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Original Communications.

SOME CONCLUSIONS BASED ON OVER FOUR HUNDRED OPERATIONS FOR APPENDICITIS.

BY HERBERT A. BRUCE, M.D., F.R.C.S. (ENG.),
Associate Professor of Clinical Surgery, University of Toronto; Surgeon to St. Michael's Hospital; Surgeon to Emergency Hospital; Assistant Surgeon to the General Hospital.

It is not my intention to give a tabulated report of these cases, as I do not think any useful purpose can be served thereby, but I shall refer to certain cases to support my contentions. I might say that the first operation was performed by me on October 5th, 1897, and the four-hundreth on February 25th, 1905. My apology for taking up this somewhat hackneyed subject is that I have observed a good deal of confusion in the minds of general practitioners as to the best time for operation, and an insufficient conviction of the importance of a very early operation in all acute cases. I am glad to see that Dr. Wm. Osler, in the latest edition of his book, classes appendicitis as a surgical disease, as, indeed, do a very large number of eminent physicians.

I should first like to mention the symptoms of appendicitis.

1. Pain in the abdomen occurring suddenly and usually of a colicky character in a patient in ordinary health.

2. Nausea or vomiting within a few hours.

3. General abdominal tenderness most marked on the right side.

4. Elevation of temperature; this however, usually does not occur for some hours or it may not be elevated for twenty-four hours. The symptoms will occur in the above order, and a diagnosis in the vast majority of cases should not be difficult.

In the course of a few hours the pain will become localized to the region of the appendix and there will then be rigidity of the right rectus over this area. A diagnosis should be made in the majority of cases within twenty-four hours.

The most important of these symptoms is the pain, and when it is very severe in character is usually indicative of a serious form of the disease. The pain usually subsides gradually, but when it subsides suddenly, within the first thirty-six hours, it is of serious import and may be due to gangrene of the appendix, rupture of the appendiceal wall, or to infectious material passing from the appendix into the cæcum.

Secondary pain, that coming on after the first thirty-six hours, is not of a colicky but an inflammatory type, and is due to the involvement of the structures arcund the appendix. Severe pain after the primary subsidence of pain, is generally due to the beginning of peritonitis from perforation.

As regards temperature—it may be two or three degrees above normal, but I have had several cases in which the temperature was never above one hundred and yet found a gangrenