but the fusion of the two sections of the profession was no more feasible than the fusion of the two nationalities, and the development has progressed along separate lines.

The third period dates from about 1860, when the influence of German medicine began to be felt. The rise of the Vienna school was for a long time the only visible result in Germany of the French renaissance. Skoda, the German Lænnec, and Rokitansky, the German Morgagni, influenced English and American thought between 1840 and 1860, but it was not until after the last date that Teutonic medicine began to be felt as a vitalizing power, chiefly through the energy of Virchow. After the translation of the "Cellular Pathology" by Chance (1860) the way lay clear and open to every young student who desired inspiration. There had been great men in Berlin before Virchow, but he made the town on the Spree a Mecca for the faithful of all lands. From this period we can date the rise of German influence on the profession of this continent. It came partly through the study of pathological histology, under the stimulus given by Virchow, and partly through the development of the specialties, particularly diseases of the eye, of the skin, and of the larynx. The singularly attractive courses of Hebra, the organization on a large scale in Vienna of a system of graduate teaching designed especially for foreigners, and the remarkable expansion of the German laboratories combined to divert the stream of students from France. The change of allegiance was a deserved tribute to the splendid organization of the German universities, to the untiring zeal and energy of their professors, and to their single-minded devotion to science for its own sake.

In certain aspects the Australasian Settlements present the most interesting problems of Greater Britain. More homogenous, thoroughly British, isolated, distant, they must work out their destiny with a less stringent environment than, for example, surrounds the English in Canada. The traditions are more uniform and of whatever character have filtered through British channels. The professional population of native-trained men is as yet small, and the proportion of graduates and licentiates from the English, Scotch, and Irish colleges and boards guarantees a dominance of old country ideas. What the maturity will show cannot be predicted, but the vigorous infancy is full of crescent promise. On looking over the files of Australian and New Zealand journals, one is impressed with the monotonous similarity of the diseases in the antipodes to those of Great Britain and of this continent. Except in the matter of par-

asitic affections and snake-bites, the nosology presents few distinctive qualities. The proceedings of the four Intercolonial Congresses indicate a high level of professional thought. In two points Australia has not progressed as other parts of Greater Britain. The satisfactory regulation of practice, so early settled in Canada, has been beset with many difficulties. Both in the United States and in Australia the absence of the military element, which was so strong in Canada, may in part at least account for the great difference which has prevailed in this mattter of the state licence. The other relates to the question of ethics, to which one really does not care to refer, were it not absolutely forced upon the attention in reading the journals. Elsewhere professional squabbles, always so unseemly and distressing, are happily becoming very rare, and in Great Britain, and on this side of the water, we try at any rate "to wash our dirty linen at home." In the large Australian cities, differences and dissensions seem lamentably common. Surely they must be fomented by the atrocious system of elections to the hospitals, which plunges the entire profession every third or fourth year into the throes of a contest, in which the candidates have to solicit the suffrages of from 2,000 to 4,000 voters! Well, indeed, might Dr. Batchelor, in his address at the fourth Intercolonial Congress, say: "It is a scandal that in any British community, much less in a community which takes pride in a progressive spirit, such a pernicious system should survive for an hour."

Of India, of "Vishnu-land," what can one say in a few minutes? Three thoughts at once claim recognition. Here in the dim dawn of history, with the great Aryan people, was the intellectual cradle of the world. To the Hindoos we owe a debt which we can at any rate acknowledge; and even in medicine, many of our traditions and practices may be traced to them, as may be gathered from that most interesting "History of Aryan Medical Science," by the Thakore Saheb of Gondal.

Then there arises the memory of the men who have done so much for British medicine in that great empire. Far from their homes, far from congenial surroundings, and far from the stimulus of scientific influences, Annesley, Ballingall, Twining, Morehead, Waring, Parkes, Cunningham, Lewis, Vandyke, Carter, and many others, have upheld the traditions of Harvey and of Sydenham. On the great epidemic diseases how impoverished would our literature be in the absence of their contributions! But then there comes the thought of "the little done, the undone vast," when one considers the remarkable opportunities for study which India has pre-

sented. Where else in the world is there such a field for observation in cholera, leprosy, dysentery, the plague, typhoid fever, malaria, and in a host of other less important maladies. And what has the British Government done towards the scientific investigation of the diseases of India? Until recently, little or nothing, and the proposal to found an institute for the scientific study of disease has actually come from the native chiefs! The work of Dr. Hankin and of Professor Haffkine, and the not unmixed evil of the brisk epidemic of plague in Bombay, may arouse the officials to a consciousness of their shortcomings. While sanitary progress has been great as shown in a reduction of the mortality from 69 per mille before 1857 to 15 per mille at present, many problems are still urgent, as may be gathered from reading Dr. Harvey's Presidential address and the proceedings of the Indian Medical congress. That typhoid fever can be called the "scourge of India" and that the incidence of the disease should remain so high among the troops point to serious sanitary defects as yet unremedied. As to the prevalence of venereal disease among the soldiers—an admission of nearly 500 per mille tells its own tale. On reading the journals and discussions one gets the impression that matters are not as they should be in India. There seems to be an absence of proper standards of authority. Had there been in each presidency during the past twenty years well-equipped government laboratories in charge of able men, well trained in modern methods, the contributions to our knowledge of epidemic diseases might have been epoch-making, and at any rate we should have been spared the crudeness which is evident in the work (particularly in that upon malaria) of some zealous but badly-trained men.

In estimating the progress of medicine in the countries comprising Greater Britain, the future rather than the present should be in our minds. The strides which have been taken during the past twenty years are a strong warrant that we have entered upon a period of exceptional development. When I see what has been accomplished in this city in the short space of time since I left, I can scarcely credit my eyes; the reality exceeds the utmost desire of my dreams. The awakening of the profession in the United States to a consciousness of its responsibilities and opportunities has caused unparalleled changes, which have given an impetus to medical education and to higher lines of medical work which has already borne a rich harvest. Within two hundred years who can say where the intellectual centre of the Anglo-Saxon race will be? The Mother Country herself has only become an intellectual nation of the firs

rank within a period altogether too short to justify a prediction that she has reached the zenith. She will probably reverse the history of Hellas, in which the mental superiority was at first with the colonies. At the end of the next century, ardent old-world students may come to this side "as o'er a brook," seeking inspiration from great masters, perhaps in this very city; or the current may turn towards the schools of the great nations of the south. Under new and previously unknown conditions, the Africander, the Australian, or the New Zealander may reach a development before which even "the glory that was Greece" may pale. Visionary as this may appear, it is not one whit more improbable to-day than would have been a prophecy made in 1797 that such a gathering as the present would be possible within a century on the banks of the St. Lawrence.

Meanwhile, to the throbbing vitality of modern medicine the two great meetings held this month, in lands so widely distant, bear eloquent testimony. Free, cosmopolitan, no longer hampered by the dogmas of schools, we may feel a just pride in a profession almost totally emancipated from the bondage of error and prejudice. Distinctions of race, nationality, color and creed are unknown within the portals of the temple of Æsculapius. Dare we dream that this harmony and cohesion so rapidly developing in medicine, obliterating the strongest lines of division, knowing no tie of loyalty but loyalty to truth—dare we hope, I say, that in the wider range of human affairs a similar solidarity might ultimately be reached? Who can say that the forges of time will weld no links between man and man stronger than those of religion or of country? Some Son of Beor, touched with prophetic vision, piercing the clouds which now veil the eternal sunshine of the mountain top—some spectator of all time and all existence (to use Plato's expression)—might see in this gathering of men of one blood and one tongue a gleam of hope for the future, of hope at least that the great race so dominant on the earth to-day may progress in the bonds of peace—a faint glimmer perhaps of the larger hope of humanity, of the day when "the common sense of most shall hold a fretful world in awe." There remains for us, Greater Britons of whatsoever land, the bounden duty to cherish the best traditions of our fathers, and particularly of the men who gave to British medicine its most distinctive features, of the men, too, who found for us the light and liberty of Greek thought—Linacre, Harvey, and Sydenham, those ancient founts of inspiration and models for all time in Literature, Science, and Practice.

TREATMENT OF GASTRO INTESTINAL CATARRH.*

By Dr. H. D. Livingstone,
Rockwood.

IN presenting the accompanying paper—the treatment of acute gastro intestinal catarrh in infancy—I limit the term to those cases of intestinal derangement occurring most frequently in children under the age of two years, and confined chiefly to the summer months.

I think a more or less common error, especially among the younger practitioners, is a failure to attach due importance to this branch of pædiatrics, and, in overlooking the fact that we are dealing with an extremely delicate organization in the infant, to modify the treatment on the plans most commonly observed in adult cases.

Although of a very susceptible constitution and prone to the contraction of disease, the child, on the other hand, possesses great elasticity, and it is this very sensitiveness to surrounding influences, which forms in our prognosis a potent factor for good or evil, as readily responding to proper management as to succumb to injudicious measures of treatment.

On considering the most recent views on the etiology of this affection, it becomes evident that the cause is of a toxic nature, some bacteria probably being ingested with food, others produced as the result of its decomposition, and a few which are no doubt always present in the intestine, awaiting only a condition of lowered vitality and perverted secretion to excite an acute diarrhœa.

Without doubt, in the large majority of cases, the disease is, in its primary stage, a condition of gastric indigestion, perhaps at first scarcely noticeable, but gradually leading to those fermentive changes in the stomach contents which originate the trouble.

The direct cause in many cases, can be traced, not so much to the influence of great heat, or to the ingestion of contaminated food, as to the habit of indiscriminate feeding in children under two years of age, and I have frequently found on enquiry from the parent, that previous to an attack, the child had committed some gross indis-

*Read before the Ontario Medical Association, Toronto, June, 1897.

cretion in this direction, simply from the fact of being allowed to partake, and often in excessive quantity, of everything which appears on the table. Under such circumstances it is not hard to understand how the delicate and undeveloped stomach of the child should revolt, sooner or later, against a diet totally out of proportion to its powers of digestion, and capable of exciting a diarrhœa which is often both toxic and mechanical in its nature.

The above facts direct attention to the most common cause of this intestinal affection in children and to a consideration of the remedies in vogue for its cure.

Of medicinal agents there are probably none so harmful in effect and yet so frequently and carelessly administered as opium.

If we accept the almost universal view that the summer diarrhœa of infants is toxic in character, we are defeating our own ends in giving opium at all except as a last resort. The tendency in this affection is nearly always towards natural recovery, the frequent movement of the bowels simply an effort to rid themselves of irritant material, and why should we retard that object?

The evil effects of opium are evidenced in many ways. By its stimulating effects on the inhibitory fibres of the splanchnic nerves it lessens intestinal action, allowing the retention of decomposition products, and accumulation and absorption into the general circulation of toxic material. At the same time it of necessity disorders digestion in the stomach, which is already deranged, for be the dose however small, if it is sufficient to produce any constipating effect on the intestines it must also indirectly influence the stomach. In addition to this, if given in overdose, or its use continued too long, it paralyzes the inhibitory fibres of the splanchnics, and as a result of the withdrawal of the natural restraining influence on the intestinal walls, increased peristalsis ensues, and an aggravated condition of the original trouble is produced. Thus in the administration of opium, not only are we combatting the natural effort on the part of the gastro-intestinal tract to rid itself of foreign and irritating material, but we lock up the secretions of those glands whose duty it is to provide juices which are necessary for intestinal digestion, and for a medium antagonistic to the development of bacteria.

It may be argued that opium might be justifiably used in small doses, provided evacuation and cleanliness of the bowels have been secured. Even with initial catharsis and thorough irrigation of the tract, can we be sure that some irritating material has not remained, to find the most favorable possible ground for toxic development, in the condition of arrested motion of the bowels induced by the exhibition of opium?

Considering the extreme susceptibility of infants to the use of this drug, it would certainly appear distinctly contra-indicated under the above conditions, and if used at all, reserved only for the most severe cases, characterized by the continuance of much pain and frequent watery movements, and even then would stimulants not be more beneficial? It should decidedly not be used unless strict evacuation and irrigation of the bowel has preceded it, and then never in composition, but always alone and in small repeated doses, that its effects may be more carefully watched.

Many other medicinal agents are recommended and used as routine treatment, the essential oils, astringents, etc. On what ground is their efficacy based? Apart from the irritating effect many of them possess, their action does not seem to meet the indications in the present case.

Perhaps the only astringent drug which is really of service in this connection is bismuth, which also possesses sedative qualities and may be safely used, when required, in fairly large and repeated doses.

In considering the foregoing remarks, and viewing the disease as toxic in character—chiefly due to disordered function—the main therapeutic indications which suggest themselves appear to be:

Elimination, antisepsis. perfect digestion.

Elimination claims the first attention. By it we endeavor to assist Nature in her effort to expel offending material from the gastro-intestinal tract. Once decomposition and fermentation start in food and the digestive functions in abeyance, and we have all the conditions necessary for a perfect culture medium for germs. If we can hope to at once sweep out this irritating substance, and, by allowing the stomach and bowels as complete rest as possible, to restore digestion, at the same time endeavoring to keep the tract fairly antiseptic, we may reasonably look for natural recovery. Some cases point directly to the occurrence of an attack, following the ingestion of food known to have been irritating or unsuitable. Prompt emesis in these instances will frequently be followed with good results, and serve to shorten an otherwise tedious attack. In all severe cases, whatever the cause, much benefit will be experienced from thorough irrigation of the colon.

As an initial cathartic, calomel would appear to possess decided advantages. It is usually well borne by the stomach. It aids digestion, stimulates the glands to activity, thereby tending to restore their tone and is known to possess decided antiseptic properties.

In considering antisepsis in this connection, calomel again may

be said to hold an equal, if not superior, position to others commonly employed. Recent authorities appear to agree in the opinion that we have no reliable intestinal antiseptic, and mercury in some form has the additional advantage that it stimulates the flow of bile, the natural antiseptic of the bowels, that its effects may be continued in small doses after the initial catharsis has been produced, and while exerting its antiseptic properties tends to maintain a certain amount of movement which is necessary for the expulsion of foreign products.

This brings us to the consideration of digestives. During the first twelve or twenty-four hours of an ordinary attack complete rest should be allowed the stomach, nothing in the way of nourishment being permitted except plenty of boiled water and small amounts of such articles as either whey, albumen water, barley water, or freshly-expressed, home-prepared beef juice. After this interval it becomes necessary in most cases, especially if the attack appears likely to be a prolonged one, to administer some more nourishing food, and at the same time a medicinal aid to its digestion. Some preparation containing pepsin and hydrochloric acid in combination meets the latter requirement, and may be obtained in different attractive and palatable forms.

The importance of at once securing as perfect digestion as possible is paramount when we consider the frequent tendency that this affection has, if mismanaged, to merge into an inflammatory condition of the lower bowel, or, to be the forerunner of cholera-infantum.

In preparing the foregoing paper I have endeavored merely to outline the treatment of those more important indications which the etiology appears to suggest, and which are often abused by the indiscriminate use of harmful drugs.

DECIDUOMA MALIGNUM.

By J. C. Webster, M.D. Edin., F.R.C.P.E., F.R.S.E.

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In 1888 Sanger, of Leipsic, introduced this term to apply to two cases in which, after abortion, soft, spongy tumors developed in the uterus, with metastases in the lungs, ribs and other parts, and believed by him to belong to the sarcoma group. Since that time a considerable number of cases have been described, but owing to the varying nature of the accounts there is the greatest confusion as to the nature and origin of the growth. At the present time the views which exist may be stated as follows:

Relationship to Pregnancy.—These cases have been described as occurring within a few days, weeks or months after full-time labor, abortion, hydatid mole, ectopic gestation. A large proportion have been described in relation especially to hydatid mole. It is possible that in some cases the primary growth may begin to grow before the pregnancy is ended. The condition has been found at all periods of the sexual life, the largest proportion having been between the ages of 20 and 30.

Clinical Features.—Hæmorrhage from the uterus is usually the first and most marked symptom. It occurs irregularly. The uterus is enlarged by the soft growth of the mucosa, which may affect the thickness of the whole wall. After curetting of the mass rapid return is usual. The rapid development of metastases is a prominent feature. They are most frequent in the lungs; common in the vagina; and may occur in other parts, *e. g.*, ribs, iliac fossa. The disease progresses rapidly and death usually takes place within six months of the appearance of symptoms.

Pathology.—There is the greatest discordance of opinion as to the pathology of this condition. By some the growth has been described as carcinoma, by others, as sarcoma, and by others, as a mixture of carcinoma and sarcoma.

As to the starting point, some cases are described as maternal in origin, either from epithelial, connective tissue or muscular elements; others are described as fœtal, either from the epithelium or connective tissue of the chorionic villi, or from both; and others are described as a mixture of fœtal and maternal elements.

From a careful examination of the literature it appears that the cases may be divided into the following groups:

1. Those in which the primary growth and metastases are composed of cells of sarcomatous, carcinomatous or mixed sarcomatous and carcinomatous types.

2. Those in which the structure is that found in group 1, along with syncytial structures, irregularly shaped masses of nucleated plasmodial protoplasm.

3. Those in which the structure is that found in group 2, along with structures resembling placental villi.

Group 1. In regard to group 1 very little need be said, except to point out that the difficulty of deciding as to the carcinomatous or sarcomatous nature of some malignant uterine growths is much older than the discovery of deciduoma malignum, and has been pointed out in connection with the uterus apart from the influence of pregnancy as well as in connection with it. Virchow, Hegar, Gusserow, Klebs and others have referred to this point, and the latter author was so impressed with the tendency of these growths to occur together in the corpus uteri that he proposed to call them by the term *carcinosarcoma*. The difficulty of establishing their histological nature will be increased by the complication of the influence of pregnancy.

Should the growth occur soon after delivery, the remains of the decidual tissue and of glandular elements may present appearances exceedingly hard to interpret correctly; moreover, it is to be remembered that normally the range of variation in the structure of the mucosa in pregnancy and after delivery is considerable. (*Vide* my investigations on the changes in the uterine mucosa during pregnancy, and in the attached fœtal structures, described in the *Amer. Gyn. and Obstet. Journ.*, 1897.) The chief feature of these tumors is the large type of the cells which compose it. Now, it is to be noted, that everywhere else in the body rapidly-growing sarcoma is of the small-celled variety. When sarcomata develop in the uterus of a woman who has not been pregnant, or in whom pregnancy has not taken place for a long time, there is no tendency to the formation of large cells.

It is evident, then, that this is a characteristic related to pregnancy and the explanation is probably as follows: The genetic

influence which is due to fertilization, and which in the beginning of pregnancy leads to the formation of a decidua, is probably not lost for a considerable while after pregnancy, and may be so excited by the irritation of a new growth that the connective tissue elements multiply and take on that development to which they are physiologically peculiarly disposed, viz, the formation of cells of large size. This will probably be all the more noticeable when the new growth is one developing in connection with the connective tissue elements. The occurrence of large cell formation in the inter-glandular tissue of the uterine mucosa has not been noted where the influence of a pregnancy does not come into play. Thus in Overlach's phosphorus poisoning and in Ruge's endometritis case where large cells were found, the influence of a past abortion could not be excluded. Such cases prove that the genetic influence may extend for many weeks after labor; and we already know that it may act at a distance because decidual formation may take place in the uterus when fertilization occurs in one tube, or it may occur in the opposite non-pregnant tube, as I have shown by my researches in ectopic pregnancy.

It is not, therefore, remarkable that sarcomatous (or carcinomatous) changes in the uterine mucosa, which has recently been submitted to the influence of pregnancy, may be marked by the formation of cells of a large or decidual type; and it seems to me unnecessary to apply the term "deciduoma malignum" to this group. As regards the rapidity of growth, it has long been known that this is a special characteristic of malignant growths of the uterus developing in the puerperium—very possibly related to the weakened condition of the woman in association with the profound changes which have occurred in the body metabolism.

Group 2. In this group, of which the case published by Whitridge Williams may be taken as a type, besides the large, malignant, decidua-like cells which compose the great part of the tumor, there are masses of syncytium, varying in size and shape, though often in bands composed of granular, nucleated protoplasm—plasmodial in appearance, and vacuolated in different parts. Sometimes the masses may be found burrowing through the walls of venous sinuses.

This structure is also found in the metastatic growths, where it may be more abundant and in more varied shapes than in the primary growth. Some of the masses exactly resemble sections of the early epiblastic buds found growing from the chorion in pregnancy. In the midst of the cells of the tumor, blood is found, though often no distinct vessels can be made out.

Regarding these growths, there is very great dispute, especially with regard to the syncytium. Some regard them as sarcomata or carcino-sarcomata of maternal origin. Kaulbach and others regard them as sarcomatous developments of the connective tissue of the mucosa, the syncytial masses being due to degeneration in the sarcomatous cells. Those who are opposed to this view state that the syncytium is too abundant and too distinct a formation to be accounted for in this way, and that no such marked appearances are ever seen in sarcoma occurring elsewhere in the body.

Others believe that these tumors are entirely of fœtal origin, the decidua-like cells being derived either by sarcomatous changes in the mesoblastic core of the villi or by proliferation of the deep layer (Laughans') of the epiblastic covering of the villi; the syncytium being derived from the superficial layer of the epiblast, which is a syncytial structure.

Another view is to the effect that the tumors are made up of a mixture derived both from fœtal and maternal sources.

The important feature of the tumors of this group are the syncytial masses. All observers are agreed upon their great resemblance to the syncytium normally found in the uterus in pregnancy. If it can be established that their formation is not due to degenerative processes in the sarcoma, but that they are identical with the syncytium of pregnancy, then it will be necessary to regard the growth as of undoubted fœtal origin—*an epiblastoma*, if I may use the word. For there can now be no doubt that the syncytium of pregnancy is derived entirely from the outer portion of the epiblastic covering of the ovum. That it is not of maternal origin, the researches of Kastscheuko, myself, and others clearly show. It is found at first on the early ovum, from which it spreads to the surface of the decidua which is related to the chorion; it has trophoblastic powers, and can penetrate the decidua, reaching even into the muscular part of the wall; it opens the maternal sinuses in the serotina, and portions of it may be found free in the veins, and may be carried by the blood-current some distance from the uterus, even to the lungs.

It would not, therefore, appear to me marvellous if the fœtal epiblast should sometimes overstep the normal range of its activity and take on malignant action. A dermoid cyst of the ovary is a tumor derived from the early epiblast, and it is widely recognized that, in case of rupture, it is very apt to set up secondary growths in the peritoneum as a result of infection by its epiblastic elements. These may become malignant.

Group 3. This is composed of cases in which the tumor has developed after a hydatid mole has been expelled from the uterus. The new growth and metastasis are, in some cases, composed entirely of masses of syncytium and of structures exactly resembling on section villi in various stages of development, *i.e.*, solid syncytial buds, vacuolated buds or rings of epiblast filled with mucoid tissue; in other cases, besides these elements, there are large cells which may possibly have originated from the deep layer (Laughans') of the epiblastic covering of the villi.

The appearances presented by the first of these classes are so very like those seen in microscopic sections of the placenta, both in uterine and ectopic gestation, that one is inclined to agree with Klebs in regarding the new growth as a case of fœtal parasitism due to malignant changes in fœtal remains left in the uterus.

Selected Articles.

ULCERS FROM AN EXTENSIVE BURN TREATED WITH BOVININE.

By F. R. Blanchard, M.D.,
Lakeview, Mich

On the morning of April 28, 1897, I was called to see W.T.B., aged forty-three years, engineer in a stave factory, who had been injured by the explosion of the mud drum. I saw him an hour after the accident and found him suffering intense pain, and wildly delirious.

Whisky had been administered to overcome the shock, and three eighth-of-a-grain morphine pills to relieve the pain. I immediately gave a hypordermic of morphine, a quarter of a grain, and atropine, one one hundred and fiftieth of a grain, which soon quieted him, and then examined his injuries, finding the following conditions: Upper extremities severely burned about the face, neck, and upper portion of the chest, the left eye, ear, and nose being most severe; left arm, at elbow, wrist, and entire hand; right arm at wrist. Lower extremities: right buttock, over one half of the surface; right leg on the patella, calf and ankle; left buttock, thigh and leg, over the whole posterior surface, patella, and a strip two inches wide running nearly around the ankle.

The burns were all of the second degree and healed without sloughing, except on the left calf and ankle.

The appearance of the left eye was bad, the cornea being cloudy, and my prognosis was guarded, but the eye afterward cleared up and sight is normal.

I dressed the wounds with limewater and linseed oil, equal parts, applying it on old linen cloths saturated with the mixture, and coving it with wadding obtained at a dry-goods store.

In the evening, when I changed the dressings, I found vesicles and large bullæ had formed containing clear serum, the largest to

the amount of four ounces, all of which I punctured, removing all loose strips and hanging folds of epidermis.

The limewater and linseed-oil dressing was used four days and then discontinued, a dressing of plain vaseline being substituted. As soon as pus began to form the wounds were thoroughly cleansed with corrosive-sublimate solution (1 to 3,000), using small pledgets of absorbent cotton, then dusted with acetanilide and boric acid, equal parts, applied with a pepper duster, and the vaseline dressing applied; dressing changed every twenty-four hours.

The corrosive sublimate solution seeming to cause too much irritation, I changed to two per cent. carbolic acid solution, which worked admirably.

The eyes were treated with ice compresses, the pupils were kept fully dilated with atropine sulphate, and the following eye wash was ordered: ℞ acidi boric, sodii biborat., āā ℈ j; aquae camph., aquæ, āā ℥ ij. M.

The internal treatment was with morphine to quiet pain, and aconite when the pulse was too full and strong.

May 22nd.—Twenty-five days after the accident the wounds were all healed except those of the calf and ankle of the left leg; on the calf was an ulcer eight inches long by four inches wide, and on the ankle a strip two inches wide, running nearly around the leg, both having a very unhealthy appearance, with deeply cut edges. I concluded it would be necessary to try skin grafting, but wished first to get a healthy granulating surface. It was then I conceived the idea of treating it with bovine blood.

23rd.—I first cleansed the ulcers thoroughly with the carbolic solution, then saturated plain aseptic gauze with bovinine and covered the ulcers; over this I put a layer of gutta-percha tissue, and covered the whole with wadding. The following morning when I removed the dressings there was no pus, and healthy pink granulations were springing up over the ulcers. I changed the dressings every twenty-four hours, and could see a rapid improvement each time, the new skin extending in more and more from the edges. Improvement was so rapid I concluded grafting would not be necessary, and continued the bovinine dressings, dusting the new granulations with calomel if they became at all exuberant.

June 4th.—Twelve days after beginning these dressings the ulcers were entirely healed. I then put on a dressing of plain vaseline, applied a bandage, to be worn during the day as a support to the circulation, and discharged the case.

12th.—At this writing there are no signs of any remaining scars.

One thing noticeable with the blood treatment was the absence of pain. Before I used it the ulcers were very painful, but after applying the blood dressing there was immediate relief, and the patient experienced no more pain.—*N. Y. Medical Journal.*

MEDICAL LEGISLATION IN CANADA.

ONE of the most important subjects now being considered by the medical profession of Canada is, undoubtedly, that which refers to a uniform standard of medical education, and a common license for the whole Dominion. The subject is by no means new. At a meeting of the Canadian Medical Association held sixteen years ago in Halifax some informal discussions on inter-provincial registration took place, and those from the west, especially Ontario, were rather surprised to find that the profession in the maritime provinces held very pronounced views on the subject.

We intend to devote a considerable portion of this issue to the question of medical legislation in Canada, and will publish extracts from various papers and addresses written and delivered during the last five years, which will give a fair insight of the various aspects of a very complicated subject. In this province there has been displayed a certain amount of apathy, or indifference, about the matter, that is rather surprising, and has caused some strong expressions of disapprobation in other provinces both east and west of Ontario.

The Medical Council of this province has received a fair share of censure from various sources. Many members of that body have shown a decided interest in the subject, and a strong desire to find a solution of the numerous difficulties which exist; but, we fear, there is some reason for the opinion of many that the Council as a whole has shown very little interest in the matter. It was certainly unfortunate that at the recent conference, held in Montreal, Ontario was not prepared to present an official report of any description.

After many ineffectual efforts to get a meeting of representatives from all parts of the Dominion, a conference took place at Ottawa in September of 1892, during the meeting of the Canadian Medical Association, when the following resolutions were carried unanimously:

(1) "That in the opinion of this conference there should be in each province in Canada a central examining board to examine all candidates for medical registration therein.

(2) "That as soon as a central examining board is formed in each province a committee should be appointed from each provincial medical council in order to have established a uniform standard of matriculation and of medical education throughout Canada, and also reciprocity between the provinces in regard to medical registration."

It was supposed at that time that the principal obstacle existed in Quebec, where the universities were opposed to handing over their licensing powers to a central examining board. During the session of the Quebec Parliament—1891-2—a motion to establish such an examining board was defeated by a majority of one. We have no desire now to discuss the various aspects of the question in detail, but simply to give the views of various parties who have considered the matter more or less carefully. In the first place we will extract from the presidential address of Dr. Jno. L. Bray, of Chatham, delivered at the Ottawa meeting in 1892:

DR. BRAY ON MEDICAL RECIPROCITY.

And this brings me to the second part of my subject, viz., the question of medical reciprocity between the provinces. In reading over the Medical Acts of the different provinces, I find that Ontario is the only one that has a central examining board appointed by the council, before whom every student desirous of practising in that province, no matter from what country he may come or from what university he may have a degree, has to pass. I further find in the Ontario Medical Act this clause: 'When and as soon as it appears that there has been established a central examining board similar to that constituted by this Act, or an institution duly recognized by the legislature of any of the provinces forming the Dominion of Canada, other than Ontario, as the sole examining body for the purpose or granting certificates of qualification, and wherein the curriculum is equal to that established in Ontario, the holder of any such certificate shall, upon due proof, be entitled to registration by the Council of Ontario if the same privilege is accorded by such examining board or institution to those holding certificates in Ontario.

I find in the Manitoba Medical Act that the University of Manitoba is the sole examining body for the province, and in that respect comes nearer to the requirements of Ontario than any other and I see no reason why as long as this remains so reciprocity should not exist between Manitoba and Ontario. Now it appears to me there are just two ways whereby reciprocity between the provinces can be brought about, and these are, first, the repeal of

that portion of the British North America Act which gives the various provinces sole control over all educational matters, by taking from them this right and vesting it in the Federal Government, and the appointment of a Dominion Medical Board; or, secondly, the estab lishing of Medical Councils for each province, which shall appoint a Central Examining Board similar to that of Ontario, and when this is done let representatives from each provincial council meet, say, in Ottawa, and fix one uniform standard of medical studies to be adopted by all the provinces. Now, as to the first, I think it is entirely out of the question, and can be put aside as utterly impracticable, as I feel sure the local legislatures would never consent to have the control of the educational system taken out of their hands. As to the second proposition, I see no good reason why it should not be adopted. In all the Provincial Medical Acts, so far as I am aware, full power is given the councils to fix the periods of study, make their own curricula, and conduct their own examinations in the way which to them may seem best. Now, all the colleges and universities in the Dominion, so far as I can learn, require four full years of study from a student before going up for his degree, excepting those of British Columbia, whose council is satisfied with three. The teaching in all these institutions is very similar, so that it would not be a difficult task to make them uniform in this respect. Then all that remains to be done is to appoint a Central Medical Examining Board for each province, to examine and recommend for license all graduates, leaving the universities the power of granting degrees only.—CANADIAN PRACTITIONER.

THE OTTAWA MEETING.

After the committee brought in the report, to which we have previously referred, at the Ottawa meeting a short discussion took place, but no definite conclusion was reached. It was decided to make the committee somewhat larger and ask for a more extended report to be presented at the next meeting.

THE LONDON MEETING.

At the meeting held in London, Sept, 1893, the committee, in accordance with instructions received at Ottawa the praye eicndger, presented a report in which it was proposed that a Dominion Medical Council be formed "to take general surveillance of the medical curriculum, and of all matters affecting the general public and profession of the whole Dominion," formed either by representatives (one each) from the members of the various provincial Medical Councils, or

elected by the medical population of Canada irrespective of provincial lines; or on the "line of the British Medical Council." Its duties should be the equilization of the medical curriculum to a just and high standard; to secure interprovincial reciprocity; to have the power to withhold or take away a Dominion license from a provincial graduate for just cause; to approve all provincial examination papers before they were presented to candidates. There should only be one examination for the provincial and Dominion licenses, and extra fee for the latter. If it followed the British Medical Council in its formation, the British Medical Council regulations should be operative as applicable to the Dominion. All men now on provincial registers to be entitled to Dominion registration within the year of the formation of the first Dominion Medical Council on payment of $10. All practitioners outside of Canada and Great Britain would be allowed a Dominion license upon passing the prescribed examination. All those on the British register would be entitled to registration upon payment of $25 as soon as Great Britain extended the same privilege to Canada. The committee further recommended that the association, through a committee, should present these views to the provincial councils, and by concerted action with them to apply at the next session of legislature for such permissive legislation as would be required to establish the powers and duties of the Dominion Medical Council. If any provincial council refused to accede to the demands of the general profession for these objects, that this association should instruct their delegates to go to the legislature of such province and secure the required concession.—CANADIAN PRACTITIONER.

This report was not considered satisfactory, and after a brief discussion was "tabled." After this there was but little done for a couple of years, although there were many complaints made, especially by practitioners in the maritime provinces, respecting the alleged hostility shown by the profession of Ontario to interprovincial reciprocity. At the meeting held in St. John, N.B., 1894, a new committee was appointed.

The Montreal Medical Journal contained the following editorial before the Kingston meeting:—

RECIPROCITY OR DOMINION REGISTRATION.

At the coming meeting in Kingston of the Canadian Medical Association a committee, appointed last year, will report on the important questions of reciprocity and Dominion Medical Registration. What the result will be, it is difficult to predict. Much

will depend on the humor of the delegates from the various provinces, comprising the committee. Judging from the tone of the discussion on this subject, at the meeting of the Ontario Medical Council, the other day, we fear that the representatives from that province will again demand more than those from the Province of Quebec at any rate will be prepared to grant. It will be a great pity if some definite understanding cannot be arrived at on these important questions. Reciprocity would answer the purpose for the present. There is already an understanding between Quebec and Manitoba, so that the licenses granted by the boards of these respective provinces allow candidates to practice in either without further trouble. Quebec and New Brunswick had a similar understanding, up to a short time ago, when some irregularities occurred, and they no longer reciprocate. Reciprocity would be specially desirable between the great provinces of Ontario and Quebec; both because of the larger population in these provinces, and the very great length of frontier line. Does it not seem absurd that a medical man cannot cross the River Ottawa, to attend an urgent call, and perhaps save a life, without making himself liable to arrest and fine? Such, however, occurs constantly, and must have the effect of lowering the profession in the estimation of the public, giving them the impression that we are a narrow-minded lot. It is not generally known that even between France and Germany—countries always most unfriendly in other respects—a neutral territory is established, extending for fifteen miles on either side of the boundary line, which can be traversed without molestation by medical men of either country in the discharge of their professional duties. Let us hope that the members of the committee referred to, and the Association generally, will meet this question in a loyal and fraternal spirit, so that some amicable and practical understanding may be arrived at.

Some form of Dominion medical registration, would, of course, be the ideal thing, but we fear that that must be delayed until reciprocity has been in operation long enough to satisfy the public and the authorities at Ottawa that we are united as a profession on this subject. The late Sir John Thompson is known to have held the opinion that, while in accordance with the British North America Act, all questions of education were relegated to the various provinces, it was possible to have a Dominion examining board and board of registration, providing only the profession representing the various provinces were unanimous in their presentation of the case to the government in power. This would not necessarily interfere

with provincial rights. Each province should, if so disposed, still have its own examining or licensing board, or both, for the purpose of examining and licensing candidates who were going to be satisfied to practice in the limited sphere of that province. More ambitious candidates would prefer the stiffer examination of the Dominion board; but they would have the supreme advantage of being permitted to practice in any part of the British Empire. It is rather galling to the Canadian to find the Australian graduate in medicine settling in London without further examination by simply paying his registration fee. The Medical Council of Great Britain will give us the same privileges as soon as we shall have arranged some form of federal registration.—*Montreal Medical Journal, August, 1895.*

DOMINION MEDICAL REGISTRATION.

The following editorial appeared in THE CANADIAN PRACTIONER, October, 1895:—"It is unfortunate that the question of medical registration for the whole Dominion is surrounded by so many difficulties. The matter has frequently been been discussed at meetings of the Canadian Association, as it is naturally supposed that that is the proper body to consider the question. It was hoped that the committee of this association which was appointed at the St. John, N. B. meeting in 1894, to consider and report on the question, would be able to do something in the way of removing the difficulties which prevent a satisfactory settlement of the whole matter. In the report presented, the members of the committee "expressed their regret that, by the system which at present obtains, a graduate in medicine entitled to practise in our province is not free to exercise his functions in all the provinces in this large but sparsely settled Dominion; that this condition of things prevents the names of medical practitioners in this Dominion being placed on the British register, becoming thereby British practitioners. This latter is a boon which the council of Great Britain has more than once signified its willingness to grant. To secure these ends, it is considered most desirable that a uniform standard of medical education for the whole Dominion be established. In order to affect this purpose, it is suggested that the secretary be instructed to communicate with the various provincial councils before the next meeting, asking that each council discuss the position, and, if possible, appoint one or more delegates to a Dominion committee for the purpose of adjusting a suitable curriculum to carry out the suggestion herein, and that such committee be requseted to forward its findings to the provincial

councils and to the secretary of the association before the next meeting."

This report is somewhat disappointing to those who hoped that the committee would have worked in the direction of communicating with the various provincial councils, instead of simply suggesting that something of this sort be done in the future. What we wanted to get from the committee was work, and not suggestions. We have been deluged with suggestions for some years; we want now to get one step farther.

The Montreal Medical Journal fears that the representatives of Ontario will demand more than those of Quebec will be prepared to grant. It also suggests that reciprocity would answer the purpose for the present, and states that such reciprocity now exists between Quebec and Manitoba. If Ontario and Quebec could agree, it is likely that the other provinces will fall into line. We think a good deal will depend on the attitude of the Ontario Medical Council, which, in the past, has not always shown a conciliatory disposition. We have reason to think, however, that a majority of the present council are anxious for reciprocity or Dominion registration, and will gladly confer with delegates from the other provinces, and assist in finding a solution of the many opposing difficulties."

INTER-PROVINCIAL REGISTRATION.

That vexed question, inter-provincial registration, which has occupied the earnest attention of the profession in Canada for nearly thirty years, was undoubtedly advanced a stage at the recent meeting of the Canadian Medical Association in Kingston. The following composed the committee appointed last year at the meeting in St. John to report on this question: Sir James Grant, Drs. Cameron and Pyne, from Ontario; Sir William Hingston, Drs. Marcil, Beausoleil, Chalotte, Parke and Roddick, from Quebec; Drs. Bayard, Christie and White, from New Brunswick; Drs. Farrel and Muir, from Nova Scotia; and Dr. Warburton from Prince Edward Island. Two lengthy sessions of the committee were held, so that the matter was thoroughly discussed and the views obtained of the several representatives. No very definite scheme, however, resulted, but the following resolution was unanimously adopted for the guidance of the association:

"The committee appointed at the last meeting to look into the question of inter-provincial registration would beg to express thei regret that by the system which at present obtains, a graduate in

medicine entitled to practise in one province is not free to exercise his functions in all the provinces of this large but sparsely settled Dominion;

"That this condition of things prevents the names of medical practitioners in this Dominion being placed on the British registers, becoming thereby British practitioners, which the Council of Medical Education of Great Britain has more than once signified its willingness to grant;

"That with this end in view it is, therefore, most desirable that there should be a uniform standard of matriculation, a uniform standard of medical education, and a uniform method of examination for the whole Dominion.

"That to effect this purpose, the secretary be instructed to communicate with the various Provincial Councils, before their next meeting, asking that each Council discuss the question, and, if possible, appoint one or more delegates to a Dominion committee for the purpose of adjusting a suitable curriculum and carrying out the suggestions herein contained, and that such Committee be requested to forward their finding to each of the Provincial Councils and to the secretary of this association before the next annual meeting."

The committee were fortunate in having present Dr. Pyne, Registrar of the College of Physicians and Surgeons of Ontario, as he was in a position to give official information regarding the attitude of that province on this question. He made it plain that the Medical Council of Ontario was pledged to grant reciprocity to any province having a Central Examining Board and whose curriculum was equal, in the main, to theirs. With reference to the course of five years of study now exacted, it was thought by all the members of the committee who represented Ontario, that four sessions of nine months each might be taken as equivalent. In fact there was a general impression that, while the conduct of the Ontario Medical Council in this connection might at times have been arbitrary, it was not, on the whole, inconsistent.

We shall take occasion to refer again to this matter in an editorial way, and trust in the meantime that the various Provincial Councils will give the above resolution their earnest consideration, so that, at the meeting of the association, to be held next year in Montreal, some definite scheme for reciprocity and inter-provincial or Dominion registration will be consummated.—*Mont. Med. Jour.*, Oct., '95.

DOMINION REGISTRATION.

We are pleased to note that the discussions which are being

carried on, especially in medical journals, in various parts of Canada, on the subject of Dominion or inter-provincial registration, are thoroughly earnest, and yet moderate in tone. There seems to be no doubt that all the provinces want something of the kind; and, if so, surely there are no insuperable obstacles in the way. It happens that the Ontario Medical Council has, by its rules and regulations, caused a certain amount of irritation among certain sections of the profession in other provinces. Without any reference to the merits of the case, we have to state that the council of this province has often been misunderstood by outsiders. We had very good evidence of this at the meetings of the committee appointed by the Canadian Medical Association, and held during the last meeting of that association, when Dr. Pyne, registrar of the council, gave a good deal of information with reference to the attitude of our medical parliament on this question. He showed clearly that our council had, years ago, passed a statute, which still exists, pledging that body to grant reciprocity to any province having a central examining board, with a curriculnm equal to that which prevails in Ontario.

This, apparently, caused surprise in some members of the committee, but led to a very important discussion as to the proper length of a medical course. Ontario now requires five years. The majority of the members of the committee appeared to think that a course including four sessions of eight or nine months each would be preferred by most of the provinces. We think that would be a fair compromise, which would not be opposed by the majority of the profession in Ontario. The question as to the standard of matriculation may cause differences of opinion; but there is no reason, so far as we have information, why a solution should not be reached. A *friendly* conference could, probably, accomplish all that is desired in a comparatively short time. Let us have such a meeting between representatives of the different provinces as soon as possible.—CANADIAN PRACTITIONER, November, 1895.

INTER-PROVINCIAL REGISTRATION.

It's hardly necessary in these days to show by argument that inter-provincial registration is a desirable measure, for although the number of physicians who emigrate from our province to another is small, and perhaps will always be small, yet we all wish to feel that if for reasons of health, finance, or of any other nature, we should at any time contemplate a change of residence from one part of the Dominion to another, that no obstruction will stand in the way of our registering when we make the change. The diseases met with

in one province are the diseases met with in all, and there are no peculiarities of treatment special to any of them. A physician qualified to practise in our province is qualified to practise in all, and it would seem as if he ought to be able to do so, and not find, as he does at present, a closed and impassable door at the threshold of every province outside of his own. Another important reason in its favor is that until it is accomplished, reciprocity with the mother country cannot take place; while upon its satisfactory accomplishment a registered physician will be able to practise anywhere in Canada or the United Kingdom. Meanwhile the experience of these maritime provinces, in which reciprocal registration has been definitely arranged, shows favorable results without any disadvantages that we have heard of. The subject has for several years past occupied the attention of the Canada Medical Association, but year after year, the report of the various committees appointed to investigate the matter and present a suitable scheme, was a monotonous and helpless *non possumus*. At the meeting before the last, this report was not received kindly, and it was stated plainly by various members, that if there was to be any earnestness shown in the matter, it was time it was apparent, that it had been played with too long, and that a definite result should be obtained, whether favorable or unfavorable. The consequence was the appointment of a strong committee, who met last year at Kingston. This committee, if they did nothing more, were successful in locating and bringing to light what all along has been the great stumbling-block, viz., the opposition of the Province of Ontario to any scheme which would differ in any material manner from the course of study and length of time of study authorized in that province. The members outside of Ontario were told, and in rather a patronizing manner, too, that inter-provincial registration was a very good thing indeed, but in order to obtain it they must insist on a five years' course of study, as Ontario does, and make the curriculum in all points equal to hers, if this desirable object was to be gained. But the Ontario representatives were promptly told that while it was true that province demanded a five years' course, yet, as the course was only six months, their total number of months consumed in study was only thirty; while the McGill students, for instance, whose course only extended over four years, yet each course being of nine months, occupied in study thirty-six months, and thus had a longer curriculum than the Ontario men. So far, then, from the McGill men being asked to raise their standard to that of Ontario, the boot was on the other foot, and they were in a position to ask Ontario to raise its standard to theirs. Thus for the first

time the complaisance of the Ontario representatives received a rude and unexpected shock, and when they were told that if they obstinately adhered to their Chinese wall, that that wall would be the means not only of keeping men out of their province, but that in the future it would be the means of confining their men within their province, in other words, that if Ontario shut ten Ontario men out, then, these gentlemen began to see that their position was not so impregnable as they imagined, and that it would be wiser to take a wider and deeper view of the matter than they had hitherto taken. It will be seen that now at last the various parties are in a position to treat, and this is an advance that has not hitherto been made.

The committee appointed at the St. John meeting consisted of the following: Sir James Grant, Drs. Cameron and Pyne, from Ontario; Sir William Hingston, Drs. Marcil, Beausoliel, Chalatte, Parke, and Roddick, from Quebec; Drs. Daniel, Christie, and White, from New Brunswick; Drs. Farrell and Muir, from Nova Scotia; and Dr. Warburton, from P. E. Island. The result of the work of this committee is embodied in the following resolution, which was passed unanimously, and after the matter had been thoroughly discussed:

"The committee appointed at the last meeting to look into the question of inter-provincial registration would beg to express their report, that by the system which at present obtains a graduate in medicine entitled to practise in one province, is not free to exercise his functions in all the provinces of this large, but sparsely-settled, Dominion;

"That this condition of things prevents the names of medical practitioners in the Dominion being placed on the British register, becoming thereby British practitioners, which the Council of Medical Education of Great Britain has more than once signified its willingness to grant;

"That with this end in view it is, therefore, most desirable that there should be a uniform standard of matriculation, a uniform standard of medical education, and a uniform method of examination for the whole Dominion.

"That to effect this purpose, the secretary be instructed to communicate with the various Provincial Councils before their next meeting, asking that each council discuss the question, and if possible, appoint one or more delegates to a Dominion Committee for the purpose of adjusting a suitable curriculum and carrying out the suggestions herein contained, and that such committee be requested to forward their finding to each of the Provincial Councils and to the secretary of this association before the next annual meeting."

It is to be hoped that each Provincial Council will thoroughly discuss this question, so that the delegates they appoint will receive full instructions, and be in a position to cast their votes intelligently; in this way there is every probability of a definite scheme being obtained.

We are in a position to state that the Council of Physicians and Surgeons of New Brunswick discussed this matter at a meeting held last month, and appointed three delegates to this committee.—*The Maritime Medical News, April, 1896.*

INTER-PROVINCIAL REGISTRATION CONTINUED.

In our last reference to the subject of inter-provincial registration, the difficulties met with by the various committees of the Canada Medical Association were referred to, more especially those offered by Ontario. One of the results of the meeting last held, and one of the most important, was the statement by Dr. Pyne, Registrar of Ontario, and the other members of the committee from Ontario, that they were willing to accept the four years of nine months each as equivalent to their course of five years. This would seem to bring matters within an appreciable distance of adjustment.

The time of study required by the various Provinces, so far as we have been able to obtain the information, is as follows: viz. British Columbia three years, Ontario five years, the other Provinces four years. In all these Provinces in addition, except in Nova Scotia, there is required an examination by the Medical Council. If, therefore, the term of four years of nine months each should be adopted as a minimum, the greatest change would be required in British Columbia, and we think the other Provinces now have legislative authority to change from a six months' to a nine months' course if they wish. Nova Scotia would require to obtain power to examine all candidates for registration.

The next difficulty would be the obtaining of an uniform standard of matriculation, and an uniform method of examination for the whole Dominion. With regard to the first, little difficulty should be experienced, the standard of the Council of Medical Education of Great Britain might be adopted, and indeed this standard is now practically adhered to.

An uniform method of examination would be somewhat more difficult to obtain, but is not at all unattainable. The simplest method would of course be, to have one central examining board and compel every candidate to appear before it. In this country of magnificent distances, however, this would entail too much hardship

and expense on students, and some modified scheme must be adopted. It might be possible to have one central examining board on which each province should be represented, who should prepare the examination papers and send them to the various councils, who should hold the examinations, and return the answered papers to the central board for final disposition and judgment. Or, again, there might be a central board who should have the right and duty of examining all the answered papers of the candidates and advising the various councils if their standard of examination was not efficiently maintained; the latter notification taking with it the penalty of refusal of inter-provincial registration. Or, again, the central board might consist of a certain number of inspectors, one or more of whom should be present at all examinations held in the various provinces, either with power to supplement any examination they might consider weak, or simply to report to the various councils their opinion on the examinations, leaving it with the other to take punitive action. There are plenty of methods by which an uniform standard of examination may be obtained, but the best can only be decided on after debate by a competent committee.

It is an encouraging and noteworthy fact, that our neighbours to the south are becoming every year more alive to the necessity of dealing with the subject of medical education and practice in such a way as to make it more and more difficult for uneducated and ignorant men to obtain an entrance into the profession. In that country, although a few years ago there was practically no legal restriction on the practice of medicine, now, more than half of the States and Territories have laws on the subject, dealing with it, of course, in various degrees of completeness. But the tendency among them all is to place the licensing power in the hands of State Boards, and thus reduce the power, frequently for evil, of the shadowy pretensions of a mere diploma, and require the possession of knowledge as well as a sheepskin. It is also very gratifying to know that the matter of extending the medical curriculum in that country to a four years' graded course is steadily gaining ground, and that the number of medical colleges which make this term necessary for graduation is constantly increasing.

There is also in the United States, an Association of State Medical and Licensing Boards, who meet once a year in "National Conference."

The following propositions which were carried at their meeting last year, show that their object is very similar to what we are now discussing in Canada:

1. "That as the system of state medical licensers has been adopted in a number of states, and there being a decided probability that the system of state control, in some form, will eventually be adopted by all the states, it is *necessary* that the several State Examining Boards should *at once* take measures for approximating, as nearly as possible, *substantial uniformity* as to rating and standards of requirements.

2. "That there should be at once established a system of *reciprocal inter-state action* on the part of state examining boards, under which licentiates may be able to acquire a legal status, on removing from one state to another, without re-examination.

3. "That measures be at once instituted for largely increasing the powers and influence of the National Conference, by which it may be placed more nearly in touch with the members and representatives of state examining boards, in order that its advisory and semi-judicial decisions and orders may gain increased force and corresponding effectiveness."

Like ourselves, this "National Conference" is endeavoring to obtain inter-state registration, and is working along the same lines. It is more than likely that the conference of delegates at the next meeting of the Canada Medical Association will be able to evolve a scheme so generally satisfactory, that it will meet with the approval of all the provinces.—*Maritime Medical News, June, 1896.*

HIGHER MEDICAL EDUCATION AND ONE QUALIFICATION FOR CANADA.*

To elevate the standard of medical education is a duty devolving upon us, and if every province in Canada will do the same, then a physician legalized in one province is legalized all over Canada. We have reciprocity in the Maritime Provinces, which is a step in advance.

In Canada we ought to aim at one qualification. How is it to be accomplished? Ans: by provincial and federal or remedial legislation. Every Medical Council should raise by common consent their curriculum of studies to four yearly sessions of nine months, and insist on a state examination for Canada. The Provincial Legislatures should give their consent by a short statute defining the provincial qualifications for medical practice, and delegating authority to the federal parliament to petition the Queen for an amendment to the British North America Act, so that the federal government could give us a law for Canada. One board of ex-

*Read before Maritime Medical Association, July, 1896, by R. McNeil, Stanley, P. E. I.

aminers to prepare the papers—the oral and written examination to be held in every province before the councils as now constituted, but the results and valuation of papers made by the central examining board. Such a qualification would be an admission to practise all over Canada—and would secure reciprocity with Great Britain and the United States, aye with the whole world. The profession will be what you make it, and will require of those who practise it that they take a broader view of the matter than we have hitherto done. Provincial legislation will secure for us powers to legislate on the question at Ottawa, and the profession in each province should make a united presentation of their case to to the local governments and armed with their authority to unite the profession the federal government would be able to secure from the British parliament the required legislation. Gentlemen, this question is worthy your serions consideration, and no sectionalism or local jealousies should interfere. Every man who engages in medical practice, owes a duty to himself, to his brethren and his posterity—that it has been his aim to improve the science and leave behind him a name worthy of emulation. No profession can be respected that does not respect itself, and no profession can mantain a high standard without a corresponding higher preliminary and higher medical training.—*Abstracted from the Maritime Medical News, September, 1896.*

ON INTER-PROVINCIAL REGISTRATION.

In the Montreal *Gazette* of December 11th was printed a leading article, written, we are informed upon good authority, by a layman, and headed "A Great Opportunity." This article so fully expresses our own opinions upon the matter, and withal is written in so vigorous a style, that we venture to reproduce it.

"The annual meeting of the British Medical Association in Montreal is for many reasons an important occasion. The mere sending out of the programmes will draw attention all the world over to the attractions of Canada for tourist travel, and the advent of so many visitors is certain to make widely known the material resources and the industrial and social advancement of the Dominion. These are facts which it is to Canada's advantage to have known in the old country, and there is no class better fitted to spread that knowledge than the medical profession, who are constantly brought into friendly relations with all classes of the population. But there is another advantage likely to accrue from the meeting, of no less moment. It will give an impetus to medical education and research

all over the Dominion, and will bring the doctors here into touch with the profession in the old country. It will also show the most influential members of the profession in the United Kingdom what a high standard of medical education has been reached here, and that our institutions will not suffer by comparison with those on the other side of the Atlantic. But to take full advantage of this opportunity, it is necessary that an important step should be taken in the interim. The Canadian Medical Association will meet at Montreal on August 28th and 30th, immediately before the British Medical Association meetings, and the scheme of inter-provincial registration, which was referred to the provincial council at the last annual meeting, will come up for discussion, and, it is to be hoped, for final adoption. The medical profession in Canada have had this subject under discussion for many years, and it is quite time that it should be finally dealt with. The present condition of affairs is anomalous and vexatious. A doctor on one side of the Ottawa River cannot attend cases on the other, and Montreal specialists are prevented from being called in in to consult on cases in Ontario. Even in the matter of legal evidence, opposing counsel may prevent a doctor from being heard because he has not the provincial qualification. All this is very absurd, and a serious injury to the public, which has a right to the best medical attendance procurable in the Dominion, wherever patient or doctor may happen to reside. The present arrangement is also a great disadvantage to medical students, who do not always know where they will find their best opportunity to practise, and are therefore compelled, as a matter of precaution, to take two or three provincial qualifications, thereby needlessly increasing the fees and the examinations. Another unfortunate result is that no Canadian qualification is recognized by the Medical Council of Great Britain as giving a right to practise in the old country, and Canadian diplomas are not regarded with the esteem they deserve. The McGill and Bishop's courses are accepted as a sufficient guarantee for the preliminary work, but the Canadian graduate has still to do some months' sudying in England and take the final examinations before he can obtain an English qualification. In Australia, where the various colonies have a common standard of examination, the graduates have obtained the right of registration in England on merely presenting their diplomas. Medical education in Canada is quite as far advanced; but the General Medical Council of Great Britain say, reasonably enough: 'We cannot be expected to enquire into the various qualifications that obtain in the different provinces of the Dominion; adopt a common inter-

provincial standard, and we will gladly admit you to registration. At the meeting of the British Medical Association in Montreal next August there will be an unparalleled opportunity for advancing in this direction, if the scheme of inter-provincial registration now before the provincial boards is adopted in the meantime. The British Medical Association takes cognizance of all matters of interest to the profession, and after seeing our system of medical education, the equipment of our institutions, and the men who administer them, it might very properly pass a resolution recommending the Medical Council in England to admit Canadian practitioners to registration in the old country on presentation of their diplomas. Such a recommendation could hardly fail of its effect, for the leading members of the Medical Council are also leading members of the Association, which is thoroughly representative of the profession in the United Kingdom. But, in order to gain this valuable privilege, it is absolutely necessary that there should be a common standard of examination throughout the Dominion. So long as the various provinces refuse to accept each other's qualifications, one can hardly expect the British Medical Council to accept any of them."

There are in this article one or two points that require possibly some little explanation. We believe, for example, that the reason why the authorities in England permit Australian practitioners to register, is not that there is a common standard of medical education throughout the Australian colonies, but because those colonies have up to the present time remained separate and are not confederate. If, as is not outside the range of possibility, the Australian colonies unite, then according to the present British law they will lose their privilege unless they establish some scheme of inter-provincial registration. But, as the matter stands at present, undoubtedly the Australian graduate can register in Great Britain, and can in consequence practise over a large portion of the empire, and the Canadian cannot, until some common scheme of licensing is agreed upon by the provinces of the Dominion.

We are glad to learn from the pages of our esteemed contemporary, *L'Union Medicale*, that in the Province of Quebec the report of the inter-provincial reciprocity of the Canadian Medical Association has already been brought before the Provincial Board of Medicine of Quebec, and that a committee composed of Drs. D. Marcil, A. T. Brosseau, J. M. Beausoleil, E. E. Laurent, and C. S. Parke have reported to the Board in favor of adopting the scheme put forward. This committee asks that the officers of the Council

be authorized to sign a preliminary treaty with the other provincial Boards of the Dominion, and with that of Prince Edward Island, so as to be able to give a special license conferring the right to practise throughout British North America.

As the *British Medical Journal* remarks in another able leading article, it is fitting that the sixtieth anniversary of the Queen's accession be celebrated in the profession by an act which indicates the imperial unity of our profession, namely, this Montreal meeting of the British Medical Association. The members of the profession in Canada can, it seems to us, celebrate the great occasion in no more memorable way than in drawing together and, by accepting interprovincial registration, gaining great and imperial opportunities.—*Montreal Medical Journal, December, 1896.*

REPORT OF THE COMMITTEE ON INTER-PROVINCIAL REGISTRATION.*

"Your Committee beg leave to report that, having examined the present requirements of the Licensing Boards of the several provinces, with a view to obtaining by mutual concession a uniform standard of matriculation, education and examination, would recommend the following:

"I. Matriculation—The schedule of subjects shall comprise (1) English language, including grammar, composition and writing from dictation; (2) Arithmetic, including vulgar and decimal fractions, and the extraction of the square root; (3) Algebra, to the end of the simple equations; (4) Geometry, Euclid, books 1, 2 and 3, with easy deductions; (5) Latin grammar, translation from specified authors, or of easy passages not taken from such authors; (6) Elementary mechanics of solids and fluids, comprising the elements of statics, dynamics, hydrostatics, and elementary chemistry; (7) History of England and Canada, with questions in modern geography; (8) and any one of the three following subjects: French, Greek and German, the requirements being the same as in Latin.

Fifty per cent. of the marks in every subject shall be necessary for a pass, and 75 per cent. for honors.

"In lieu of the above will be accepted a degree in arts of any university in Her Majesty's dominions, or from any college or university that may hereafter be recognized, but no matriculation in arts in any university will be accepted.

"II. Professional Education—(*a*) The curriculum of professional studies shall begin after the passing of the matriculation examination, and shall comprise a graded course in the regulation

* Presented at Montreal meeting, 1896, by Dr. Roddick.

branches of four yearly sessions of not less than eight months of actual attendance on lectures in each year. (*b*) The subjects to be anatomy, physiology, chemistry, materia medica, therapeutics, practical anatomy, histology, practical chemistry, pharmacy, surgery and clinical surgery, medicine and clinical medicine, including diseases of eye, ear, throat and nose, mental diseases, diseases of women and children, medical jurisprudence, toxicology, hygiene, pathology, including bacteriology. (*c*) That at least twenty-four months out of the graded four years, eight months each, be required for attendance on hospital practice, to begin with the second year of study. (*d*) That proof of attendance on not less than six cases of obstetrics be required.

"III. Examinations—(*a*) All candidates for registration in the various provinces, in addition to having fulfilled the foregoing requirements, shall be required to undergo examination before examiners to be appointed in each of the provinces by their respective councils, or by means of assessors, as in the Province of Quebec, or by delegating their authority to one central body, as has been done in Manitoba. Such examination shall comprise all the subjects of professional study, shall be both written and oral, and 50 per cent. of the marks shall be required in every subject for a pass. (*b*) The Committee make these resolutions merely as suggestions for the consideration of the councils of the several provinces as a mutual basis of agreement, and desire that each be requested to report thereon to the next annual meeting of the association, and also send one or more delegates to represent them at that meeting.

"In order that the councils may be enabled to consider the question with a full knowledge of the facts, it is also desired that each registrar should send to every member of every council in Canada a copy of the statutes and of the regulations in connection with the council that he represents."

In the year 1897 several references were made to the subject at various medical meetings and in the daily press of Canada.

Dr. Moore, at the meeting of the Canadian Association, spoke as follows in his presidential address:

MEDICAL LEGISLATION.

The third object, I regret to say, has not yet been reached, but I feel confident that through the efforts and influence of the members of this association it soon will be an accomplished fact. By the provisions of the British North America Act all matters of an educational nature were given over to the legislatures of the pro-

vinces, they to make such laws, rules, and regulations as to them seemed proper. Whether this was wise or not I am not prepared to say, but it appears to me that the question of education is of a national rather than a provincial character, more especially medical science, as it knows no geographical confines. Soon after the formation of the legislatures the medical profession in each province, believing it to be in their interest as well as in the interest of the public, sought and obtained from their respective legislatures an act entitled "The Medical Act," which provided for the formation and election of a Medical Council. By virtue of the provisions of this act the licensing power and the complete control of medical education were given to and vested in this body. This council was to be a representative body, and to be re-elected once in a given number of years. Unfortunately no concerted action took place between the members of the profession in the different provinces before appealing to the legislatures, and the results were just what might naturally be expected, striking differences in the acts asked for and obtained. These diversities still exist, and it is these dissimilarities that offer to-day the greatest barrier to inter-provincial registration. To my mind there is nothing of more importance to the medical profession in Canada than uniformity in medical legislation. Now that we are nearly all of one mind, only divided upon issues which are of no vital importance, let us make an earnest appeal to the lawmakers and have the clauses not in harmony repealed. I trust that at this meeting a representative committee may be appointed to draft a medical act suitable for the whole Dominion. When this is accomplished a copy can be placed in the hands of each Provincial Medical Council, with the request that they appeal to their respective legislatures to amend their existing medical acts so as to harmonize them with the proposed one and have them become law. Inter-provincial registration will then be an easy matter and would be readily accomplished. Then we could turn our eyes eastward to the Mother Country and seek reciprocity with her, and as she has always listened attentively to any reasonable request made by us we might confidently look for the day soon to arrive when our prayer would be allowed, and any man obtaining a license in any of our provinces would be free to practise medicine in any clime where floats the Union Jack.

Dr. Roddick, in his presidential address before the British Medical Association, spoke as follows :

MEDICAL LEGISLATION IN CANADA.

Time will not permit of my discussing the subject of medical

legislation in Canada at any length; and besides you will find it very fully treated in the excellent official guide or souvenir, prepared for you by the executive committee. In addition I might explain, however, that when the British American provinces became confederated in 1867, under the British North America Act, the governance of educational matters was taken away from the federal authorities and handed over to the provinces, each to look after them in its own way. In consequence we have since had a curious complexity of medical legislation, there being practically no uniformity amongst the provinces in regard to standard of study or qualification for practice. Each province has its own medical board or Medical Council, as the case may be, which has the power to grant license to practise either after examination or on simply presenting the diploma of certain recognized universities. In the Provinces of Ontario and British Columbia an examination is exacted; in the others the license is given under certain restrictions on presentation of the degree, although in the Maritime Provinces an examining board is now about to be established. In this way, as can readily be seen, a Chinese wall is built round each province, and the frontier is carefully guarded so that it is unsafe for a medical man to pass from one to the other unarmed with a license, because of the risk of fine or even imprisonment. Such a condition of affairs is hardly credible and probably exists nowhere else to the same extent. What is the remedy? Two remedies have been suggested—either the establishment of a central examining board in each province with a uniform standard of matriculation and a uniformly high standard of curriculum, which shall in time lead up to a general scheme of reciprocity; or, secondly, a Dominion Examining Board. The first scheme is at present under serious consideration; although there are many difficulties in the way of its accomplishment, no one of them is insuperable, however, providing a spirit of conciliation prevails. The second alternative (a Dominion Examining Board) would in many respects be more desirable, because not only could the licentiate practise in any part of the Dominion, but he could register in Great Britain, and thus receive recognition all over the Empire. As you are doubtless aware, we, as a profession, suffer in this country from being inhabitants of provinces which are confederated. Under the Medical Act, now of some twelve years' standing, it has been decided, in effect, that the Medical Council of the United Kingdom can recognize the degrees of universities situated in autonomous provinces only. As a consequence, Australians obtain privileges which are denied to us, being permitted to register in

Great Britain without examination. We are being punished for belonging to a colony whose form of government is recognized to be in advance of theirs, and likely to be imitated by them. Let us give our Australian brethren a hint: If the confederation of your provinces be in contemplation, see to it that all matters of professional education are left in the hands of the central government, at least as far as qualification for registration is concerned. By so doing you will avoid the almost inextricable tangle in which we in Canada find ourselves. Let common school education go to the various provinces if you will, but for the profession of medicine (and doubtless law also) there should be a uniform standard of matriculation, a uniform curriculum of medical studies, and one Central Examining and Registering Board composed of the best men from all the universities. We hope in Canada to reach that ideal at no distant date; in fact I have the very best authority for stating that it is not impossible of accomplishment. Some scheme of reciprocity first arranged would doubtless make the task less difficult, but failing that, our duty is to arrange for some legislation which shall give our better and more ambitious students an opportunity of passing a Dominion Licensing Board (or whatever it may be called), which shall give the privilege of practising their profession not only in any part of their native country, but in any part of the world over which the British flag flies. Such a scheme need not interfere in any way with the autonomy of the provinces. Each may still retain its Provincial Board for the purpose of examining and issuing licenses to those candidates who are satisfied to practise their profession in the limited sphere of their own provinces. I think the legislators of this country will some day (and not far distant either) be induced to see that the system which at present obtains is unworthy of a great and growing country.

LONDON "LANCET" ON THE SUBJECT.

The important question of securing for the Dominion an uniform standard of medical education has been a prominent topic of the week. It was debated at the annual meeting of the Canadian Medical Association on Monday and Tuesday, when also a scheme for inter-provincial registration was discussed and adopted by the Provinces of New Brunswick, Quebec, Manitoba, and Prince Edward Island. It was also referred to by the president of the British Medical Association in his opening address, and in commenting upon this Lord Lister, in moving the vote of thanks to the president, made some judicious remarks. Lord Lister thought that the great

objection to a central examining board was that the examinations would be conducted by those who were ignorant of the curricula of the various schools, and for himself preferred the system obtaining in England of a central controlling body (the General Medical Council) with power to inspect and visit the various licensing bodies. Any opinion of Lord Lister's must have great weight—although it cannot be forgotten that some twenty years ago the idea of a conjoint Examining Board for England was on the eve of accomplishment, some of the bodies concerned voluntarily consenting to abrogate their right to grant licenses. Theoretically a single and uniform standard for the whole country would seem to be the ideal to be aimed at—all additional qualifications and degrees being regarded as academic distinctions; but it may be, as Lord Lister evidently fears, that the practical working of such a scheme could not be effected without injustice to candidates trained on various methods. —*Special Canadian Supplement to The Lancet.*

A DOMINION MEDICAL COUNCIL.

We are pleased to see that the medical fraternity is fully alive to the importance of bringing about a uniformity amongst the provinces in regard to the standard of study and qualifications for practice. In his opening address before the British Medical Association, now in session in Montreal, the president, Dr. T. G. Roddick, of Montreal, devoted considerable time to this question. At present, as Dr. Roddick said, "a Chinese wall is built around each province, and the frontier is carefully guarded, so that it is unsafe for a medical man to pass from one to the other unarmed with a license, because of the risk of fine, or even imprisonment. Such a condition of affairs is hardly credible, and probably exists no place else to the same extent." Each province has its own medical board or council, which grants the right to practise in that province on its own terms. Ontario and British Columbia require an examination in every case, no matter what diploma the applicant may possess; in the other provinces a diploma is accepted with certain restrictions. Dr. Coventry, of Windsor, in his presidential address before the Ontario Medical Association in June last, in this city, referred to the same unfortunate condition of affairs, and quite as strongly as Dr. Roddick urged a remedy.

The cause of the lack of uniformity is to be found in the fact that the British North America Act gave to the provinces the government of educational matters. There were special reasons why the provinces should control the common schools, but, as Dr. Roddick

points out, there are absolutely no reasons why professional education should be provincial. All the reasons are on the other side. A man who is fully qualified to practise in one place is equally qualified to practise in any other. Why should legislation prevent a Toronto doctor practising in Montreal or Winnipeg? If the provinces were hostile nations some justification for this exclusiveness might be urged; but when they together form one nation, which it is the aspiration of all patriots to consolidate and make really one, all barriers should be done away with. Dr. Coventry dwelt upon this aspect. He said: "I am intensly impressed with the idea that if we are to be entrusted with the development and destinies of this new country, we must not add a medical barrier to the religious, racial, and other obstructions having a tendency to prevent and postpone the unity of this country." Another decided disadvantage is found in the regulations of the British Medical Council. This body decided, some twelve years ago, to recognize only the degrees of universities situated in autonomous colonies. The result is that a doctor from any one of the Australian colonies can register in Great Britain without examination, while an Ontario doctor, for example, cannot. If a Dominion diploma were granted, a Canadian doctor would be recognized throughout the British Empire.

There are two remedies suggested—"either the establishment of a Central Examining Board in each province, with a uniform standard of matriculation and a uniformly high standard of curriculum, which shall in time lead up to a general scheme of reciprocity; or, secondly, a Dominion Examining Board." This latter is, of course, the more desirable. It is the only one that will fully meet the case. Special legislation would have to be passed, however, and while this is being prepared for efforts should be directed toward obtaining uniformity of the educational standards in the different provinces, since this in any case must be done. —*Toronto Mail and Empire.*

MEDICAL FEDERATION.

It is gratifying that the visit of the British Medical Association to Montreal has not overshadowed the very important meeting of the Canadian Medical Association brought to a conclusion yesterday. On the contrary, the British Medical Association meeting has only served to bring into greater prominence the most important subject with which the Canadian Association had to deal—that of inter-provincial registration—for Dr. Roddick made this one of the main subjects of his presidential address, and Lord Lister, in the

course of a short speech, made a notable reference to it. It will be seen, on reference to the report appearing in another column, that terms of agreement have been arrived at between all the provinces except Ontario. It is a matter for universal regret that Ontario is left out, but in the case of that province there are legal difficulties which cannot easily be overcome. The Ontario Act lays down three conditions for reciprocity with another province as to medical qualifications :

(*a*) The province must have a central examining board, which has the sole right of granting certificates of qualification.

(*b*) The course of study and standard of qualification must be equal to those required in Ontario.

(*c*) The province must grant similar privileges to Ontario.

The third condition is, of course, fulfilled by an understanding such as the other provinces have arrived at. As to the first, it is a question of system on which there is ample room for difference of opinion. A central examining board is not by any means an unmixed blessing. It is, no doubt, a powerful engine for enforcing a higher standard of efficiency, but, on the other hand, it tends to a uniformity in medical education which is not altogether desirable. Reciprocity in qualifications is certainly to be desired, and uniformity of standard is almost a necessary condition; but in order to secure this it is not necessary to sacrifice diversity of method—in itself a great advantage. When all medical students undergo the same examination there is a tendency for medical education to conform itself very closely to that examination. As Lord Lister pointed out, greater freedom is desirable, and it was, no doubt, with this idea in his mind that he recommended the English system. The Province of Quebec, it may be remarked, follows on the same lines. The universities pursue those methods of medical education which seem best fitted to the class of students they have to deal with. The Medical Board of the province does not itself hold the examinations, but by means of assessors, independent of the universities concerned, it takes cognizance of the university examinations, and thus secures the maintenance of a sufficiently high standard. There is nothing to show that this is not just as good a system as that in force in Ontario. It is better suited to this province, and it would be absurd to expect Quebec to set up a central examining board because that plan happens to suit Ontario.

As to the question of standard of qualification and courses of study, Quebec asks for no concessions. But having in view the limited resources of the smaller provinces, it is reasonable that for

the advantage of the profession as a whole, the larger and wealthier provinces should not be too exacting. A boon like federation can only be obtained by mutual concession and compromise, and those who are richest and strongest can afford to give the most. These were the principles on which the Dominion was founded, and if the doctors want to build with the same success they must follow on the same lines. It is to be hoped the Ontario doctors will be brought to see this question in the same light as the founders of Confederation from that province. The legal difficulty is perhaps not so great if it is tackled resolutely. The doctors are an influential body, and ought not to be afraid of the small band of Patrons in the legislature, for we believe that is the real bugbear. It is sincerely to be hoped that the Ontario Medical Council will take heart of grace and fall into line. Any concession it may make for the moment will be compensated for by future gains. At present a doctor with an Ontario qualification cannot attend a patient on the other side of the Ottawa in the Province of Quebec. This is not as it should be. For the sake of the public, as well as for the credit of the profession, it ought to be altered.—*The Gazette, Montreal, September 1, 1897.*

CANADIAN MEDICAL ASSOCIATION.

At the Montreal meeting the committee brought in the following report:

"The committee beg leave to report that the Medical Councils of Quebec, Prince Edward Island, Nova Scotia, New Brunswick, and Manitoba have signified by resolution their approval of the resolutions of the committee of 1896, and have accepted them as the basis of agreement for inter-provincial registration. We therefore recommend that the matter be referred to the councils mentioned to formulate an agreement, and to carry it into effect. Signed by Dr. D. Marsil, Dr. C. S. Parke, Dr. H. Cholette, Dr. Beausoliel, of Quebec; Dr. George Coultheard, jr., Thos. Walker, of New Brunswick; Dr. Ed. Farrell, Dr. W. S. Smith, of Nova Scotia; Dr. Joseph MacLeod, Dr. James Warburton, of Prince Edward Island; Dr. R. S. Thornton, of Manitoba; Dr. James Christie, of British Columbia."

Dr. Walker moved the adoption of this report. Ontario did not appear as one of the assenting councils, and this was explained by doctors from that Province as due to the fact that they could not reciprocate while the Provincial law remains as it is. They would not

consent to reduce the term of study from five years to meet the other Provinces. Ontario doctors disclaimed any wish to be stumblingblocks, but could see no use in adopting a scheme of inter-provincial registration.

Dr. Beausoleil championed the cause of Quebec and the other Provinces and was supported by several gentlemen. They asked their Ontario colleagues to give and take, and pointed out that in Quebec the profession was endeavoring to harmonize the curriculum and standard with that of Ontario. Moreover, it was argued that a four-year course of eight months each was at least equal to a five-year course of six-months each.

Dr. Pyne, Toronto, came out for Imperial federation of the medical profession, and declared that it would be impossible to obtain this or even reciprocity with the motherland if the standard of Ontario was lowered. It was an easier method for the other Provinces to come up than for Ontario to go down.

Dr. Thorburn, Toronto, spoke in a similar strain, while expressing sympathy with the other Provinces.

The report was adopted, many Ontario delegates voting aye.

This is a very imperfect report of the discussion which followed the presentation of the report. Among others who spoke were Drs. Dickson, Bray, Thornton, and H. P. Wright.

Many letters have been written to the lay and medical press. We have not space for many of these, but we think the following letter from Dr. Niven is well worthy of reproduction:

MEDICAL FEDERATION.

To the Editor of the *Mail and Empire*:

SIR,—At a meeting of the Medical Association of Canada, held in Montreal, the provinces, Quebec, Nova Scotia, New Brunswick, Prince Edward Island, Manitoba, British Columbia, approved of a resolution that such a federation was necessary, and referred the whole to the various Medical Councils to form an agreement on this basis. Ontario alone refused to have anything to do with this step, which in this enlightened age seems to be the only proper thing to do. The argument urged by the Ontario member, Dr. Bray, was that the graduates of other universities could not pass the Ontario matriculation examination. I should like to give the reasons why well-educated (which undoubtedly they are) matriculants and degree holders of other universities cannot pass the Ontario Board. It can be answered in about a dozen words. They have not studied the Ross library. Ontario may boast of its

very liberal education, yet I do not know of any other country in the world where education is so narrow, and where the class books, which must be read and studied in order to pass their departmental examination, contain as much bad English. I do not give this on my own authority, but on that of one of the best informed educationists in the province. As for the Ontario rules of classical pronunciation, it would make Porson turn in his grave if he heard a high school teacher reading Virgil or Homer to his class.

The Ontario Medical Council's professional examinations are up to the standard of any school, yet why should they, in the liberal examination for matriculation, want more than such a university as McGill? The only reason that I can see is that in order to pass for Ontario it is necessary to buy and study the books that are so badly gotten up by the Ontario Education Department. This is not liberal education; it is departmental education, which turns out more illiberal educated men than any other system in the world.

I don't think that the medical men as a whole in Ontario wish to set up an unsurpassable barrier against other provinces, but a few school men in this province wish to keep all the fees to their own schools; and as the schools govern the Medical Council to a very large extent, what they determine must rule the medical affairs of this province. It should not be so. We are supposed to be a liberal profession, but what I read in the Montreal papers of the past week I am a little afraid that the certain men who represented us there were far from liberal in their ideas. Would it not be much more creditable for us to further federation from the outside than to be forced into it, as undoubtedly we will be, for, as Dr. Bray says, the Legislature of Ontario is not very sweet on the council, and may take a hand in and compel federation on line that would not be so good as are laid down by the other provinces.

Yours, etc.,

J. S. NIVEN.

September 8, 1897.

MEDICAL SCHOOLS AND MEDICAL FEDERATION.

Some statements made in this letter are worthy of careful consideration. Dr. Niven is a physician of standing and culture who received his education in Trinity College, Dublin. He is in a position to give an opinion that is perfectly unprejudiced by any selfish considerations. His statement, that a few school men in Ontario form the chief barrier against the other provinces, is rather a serious one, and we do not know that it is correct. As a matter of fact it

is difficult to ascertain the views of the school men on the subject because they do not appear to have paid sufficient attention to it. We consider that their indifference and, in some cases, ignorance as to the various aspects of the whole vexed question are somewhat remarkable. If the school men oppose inter-provincial registration from any selfish motives they will deserve condemnation from the great mass of the profession.

Dr. Niven makes another important statement to the effect that, if our representatives from Ontario do not show more liberality in the future than they have in the past, the Legislature of Ontario is likely to interfere. We believe this is correct. There is a strong feeling respecting the matter in the minds of a large proportion of our citizens, as shown by the fact that the lay press is becoming interested, and public opinion will soon make itself felt in various quarters.

Progress of Medicine.

OBSTETRICS

IN CHARGE OF

ADAM H. WRIGHT, B.A., M.D. Tor.,

Professor of Obstetrics in the University of Toronto. Obstetrician to the Toronto General Hospital;

AND

H. T. MACHELL, M.D.,

Surgeon St. John's Hospital and Victoria Hospital for Sick Children.

ASSISTED BY

H. CRAWFORD SCADDING, M.D.,

Physician to Victoria Hospital for Sick Children.

Medical Therapy of the Female Genital Tract.

O. B. Will (*Am. Gyn. and Obs. Jour.*) makes a strong plea for more intelligent medical methods and principles concerning the genital tract. He considers the disorders to which medical resources are applicable are usually the result of infection from pathogenic germs, and under any and all circumstances accompanied by vascular engorgement if not stasis, more or less general and severe, with hyperblastic activity of varying extent and greater or less pain, it becomes necessary to select agents for the accomplishment of the following objects which seem legitimately to govern in all local therapy, viz., depletion, anæsthesia, antisepsis, resorption and reconstruction.

He asks what do we mean by depletion and how can it be accomplished. Under states of engorgement of the pelvic viscera, especially the uterus and adjacent tissues in which the vessels are distended, it seems necessary to deplete in some way, but it seems equally advisable to question the legitimacy of abstracting the serum or fluid alone from them and thus furthering an accumulation and condensation of the more solid organic contents. The healthy nutritive activities demand a rapidly moving, yet fluid, as the abnormal requires a sluggish, circulation. Any act that lessens the fluid

and increases the solid constituents of the circulating medium, above the normal standard, jeopardizes the functional well-being of any organ or tissue. And yet this is exactly what is done every day all over the country by the conventional boroglyceride and glycerine tamponade of the vagina. Although a marked sense of comfort is speedily imparted by such treatment, the relief obtained is only temporary. The conditions becoming even more aggravated and obstinate excepting possibly in œdema of the mucous membrane and immediately underlying tissues of the vagina.

As compared with the foregoing popular method we have in the time honored hot douche a much more rational and meritorious procedure and one perfectly in consonance with modern pathology and histology. By the action of the penetrating, moist heat upon the vaso-motor nervous system, as well as directly upon the tissues themselves, the blood is driven either backward or onward into receptacles of larger calibre. As in all classes of inflammation and congestion the value of moist heat is unquestioned, and in the therapy of the female genital tract it is second to none other.

He suggests the use of the fountain syringe and sterilized water, and lays considerable stress upon the patient's position and the time occupied. Like most of us he thinks the squatting position while irrigating the vagina practically worthless. Such a position is a most unfavorable one, in that gravity alone, without the inevitable aid of the patient's muscular efforts, is sufficient to force the pelvic and abdominal contents downward, choking up the outlet and mechanically obstructing the circulation—the thing that should be avoided.

The best positions are the exaggerated lateral and knee-elbow, the former being applicable with the aid of a Kelly pad, the latter in an ordinary bath-tub. In assuming either of these positions, if the patient be properly instructed as to the intent, the abdominal pressure is, of course, removed, the pelvic organs elevated, and the penetrability and efficiency of the heat in emptying the local circulatory system enhanced many fold. After such a vaginal irrigation given in a small stream, and as hot as can be borne for half an hour, the patient should be asked to maintain the recumbent posture for several hours. He deprecates the hot vaginal morning douche and then allowing the patient to be on her feet the remainder of the day. The relaxing effect of the application temporarily softens and weakens the tissues and supports and causes them to lose their resiliency for some hours, during which, if the erect position is indulged in, the pelvic organs settle down, and when the vessels fill again, as they

must, their position is more cramped than before and their tortuosity increased. On the contrary, if the recumbent posture is maintained until reaction takes place, the normal elasticity of the vascular and other tissues is restored and a greater resistance offered to all morbid impulses.

Salines, such as the chloride of sodium, may be judiciously associated with this form of depletion. They not only cleanse the mucous membrane of accumulated secretions, but so alter the glandular products as to favor and promote their rapid elimination, relieve the tension and stimulate the resolvent and nutritive forces. The bichloride of mercury may be used alternately with the saline.

The foregoing method is as applicable to the interior of the uterus as the vagina, excepting that its application must be in the hands of the physician himself or those of a competent nurse under his immediate supervision. In intra-uterine therapy glycerine has no place whatever. The pain it produces is always in excess of any possible benefit. The hot asceptic and antiseptic douches, however, are as acceptable and valuable here as in the vagina. In uterine irrigation the dorsal position is the only practicable one, preferably after a seance of five or ten minutes in the lateral or knee-elbow attitude, in order to relieve the tension of pressure. With the patient on her back and a valvular speculum in situ, the os naturally patulous or rendered artificially so, a double current cathether, or similarly constructed uterine douche point, should be introduced up to the fundus and a stream of water, saline or antiseptic, of a temperature at first slightly in excess of that of the body, increasing to 120° F., should be turned on from a fountain elevated slightly above the level of the patient. Twenty to thirty minutes should be devoted to such irrigation.

Although such irrigations are in themselves anæsthetic, conditions of hyperæsthesia are occasionally met with, which prohibit manipulations of any kind. Here a local anæsthetic is an absolute necessity, and nothing is considered equal to cocaine. A 10 per cent. solution painted at first on the mucous membrane at the introitus vagina will enable the physician to examine the vagina, and the patient to assume a relaxed condition. A little of the same solution may be thrown into the uterus itself and thus save the patient the pain of the irrigator and the first impact of the irrigating stream This tends to prevent nervous irritation and pain, a desideratum in these patients.

The nearest approach to resolvents and absorptions is seen in the equally conventional and routine iodine and ichthyol. Iodine, as

ordinarily used, is probably of no use whatever, but in aqueous solutions, so that the absorbents or tissues themselves, by endosmotic action, can take it up and give it a chance to exert an alterative influence upon the deeper strata, it is probably of some use.

Ichthyol, of itself, is an agent of peculiar and intense penetrability and synergistic activity, but it is usually mixed with glycerine and applied on tampons to the vaginal vault. It is true that more or less benefit is obtained from it in that way, but rather in spite of than in consequence of the unholy alliance into which it is forced. Used preferably pure, or in strong, aqueous solution, in contact with a surface properly prepared for it by fair depletion and the removal of viscid secretions, it becomes in both vagina and uterus, one of the most powerful resolvent agents and satisfactory anodynes and antiseptics that we possess, and one that will accomplish more in the reduction of inflammatory and congestive, not to say neurotic, pelvic disorders than we at the present time probably apprehend.

Barring the presence of fungosities and irregular growths, he believes the method of cauterization is often the more satisfactory in the management of intra-uterine inflammatory and hypertrophic conditions from whatever cause. Of recent years the profession has been the unwilling witness of the value of these agents as applied under the stress of public demand. The country is to day flooded with, and the profession and women generally besieged by, the peddlers of scores of kinds of wafers, capsules, and tablets, consisting mostly of some powerful cauterant and astringent, masked by anodynes and astringents, for use in the genital canal in all cases of presumed "ulceration," inflammation, catarrh, etc. The repetition of their use, with the synergistic influence of hot baths and irrigations, has unquestionably served to accomplish much in a curative way, and serves to teach us, as we have been taught before, the real position which should be given to the class of agents to which these bastard preparations owe their virtue. It is in just the class of cases not amenable to the milder measures that this form of treatment gives its most brilliant results. If as much attention were given to obtaining an accurate knowledge of the nature and use of cauterants and escharotics as is, and has been given to the development of surgical procedures and technique, we would to-day be in possession of means and advantages that we do not now have and such as would revolutionize gynæcological practice. In the milder cases he had satisfaction with the use of the saturated solution of

permanganate of potash. In the more severe cases he uses the zinc sulphate, and where more severe caustic action is desired zinc chloride. These may be applied in aqueous solution to the interior of the uterus, taking care to protect the cervical canal by the introduction into it of a pledget of cotton covered with an ointment of soda bicarbonate in vaseline. No more evidence of functional disturbance has been observed after the judicious use of caustics than after surgical procedure.

The strictly professional and personal attention which this course of treatment demands seems to be our chief objection to it.

ORTHOPÆDIC SURGERY.

IN CHARGE OF

CLARENCE L. STARR, M.B. Tor., M.D. Bel. Hosp. Coll.,

Surgeon to Industrial Refuge.

Treatment of Deformity in Potts' Disease.

Although forcible reduction of deformity in tubercular caries of the spine has been advocated at various times, both in America and in Europe, and has been practised in a number of cases in France and Germany, yet it has always met with considerable opposition.

Dr. Calot, of Berck-sur-Mer, has recently published a report (*Semaine Médicale*, June 23, 1896) of thirty-seven cases in which he employed this method with very satisfactory results. None are reported as being harmed by the treatment, and in all it is claimed that the healing process is very much hastened, recovery taking place in most cases in ten months or less.

Probably the first cases treated by the Calot method in England were treated by Mr. Robert Jones and Mr. A. H. Tubby at the Royal Southern Hospital, Liverpool, on July 24th of this year (*London Lancet*), when they demonstrated on a series of cases the possibility of complete reduction of deformity.

The ages of the children operated upon ranged from three to eight years, and the deformities varied considerably, some of them being extreme.

Reduction was accomplished with considerable facility in all these cases.

The method of reduction is to make forcible traction at the upper and lower parts of the spinal column, at the same time making firm pressure over the prominence.

After the deformity is reduced, a snugly fitting plaster of Paris jacket is put on, and the case treated as an ordinary case of Potts' disease.

To the knowledge of the writer this method has never been employed in this country, and at the present time, owing to the

short time that has elapsed since operation, an exact estimate of the value of this method of procedure is impossible.

It is extremely interesting, however, as indicating the possibility of doing away with this, worst of all deformities, and adding another triumph to modern surgery.

This method is presumably only applicable to acute cases, or cases in which the disease is still in progress, and not to those cases where the disease has been arrested and recovery complete with more or less deformity.

TREATMENT OF FIBROUS ANKYLOSIS BY SUPERHEATED DRY AIR.

Mr. W. J. Walsham, of St. Bartholomew's Hospital London, presented a paper to the American Orthopædic Association (Trans. American Orthopædic Association, Vol. viii) on treatment of static flat-foot by means of an apparatus which enabled him to employ dry air, heated to a very high temperature, for a period varying from thirty minutes to one-and-one-half hours. The results were very satisfactory; a considerable degree of motion and suppleness being obtained after each application, in feet which were rigid beforehand.

Dr. V. P. Gibney, surgeon-in-chief of the Hospital for Ruptured and Crippled, New York, presented before the Practitioners' Society (*Medical Record*, January 23rd, 1897) a paper giving notes on several cases of stiff and painful joints, including rheumatic and tubercular cases, treated in the same manner.

Three of the cases were of firm fibrous ankylosis of the knee following tuberculous ostitis.

Case 1. On commencing hot-air treatment had four degrees of motion. Was given one bath daily of 40 to 50 minutes duration, at a temperature ranging from to 255° to 280° F. Gained from 3 to 4 degrees of motion each treatment or total gain of 24 degrees after seven treatments.

Case 2. Had 15 degrees of motion, and after six treatments gained 12 degrees without any force being used. It was doubtful whether active disease was fully arrested in this case and so treatment was discontinued.

Case 3. No motion, and any efforts to move the joints elicited great pain. After two or three baths, no gain was made in the correction of the deformity and joint seemed just as sensitive if any attempt at motion was made.

The adhesions in this case were afterward broken up under an anæsthetic, and on coming out from its influence, the pain which

was intense, was quickly relieved after the knee was placed in cylinder at a temperature of 280° F. These may be taken as fair samples of the good effect which one may expect from superheated dry air in this class of cases.

One case of rheumatic arthritis which had existed six years, and resisted the treatment at several of the baths of the United States, showed considerable improvement after three or four treatments at a temperature ranging from 240° to 260° F.

By massage and traction supplemented by large doses of Potassium Iodide, some improvement was obtained before hot-air plan was tried; but all motions of knees, elbows and hands were limited and painful.

After baths, as above stated, she expressed herself as very comfortable, and massage and passive motion were subsequently employed without producing any reaction, and very little pain. Breaking up some small adhesions caused some pain, but it quickly passed off, leaving all joints much more flexible.

Two cases of traumatic arthritis of knee are recorded as considerably improved—each one gaining a range of motion, freedom from pain, and general comfort, after three or four treatments.

One case of chronic sciatica, which had proven very obstinate, received a good deal of relief from pain after a single treatment.

LARYNGOLOGY AND RHINOLOGY.

IN CHARGE OF

PRICE-BROWN, M.D.,

Laryngologist to Western Hospital; Laryngologist to Protestant Orphans' Home.

The section on laryngology and otology of the British Medical Association, Montreal, was attended principally by leading English and American specialists, there being only a sprinkling of Canadians, fully one-half of the whole number being from the other side of the line.

The proceedings opened by an important and interesting discussion on "Turbinotomy." It was led by the president, Dr. Greville Macdonald, and ably supported by Drs. Delavan, Camralt Jones, J. N. Mackenzie, Lincoln, and others. The general opinion expressed by the representatives from both sides of the sea was in condemnation of too severe operations upon the turbinated bodies. Complete turbinotomy was believed to be very rarely required—while partial removal, or turbinectomy, was, in many instances, necessary. It was evident, from the discussion, that American rhinologists do not practise turbinotomy to anything like the extent that it is advocated by certain of their confrères in England. Possibly the humidity of the British climate, in comparison with the dryness of the American, may form an important factor in rendering the operation more justifiable in the one country than the other.

The second general discussion was upon the significance of "Laryngeal Paralysis." It was opened by Dr. Daly, of Pittsburgh. He said that we could prognosticate recovery from paralysis following diphtheria in from five to seven months. When the paralysis was confined to the left side, we might look for pressure upon the recurrent laryngeal nerve from tumors, aneurism of the aorta, etc. When bi-lateral, it might be of central origin, or from brain-softening, or apoplexy. Paralysis of larynx may also arise from neuritis of laryngeal nerves produced by toxins. Aphonia may be diagnosed as hysterical, only after excluding all other causes.

Dr. Shurly, of Detroit, spoke chiefly of prognosis. Physiological research, regarding the functions of the laryngeal nerves, has made

prognosis more definite now than ever before. Still we are only on the outskirts of the promised land. The laryngeal function is a double one, and has its analogues in the rectum and bladder. All of them act automatically, and are also under voluntary control. Trophic, sensory, and motor fibres are all found in the one nerve. He believes that in hysteria there are structural nerve lesions. Aberration of function cannot occur repeatedly, without lesion of the peripheral nerve leading to the part affected; or of the brain centre. Reflex phenomena are more temporary in their character. Prolonged aphonia, continuing for months, probably in most cases depends on lesion. When the lesion is in the nerve itself, particularly in the case of singers, the outlook is hopeful. When, on the other hand, the lesion is bulbar or cerebral, the prognosis is hopeless.

Mr. Lennox Browne, London, Eng., said that children were less liable to vocal paralysis from diphtheria than adults; and that when it did occur in either, the left side of the larynx was more likely to be affected than the right. When paralysis occurred on the right side, it was usually due to apical disease, either from tubercle or pleurisy. Mr. Browne strongly favored Dr. Shurly's idea, that prolonged vocal paralysis was due, in many instances, to bulbar or cerebral lesions.

Dr. Bryson Delavan, New York, spoke of the difficulty in explaining the significance of right laryngeal paralysis. That of the left was physiologically much easier. Hence right-sided laryngeal paralysis needed the most careful investigation. He cited two cases of unusually persistent paralysis following diphtheria. One had now lasted three years, and the other sixteen years, without any return of the power of vocalization.

Dr. Permewan, of Liverpool, secretary to the section, stated that syphilis is frequently the cause of laryngeal paralysis, either from the presence of gumma in the base of the brain, or from syphilitic, peripheral neuritis in the nerves of the larynx. In general paralysis of the insane, paralysis of the vocal cords is very common. One point in diagnosis he laid particular stress upon, namely, that hysterical paralysis of the vocal cords was always confined to the adductor muscles.

The third general discussion was upon "Operations upon the Mastoid in Suppurative Ear Disease." Dr. Buller, of Montreal, Dr. Buck, of New York, Drs. Blake and Morse, of Boston, and others, entered very fully into the subject, which was further illustrated by exhaustive papers and charts by several of the gentlemen named.

Among other papers read was an elaborate one by Dr. J.N. Mac-

kenzie upon "Physiological and Pathological Relations between the Nose and the Sexual Apparatus." His essay abounded in classical quotations and references to the experiences of the ancients. The main argument was, that in a number of verified instances, excessive irritation of the sexual organs had been productive of immediate abnormal irritation of the nose, and *vice versa*. He likewise drew an analogy between the so-called erectile tissue of the turbinateds and that of the virile organ. It was well known that epistaxis and sneezing were frequently the accompaniments of sexual congress. He also mentioned a case of abortion following galvano-cautery operation on the nose.

Lennox Brown mentioned a case of masturbation in a child affected with adenoids. On removal of the adenoids, without other treatment, the habit ceased. Bryson Delavan related the history of a similar case. Both these instances indicated the existence of the relationship maintained by the writer.

Dr. Fletcher Ingals, Chicago, read a paper on the "Relation of Nasal Disease to Pulmonary Tuberculosis." He believed that there was in some measure an antagonism between pulmonary disease and nasal catarrh; and that there was not that tendency for catarrhal disease to lead to tuberculosis that so many believed to exist. The opinions of the writer were strongly supported by the painstaking, statistical record he adduced. The paper created a good deal of discussion. The speakers, however, while complimenting the author on the lucidity and force with which he expressed his views, accepted them with a certain amount of reservation only.

Dr. Delavan read a paper on "Surgical Diseases of the Larynx." He said the percentage of failures, after operation, was very high. The difficulty of early diagnosis was also great, owing to the fact that simple papilloma may develop into malignant disease. In treatment he insists on the importance of doing tracheotomy, before operating for the removal of the larynx. He did not consider the operation a hopeful one.

Dr. J. N. Mackenzie favored early and complete extirpation of larynx and neighboring lymphatic glands, and was more hopeful in prognosis after operation than the writer of the paper.

Dr. Baker, of Cleveland, also favored radical and complete removal after tracheotomy.

Dr. Roe's paper on "Nasal Deformities" will be referred to later on.

Dr. Wurdeman, of Milwaukee, also read a paper on "Phosphoric Necrosis of Temporal Bone"; and Price-Brown, of Toronto, one on "Chronic Interarytenoid Laryngitis."

Dr. C. H. Knight, of New York, also forwarded a paper on "Foreign Body Removed from Larynx by Laryngo-Fissure." In the absence of the author this was read by Dr. Birkett, of Montreal.

"Saddle-Nose," and Other External Nasal Deformities.

During the last few years many surgeons have attempted, and some of them with marked success, to rectify these unsightly deformities. The methods of operation have been various, and some of them of a most radical nature. Total rhinoplasty, where the defective septum has been reproduced from the flattened bridge, and the external nose re-formed by integumentary flaps from the forehead, have been unsatisfactory; the new nose not only sinking, but also shrinking more and more, from lack of definite and firm support. Ollier and Langenbach and Konig all tried to remedy this, by taking slips of bone, from either the superior maxilla or the frontal, to help to support the softened tissues.

It remained for Schimmelbusch, of Berlin (*Verhandlungen der deutschen Gessellschaft fur Chirurgie, 1895*), to form the framework of a new nose entirely out of bone. He endeavored to construct it as nearly as possible after the plan of the natural organ; so that it would have firm walls and a proper integumentary covering. He performed the first complete rhinoplastic operation five years ago. Schimmelbusch and Von Bergman have since then operated upon twelve patients by this method. The success is reported as remarkable. All the noses have retained their form. The profile, height and lumen have remained without shrinkage. As no complications have appeared, Schimmelbusch warmly recommends the method. (*Laryngoscope.*)

To perform the operation for complete rhinoplasty, in cases where the nose, from traumatism or disease, has been destroyed, a three-cornered skin and bone flap is dissected from the forehead, the wide base being uppermost, and the narrow end at the root of the nose, which, of course, remains attached. With a broad and sharp chisel, the anterior surface of the frontal bone is chiselled off. This is the most difficult and delicate part of the operation. The loosened flap is first allowed to granulate. Then the bony flap is sawed perpendicularly on its inner surface, folded together in the form of a nose, twisted over, transplanted, and sutured on to the prepared wound—the skin side being external. In these cases the septum, if possible, is formed beforehand from the remains of the original nose, the tip being reserved for attachment to the new

organ. To keep the new bones from spreading, a silver wire is passed through them from side to side, and held in position by lateral buttons. This is retained until the parts are firm enough to admit of its removal.

Schimmelbusch's operation fo. saddle-nose, although in principle the same, differs somewhat from the above. The skin and bone flap is made in the same way; but the saddle-nose is split down the centre, raised on each side, and deflected outwards. The bone of the flap is sawed along its centre as before, but doubled in the opposite direction. It is then bent directly over and placed in position, the skin being internal. The lateral flaps of the original nose are then stretched and replaced over the raw surfaces of the new support. At first they do not entirely cover the nose but, as healing progresses, and the flap is separated at the bridge, a good form is eventually secured. The raw cavity in the forehead is recovered by stretching and suturing, after linear incisons of the integument.

The Italian Method. (*Bull. de l'acad. de Méd. de Paris*). Berger strongly advocates the method of operating successfully practised by Tagliakozza and Graefe. He has followed it with excellent results in two cases. The required rhinoplastic flap was obtained from the arm bound to the head, and retained in position by Berger's special fixation apparatus. In each case the patient submitted to the fixation for the required ten days, with but slight inconvenience.

Jormeseo (*Neuvieme Congrès Francaisde Cher.*, 1895), performed complete rhinoplasty by the Italian method in a young man æt. 25. It was performed after the removal of an enormous acneiform hypertrophy, involving the whole nose. The arm was held in position by plaster bandages. Good results followed.

Prof. Czerny, of Heidelburg (*Verhandlungen der deutschen Gessellschaft fur Chirurgie*, 1896) gives the history of two cases, where he successfully corrected saddle-nose of a mild degree, by the formation of a bridge from the chondro-osseous lateral wall of the nose. Although ultimately successful, the operations were difficult, and it took a long time for the new noses to lose their sharply-defined anæmic appearance.

For the correction of saddle-nose, Soles Cohen (*Jour. Lar.*) advocates the use of an artificial nasal saddle made of platinum. First, Rouge's operation, sliding the upper lip and nose upwards, must be performed. Then the saddle introduced, with the prongs fitted through the mucous membrane into the maxillary bones; and the

soft parts at once restored to their normal position. The combined operation must be completed at once, otherwise the swelling will prevent a successful result. Some contraction of the nares follows, necessitating the use of bougies for a while, but the result in the end is satisfactory.

C. H. Knight (*New York Med. Jour*) reports a similar operation by the use of Martin's bridge. In his case, the result for a time was highly satisfactory. Cicatricial contraction of the nares occurred, however, during the author's absence. Operative measures were resorted to, and the patient given a vulcanite tube to keep the passages open. By the use of undue force, he displaced the bridge, causing it to ulcerate through the skin. Although this case resulted unfortunately, Knight still expects good results in properly selected cases.

Roe, of Rochester, (*Med. Record*, June, 1897) has an article entitled, "The correction of depressed and saddle-back deformities of the nose, by operations performed subcutaneously, without the aid of metallic or other artificial supports." The author deals with cases in which there is an entire, or almost entire septum, but in which from traumatism of one form or another, nasal deformity has been produced. He details the history of six cases, all differing materially from each other.

At the Laryngological section of the British Medical Association, in Montreal, he again read his paper, and illustrated it by life-sized photographic plates, taken before and after treatment, all indicating marked cosmetic improvement.

In all cases the operations were done subcutaneously, to avoid facial scars—the main object being to transfer superabundant tissue, present in some part of the nasal organ in all the cases, to the situation where its presence was most required. Thorough aseptic and antiseptic measures were always used; and the support varied according to the requirements of each case. It always required time to accomplish a good result, and the main operations had usually to be supplemented by minor ones. Still, the manifest improvement in the personal appearance of the patients operated on, was a direct reward far the patience and vigilance required in treatment.

HYGIENE AND PUBLIC HEALTH

IN CHARGE OF

WILLIAM OLDRIGHT, M.A., M.D. Tor.,

Professor of Hygiene in the University of Toronto ; Surgeon to St. Michael's Hospital;

ASSISTED BY

J. W. SMUCK, M.D.

REPORT OF PROVINCIAL BOARD OF HEALTH FOR JULY.

Total number of municipalities in the province, 745; number which made returns for July, 429.

Table showing total deaths returned from the several contagious diseases for a population of 1,296,089 were 167, or at the following rate per 1,000 for municipalities which made returns, calculated on a per annum basis. (Total population of the province, 2,233,117.)

	Population and % o whole.	No. of deaths from and rate per 1,000 per annum.						
		Scarlatina.	Diphtheria.	Measles.	Whooping Cough.	Typhoid Fever.	Tuberculosis.	Total.
Cities reporting.	419,972 (92%)	3 (0.08)	12 (0.3)	1 (0.02)	0	4 (0.1)	51 (1.4)	71 (1.8)
Towns and villages reporting.	235,017 (55%)	1 (0.05)	4 (0.2)	0	4 (0.2)	2 (0.1)	17 (0.8)	28 (1.4)
Townships reporting.....	641,100 (57%)	3 (0.05)	13 (0.2)	4 (0.07)	2 (0.03)	3 (0.05)	43 (0.8)	68 (1.2)
	1,296,089 (58%)	7 (0.06)	29 (0.2)	5 (0.05)	6 (0.06)	9 (0.08)	111 (1.02)	167

Editorials.

THE MEDICAL COLLEGES OF TORONTO.

THE two Medical Colleges of Toronto were opened on Monday, October 4th. Trinity made a new departure by having the opening exercises in the pavilion of the Horticultural Gardens, where the Rev. W. J. McCaughan delivered the introductory lecture. The building was well filled with an audience composed of students, and a large number of their friends. The lecturer, who is well-known as one of our most powerful pulpit orators, chose as his subject—"Manliness," and delivered an excellent address, which was highly appreciated by those present.

The opening address in the University of Toronto was delivered by Professor I. H. Cameron, who referred to the recent visit of Lord Lister and Professor Michael Foster whom he extolled as models of the medical profession. He then spoke of the past year as remarkable on account of the Diamond Jubilee of Her Majesty, the meeting of the British Science Association, and the meeting of the British Medical Association in Montreal, and also, because of the fact that the Medical Faculty of the University, which has been pursuing a tentative, if not precarious, existence for ten years past, has at length become established as a fixed and integral portion of the institution. After making reference to the Chancellor, and the late Dr. W. T. Aikins, he went on to speak in a general way about the "medical calling," and the importance of culture therewith.

In conclusion he referred to the question of a college residence as follows: "I would lay infinite stress upon the value of college residence, and the humanizing influence of the common dining hall. Could I have my way, the land north of Hoskin avenue and east of Devonshire place would be for the most part covered with residences, each with its resident Don or Dons, and all with a common Dean: on the west side of Devonshire place, at the corner of Hoskin avenue, should be common dining halls, and a great hall of convocation, and in these colleges and halls all the undergraduates in all

the faculties should be required to live, and every professor should eat so many dinners in the halls per term. The idea may seem Utopian and provoke a smile, but I am satisfied that if some of our moneyed men in the Senate or elsewhere would take up the scheme, and conduct it on a business basis a fair return would be derived from the capital invested." Dr. R. A. Reeve, the Dean of the Faculty, after a few general remarks to the students, announced the presentation by himself of $1,000, to be divided into four annual instalments of $250 each, and to be awarded as an honorarium to the student who takes the highest stand in all the subjects included in the fourth year of the medical course.

After short addresses from the Chancellor and Vice-Chancellor this very interesting function came to a close.

WEST TORONTO TERRITORIAL ASSOCIATION.

A MEETING of the West Toronto Territorial Division Medical Association, Dr. Machell in the chair, was held on the 25th September last at Broadway Hall, to which all the regular practitioners were particularly requested to attend. After routine business was transacted a deputation, with Dr. W. W. Ogden as chairman, was appointed to interview the mayor concerning a new rule of the Council or the Health Board by which the health officer is compelled to attend gratuitously civic employees—firemen, scavengers, Board of Works employees, etc.—who may be ill or injured. It was thought that in a city the size of Toronto there would be administrative work enough to occupy fully the time of the health officer without his being compelled to run out every now and again to attend a sick scavenger or an injured fireman. Such a rule is neither in the interest of the city, for the health officer cannot give his best attention to the work of his department if his time be encroached on by purely professional visits, nor in the interest of the employees, for such attendance must necessarily be hurried and of a perfunctory character. We have nothing to say against Dr. Sheard, or we are persuaded that he has been compelled to do this work against his better judgment, and for which he does not get any increase in salary. But Dr. Sheard must know that he is doing an injustice to a number of hard-working, conscientious fellow-practitioners by taking out of their hands their own regular patients. He probably protested when asked by the council to be a party to compelling our patients to be seen by him, but if so the profession at large have no knowledge of the fact. Now that the West To

ronto Association has taken the matter up it is to be hoped we shall be able to find out whether the scheme originated with the Health Board, the Board of Control, or the Council. The time is opportune for enquiring into it—the election for aldermen is not far distant. Abuses of this kind always receive more careful consideration prior to than subsequent to a municipal election.

It seems an anomalous condition of things that the profession should be taxed to provide a health officer, and that he, in turn, should be compelled to supplant us in the attendance on men who have looked upon many of us as the family physician for nearly a quarter of a century. We hope that Dr. Ogden's committee will get to work and put the matter fairly before the council, keeping in view the interests of the city, the workingmen, and last, but not least, the medical profession.

Another matter which came up for consideration was the resignation of the chairman as representative of the division in the Medical Council. He informed the association that he had, a few days previously, been notified of the appointment made last spring as lecturer in Pædiatrics in the Medical Faculty of the University of Toronto, and before accepting it, it would be necessary to resign his position in the council. The Medical Act expressly states that certain universities shall have a representative in the council, and just as expressly declares that no professor, lecturer, or teacher of any of these universities shall hold a seat in the council, except as a representative of the university or college to which he belongs Having decided to accept the lecturership, he thereupon tendered his resignation to the association as their representative in the council, asking that the secretary be instructed to forward it to Dr. Pyne. He also thanked the profession for the honor they had done him three years ago in electing him unanimously as their standard-bearer.

It was suggested that as the meeting was a fairly well attended one—it is surprising how little interest the profession, as a whole, takes in its own affairs—that the matter be talked over calmly and quietly, and if possible, select some one who would be acceptable to the majority of the profession in West Toronto. Two names were mentioned after some deliberation—that of Dr. James Spence and Dr. Alex. Davidson. Finally it was proposed by Dr. Milner, and seconded by Dr. Davidson, that Dr. Spence be nominated as their representative for Dr. Machell's unexpired term. Dr. Spence's nomination was thus made unanimous, and was accepted by him.

Correspondence.

Victoria, B.C., Sept. 25th, 1897.

Editor CANADIAN PRACTITIONER.

SIR,—Not many months ago a Toronto medical man, while discussing the advantages offered by British Columbia in the practice of medicine, remarked that "the Victoria men are not up to much." Whatever truth there may or may not be in this statement, and however personal it may or may not be, I thought it would make an excellent text upon which to base a short report of some of our surgical work.

We have two excellent hospitals, modern in all equipment, vieing with each other for the patronage of the city, one under the Sisters of St. Anne, the other our city and provincial. In order to give your readers some idea of our work, I give the following results of the major surgery of the city (Jubilee) hospital during the last six months, which represents but a slight fraction above one-half of the major surgery done in Victoria during this period.

Cases.—Ovariotomy, 3; salpingo ovariotomy, 6; vaginal ovariotomy 1; vaginal salpingo ovariotomy, 2; vaginal myotomy, 1; ventrofixation, 1; vaginal ventrofixation, 2; vaginal section and drainage, 1; abdominal section and drainage, 1; vagino abdominal hysterectomy, 1; nephrorrhaphy, 2; colotomy, 3; pylorectomy, 3; proctectomy, 2; hermotomy, 10; appendicectomy, 18; excision of breast, 3.

Of these sixty operations, fifty-seven resulted in recovery and three in death. Of the latter one death followed pylorectomy for malignant growth, and two deaths followed appendicectomies.

In a city of less than 18,000 population, this report speaks for itself. Our staff consists of twelve physicians, all upon equal privilege *re* the hospital.

With such surgical successes as this report sets forth, our citizens are beginning to appreciate the hospital and recognize its true relation towards the community. Rarely is any opposition offered by the patient when the attendant suggests removal to the hospital.

It has become settled in the minds of Victorians that the hospital is the place for sick people. Very little but emergency work is done in the home, consequently the professional nurse have a very limited constituency. Emigrants of this class had better seek a field where hospitalism is less developed, rather than come here to meet with dissapointment.

Although diverse upon many points of practice, one thing we are agreed upon—the necessity of prompt action in appendicitis. This may seem an old story, but the lesson is not yet half learned by the profession. Delay means but ignorance fooling with death. Space will not allow reports of individual histories in which gangrene, perforation, general pecriobitis lay unsuspected by men whose diagnostic skill could not be challenged. Our experience has convinced the most conservative that here "delays are dangerous." Patients presenting symptoms of this "friend of the physician, during terms of financial depression," as Keen terms it, are at once placed in the hospital. If it be a second attack, or if the symptoms are sufficiently definite the operation is at once proceeded with. If there be any doubt, and the symptoms do not subside after the bowels are cleared, the same treatment is followed. Rarely is a case allowed to wait thirty-six hours after the first appearance of the symptoms. In no other condition does there seem to be the same disparity between the trouble within and the manifestations without. In order that the patient receive justice at the hands of his attendant, each case, howsoever "mild" should be considered the worst. No method of diagnosis yet elaborated can give the most skilful any adequate conception of appendicular pathology. Pulse, pain, temperature and rigidity may fail in their efforts to interpret the activity of this abdominal demon.

In this wild and wayward west the practice of medicine will soon become that of surgery. The time-honored and beloved family physician will soon be eliminated and numbered with the things that were, and his place taken by the sanitarian, the accoucher and the surgeon. Poultice, pill, and blister are rapidly vanishing before the evolution and application of biological principles. Recurrent colic vanishes with the appendix, and indigestion after resection of the pylorus. Peritonitis is but a secondary manifestation, and the physician who writes "inflammation of the bowels" upon a death certificate is advised to go sealing.

E. M. H.

Meetings of Medical Societies.

ONTARIO BOARD OF HEALTH.

THE regular quarterly meeting of the Ontario Board of Health was held in the secretary's office, Toronto, on Friday and Saturday, July 23 and 24, for the purpose of passing the plans for sewers and waterworks in some towns.

Dr. Bryce, the secretary, read his quarterly report. The report stated that the general sanitary condition of the province during the past quarter had continued good, and that with two or three exceptions no extended local outbreaks of disease had called for extended action.

SMALLPOX.

Cases of smallpox had occurred both in Winnipeg to the west and in Montreal to the east. "The first outbreak certainly, and possibly the second, was due to the introduction of the disease by Chinamen who passed through from Vancouver about the 22nd of May. Although vaccinated, and so personally protected, they seem to have had the infection either on their persons or in their luggage. The Montreal cases occurred at the beginning of July, and the source of their inoculation seems still in doubt.

DANGERS FROM IMMIGRATION.

At present the dangers of smallpox to Ontario are lessened by its inland position, and by the fact that immigrants for the Northwest are most likely to either sicken on shipboard or after they have arrived at their destination. Yet it cannot be overlooked that, as the tide of immigration from both east and west seems again to be setting in towards Canada, dangers which for several years past have been small will again increase. Thus it was reported recently from Winnipeg that a serious outbreak of scarlatina has appeared in a new settlement of Galician immigrants in Manitoba, and the authorities of Winnipeg are seriously alarmed at the prospective cost of having to deal with outbreaks brought to them in this manner.

LEPROSY.

In my recent trip west I learned of three cases of leprosy having appeared amongst Icelandic settlers in that province."

TYPHOID.

In speaking of the outbreak of typhoid fever in Manitoba, which had been introduced from Rat Portage, the speaker said that the undoubted cause of the outbreak was due to the imperfect water supply at Rat Portage, and the defective drainage of the town.

SCARLET FEVER.

The outbreak in Toronto of scarlatina was dealt with, and the epidemic as existing in January last, it was said, had continued to progress. The several months of 1897 had had the following cases reported and deaths occurring:

	Cases.	Deaths.
January	104	3
February	172	13
March	265	15
April	205	11
May	212	11
June	180	10
July (to date)	50	..
Total	1,188	63

The report continues: "It thus appears that for the first time during fifteen years Toronto has been visited with a widespread outbreak of scarlet fever, and it is of much interest and of the greatest importance where the Province has been practically free from this disease for so long a time to review some of its chief characteristics. Its history shows it to be a remarkable disease. Its mortality in London from 1859 to 1870 was variable, but reached its height in the latter year, the death rate being 1.22 per 1,000, and dropped in the succeeding year to .27. Since that year the death rate per 1,000 has with slight variations steadily declined."

After summarizing the principal facts associated with any epidemic of scarlet fever the epidemic of the last six months in Toronto was examined in connection with the various points. Of the 1,138 cases which occurred up to the end of June, 35 to 40 were treated in the hospital, and the balance were treated in their homes. The total death rate was 5.3 or 5.5 per cent. Taking the returns for the month of May, supplied by the City Health Officer up to the 6th of

of June, there were in all, 280 cases. Of these, 198 attended school.

To show the extreme importance of the public schools in the spread of infection, the Medical Health Officer, of London, makes a table, with three groups; first, under 3 years; second, from 3 to 13; third, over 13, and compares the prevalence amongst them for the month preceding, the month of the summer holidays, and the month succeeding, with the result:

Under 3, decrease in holiday month, 1 per cent.; 3 to 13, decrease in holiday month, 26 per cent.; over 13, decrease in holiday month, 13 per cent.

Increase in succeeding months:

Under 3, 4 per cent.; 3 to 13, 65 per cent,; over 13, 26 per cent.

It is thus made apparent that the results of the numerous modes of communicating infection amongst the infant population under 5 years, or 11 per cent. of the whole population fails to create an increase or decrease in any month exceeding 4 per cent., but that the absence of the school influence at once makes a decline of 26 per cent., and a subsequent immediate increase of 65 per cent.

The following principal reasons why the outbreak should have made such headway in so short a time were examined. They were as follows:

(1) That there had existed a population in Toronto at least up to 15 years of age largely unprotected by a previous attack.

(2) That the disease was at first mild, but not as mild as the London cases. The percentage of deaths to notified cases was 4.7 in London. In Toronto it has been 5.5 per cent. for six months.

(3) The non-reporting of mild cases in some instances early in the disease.

(4) To the non-notification of the public of infected houses by the Health Department.

(5) The re-opening of infected schools within too short a period after closing.

(6) To the comparatively few instances where the infected child has been removed from its home to the Isolation Hospital.

(7) To the too short time during which cases and members of the household have been kept from the public and school.

(8) To the lack of any systematic method of inspection of the 500 and more farms and dairies from which the milk supplies of the people have been taken.

The last of these causes was considered at considerable length and the following

RECOMMENDATIONS

to the Local Board of Health were carried :

(1) That it should, on being notified of any case of scarlatina, require the immediate removal of the case to the Isolation Hospital.

(2) That should this not be at once complied with, the household be quarantined until the six weeks from the occurrence therein of the last case shall have elapsed, and the house be placarded.

(3) That inasmuch as your committee is informed that the Isolation Hospital wards of the city set apart for scarlatina have been full during the past six months, and that they have proved wholly inadequate for the demands upon them, that the Local Board of Health be directed to supply itself with such additional hospital accommodation as is required under the act.

(4) That the board be urged to extend systematic inspection to every dairy or farm sending milk into Toronto, as is the practice in other cities of the Province, the freedom to inspect such being the condition on which a permit to send milk into the city be granted.

In conclusion, your committee, in notifying the city health authorities of Toronto of its recommendations, desires that the board express its anxiety and willingness to lend every assistance within its power to mitigate and, it is hoped, finally stamp out the serious epidemic which exists at present.

RABIES.

Mr. J. J. Mackenzie, analyst of the board, read a report urging the necessity of municipal regulations dealing with the disease. He pointed out that it was of comparatively recent date in Ontario, where it first made its appearance in 1891. It seemed to confine itself to the section of the province between Hamilton and London. Its introduction had probably been from Europe by way of the United States. That it is not a general, but rather a local disease is proven by the fact that it does not exist in Australia. The thing to be faced in Ontario was the fact that the disease actually existed here and that a human being had died from it in Dundas recently.

It was necessary that municipalities should unite on the matter since a rabid dog took a lengthy course through various districts, biting other animals which came in his path. Indiscriminate muz-

zling was unnecessary, but all dogs should be muzzled at the time of an epidemic in the district. Various provisions existed in Europe for killing rabid dogs and shutting up dogs that they had bitten until the time of incubation for the disease had been passed. Some such measures as these should be adopted. Mr. Mackenzie pointed out that the idea that rabies was a hot weather disease was false, since it occurred with equal virulence in winter time.

A resolution embodying Mr. Mackenzie's suggestions was carried.

ABUSE OF HOSPITAL CHARITY.

Mr. John Ross Robertson, M.P., spoke regarding the indiscriminate admission of charity patients to hospitals. He showed that the privilege was very badly abused, and asked the board to try and formulate a remedy.

CANADIAN MEDICAL ASSOCIATION.

THE thirteenth annual meeting of the Canadian Medical Association was held in the Synod Hall, Montreal, on Monday, August 31st, when Dr. James Thorburn, of Toronto, resigned the chair to the newly elected President, Dr. V. H. Moore, of Brockville. Dr. Roddick, chairman of the local committee, having welcomed the visitors to Montreal, Dr. Moore delivered his presidential address. He referred to the formation of the Association, just one hundred days after the formation of the Dominion, and to the election of Dr. Tupper, now Sir Charles Tupper, as the first president. He sketched the objects of the Association, which was established to promote the science of medicine, to unite the members of the medical profession in the Dominion of Canada, and to secure a uniform standard for medical education and for the license to practise in the Dominion. While the Association had been successful in attaining the two objects first named, the third has not yet been reached. Canadian medical institutions required as high, and in some instances, a higher standard of preliminary education than was demanded in Great Britain. A four years' course, and in Ontario a five years' course was already required, and in two years' time the fifth year, which was to be spent in clinical and technical work, would be obligatory. Finally the examinations for graduation and for the license to practise, were well calculated to test the knowledge of candidates. Canadian medical colleges were well equipped, the teaching they gave was of the best, the

practical instructions excellent, and the clinical opportunities plentiful. There were between sixty and seventy hospitals in Canada and over forty in Ontario alone, while there were a dozen well-equipped universities and a large number of collegiate institutes and well provided schools. In concluding his address Dr. Moore extended to the members of the British Medical Association a most cordial and sincere welcome. He trusted that they would not only derive advantage from the scientific discussions which would take place and carry away a warm memory of the hospitality of Montreal, and of Canada at large, but would also gain a knowledge of the resources of Canada, and would learn to appreciate its free institutions and the enterprise and industry of its people. The President received a warm vote of thanks for his address, and after the transaction of some formal business, the Association proceeded to the consideration of a scheme of inter-provincial registration. A report recommending the formulation of an agreement was adopted, and it was resolved that the Canadian Medical Association should meet next year in Quebec under the Presidency of Dr. Beausoleil. Dr. H. B. Small, of Ottawa, was elected treasurer, and Dr. F. N. G. Starr, of Toronto, was re-elected secretary.

Book Reviews.

A System of Practical Medicine. By American authors. Edited by Alfred Lee Loomis, M.D., late Professor of Pathology and Practical Medicine in the New York University, and William Gilman Thompson, M.D., Professor of Materia Medica, Therapeutics, and Clinical Medicine in the New York University. To be completed in four imperial octavo volumes, containing from 900 to 1,000 pages each, fully illustrated in colors and in black. Vol. II., comprising Diseases of the Respiratory System—Diseases of the Circulatory System and the Mediastinum.—Diseases of the Blood—Diseases of the Bladder and Prostate Gland. Per volume, cloth, $5 ; leather, $6 ; half-morocco, $7. Lea Brothers & Co., publishers, Philadelphia and New York.

The first volume created so favorable an impression that the appearance of the second was looked forward to with much interest. If we had not exhausted our encomiums on the former, which is certainly one of the best works upon the infectious diseases in the language, we might say more in praise of its successor. In the subjects treated in this volume there is not so much progress to report, and we, therefore, cannot look for so much that is new. Space will not permit a review of the various articles, and amongst the general excellence one finds it hard to draw special attention to one article lest it should be assumed that the others are less worthy of commendation. But the general practitioner will be particularly pleased with the very practical articles upon "Diseases of the Blood," by Shattuck and Cabot, of Boston ; and upon the "Diseases of the Nose, Naso-pharynx, and Larynx," by S. Edwin Solly, of Colorado Springs, since they cover ground with which he is, perhaps, less familiar than that covered by many of the other articles.

The volume carries out the promise of its predecessor, and among the many subscribers with whom we have discussed the work we have not met one who is not well pleased with his purchase.

Diagnosis of the Acute Exanthemata, with Especial Reference to Scarlet Fever. Dr. Rotch in the Boston *Medical and Surgical Journal*, May 27, 1897.

Many of the complications including nephritis are due to streptococci. The earlier in the course of the disease nephritis appears the more severe will be the type. Amount of albuminuria is of less consequence than the quantity of urine. A rapid diminution of the urine is ominous. During the course of a general œdema, desquamation may

cease to return again on the disappearance of the œdema. When the œdema is slight the nephritis is of a slight grade. Effusion into the pleura may occur, also œdema of the lungs and brain. The nephritis of scarlet fever has a tendency to ultimate recovery in childhood on account of their recuperative power. It is very rare for it to become chronic. Retinitis and amaurosis may occur. Concerning diuretics, non-irritating ones must be used, and the best is potd. acetate. Cathartics are more reliable than diuretics, and he mentions podophyllin gr. $\frac{1}{10}$ to a five year old child and repeated. Also pulv. japalæ co. in ten grain doses. If the skin is hot and dry use a hot bath and follow it with a dry hot blanket pack. Pilocarpin hydrochlorate, gr. $\frac{1}{20}$ by the mouth to a child two years old, and hypodermically to a five year old child. If convulsions occur an enema of Pot. Bron. and Chloral hydrate. Digitalis is a valuable remedy in the treatment of the nephritis of scarlet fever, best given as a freshly prepared infusion in one drachm doses every four hours to a child five years old.

THE MENOPAUSE. By Andrew F. Currier, A.B., M.D., New York. D. Appleton Company, New York. 309 pages.

The author begins his preface by saying that it is many years since an original work on the menopause has appeared in the English language, and thinks it high time that a lot of hoary tradition which has done duty for years both among the laity and the profession should give way to more modern ideas and conditions, and that the sooner this occurs the better it will be for humanity. He thinks the serious character of the menopause has been over-estimated, and quotes his own practice, both private and hospital, in support of his contention. The fact that malignant disease develops at this time does not prove that the menopause is responsible for such development. In regard to cancer it does not develop because menstruation has ceased, but because the vitality of certain tissues is diminished and their ability to resist irritation lessened.

In chapter II. is discussed the anatomical changes which are the result of the menopause. The author calls attention to the fact that uterine hæmorrhages, as a rule, do not cease with the menopause, contrary to the opinion of the majority of the profession, who encourage their patients to hold out till the trying ordeal of the menopause should occur. As a result of this hope held out many lives have been sacrificed.

The author maintains that there is a normal—that is, an uneventful—menopause, and that if there is no pre-existing foundation of disease, the menopause should not be considered critical in the sense that it is dangerous to life or health. In chapter IV. he discusses the morbid phenomena, especially the vaso-motor and gastro-intestinal disturbances. Chapter V. is devoted to the premature menopause. By this term he means that variety brought about by surgical means and a small

class of cases which occurs a few years in advance of the normal time, which is placed at the fortieth year. The question of the loss of sexual desire following removal of the appendages is taken up and dealt with, the conclusions agreeing with the great majority of clinical teachers of to-day.

In regard to treatment he advises carefulness and watchfulness, not ignorant inactivity as in times past. Particular attention is called to profuse hæmorrhages, which are not physiological, but are evidence of disease, and should always receive careful investigasion. He concludes in these words: "Those who are sick must be treated upon rational principles, not by superstitition or tradition. Surgical conditions should be recognized promptly and promptly treated; and those which are susceptible of relief by drugs should receive remedies which are tried and reliable, not the nostrums and cure-alls of the quacks."

The print is large, clear, and readable, and the index all that one could desire.

Medical Items.

TERRITORIAL DIVISION OF WEST TORONTO.—West Toronto has now no representative in the Ontario Medical Council on account of the resignation of Dr. Machell, as mentioned in another portion of this issue. There are now two candidates in the field. Dr. James Spence was asked to become a candidate, September 25th, and consented. On the following day a number of residents of the division induced Dr. Jas. H. Burns to become a candidate. Dr. Burns was for some years a member of the council, was vice-president of that body in 1887-8, and president in 1888 9. Both of the candidates are strong men with good backing, and either will make a good representative.

RAILWAY HOSPITAL CARS.—The latest novelty in foreign railroading is the hospital car, designed to serve a double purpose. In the event of a serious accident, these cars can be run to the place of the disaster, where the injured may be picked up and carried to the nearest large city for treatment, instead of being left to pass long hours at some wayside station while awaiting surgical attendance. It also enables the railway companies at certain seasons or upon special occasions to transport large numbers of invalids to health resorts or places of pilgrimage. The interior of the car is divided into a main compartment, a corridor to one side, and two small rooms at the end. The largest compartment is the hospital proper; it contains twenty-four isolated beds. Each patient lies in front of two little windows, which may be closed or opened at will. Each bed is provided with a movable table, and a cord serves to hold all the various small objects which the patient may require. The corridors on the outside lead to the linen closet and the doctor's apartments. Various trap doors in the floor, when opened, disclose to view an ice chest, a compartment for the disinfection of soiled linen, and a provision cellar. If necessary, a portion of the hospital chamber may be transformed into an operating room for urgent cases. Finally, as customary abroad, a small chapel for religious worship is provided. This car will be put in charge of a surgeon and nurses, and will be chiefly used to carry invalids from Belgium direct to the health resorts of France.—*Baltimore Sun.*

OBITUARY.

J. F. DANTER, M.D.—Dr. Danter died at 32 Gloucester Street, Toronto, September 24, 1897.

JAMES ACLAND DE LA HOOKE, M.R.C.S., Eng.—Dr. De La Hooke died at his home in Toronto, September 18, 1897, in his 83rd year. He received the diploma of membership in the Royal College of Surgeons, England, in 1838. He was well known in military circles, having been connected with the Queen's Own Rifles for many years. For a time he was medical officer of the Niagara camp.

J. J. C. HUME, M.B.—Dr. Hume died at the residence of his father, the Rev. Robert Hume, 6 Carlton Street, Toronto, September 8, 1897, aged 22. He received his medical education in the Medical Faculty of the University of Toronto, graduating in the spring of 1897. He took honors throughout his course, together with a scholarship in 1895, and a silver medal in 1897. Although never strong he was a very earnest and intelligent worker, and it is generally supposed by his friends that over-work caused the disease—phthisis—which resulted in death. He was, in all respects, one of the best and brightest men in his class, and his untimely death is very deeply deplored by his many friends, including students, graduates, and members of the medical faculty.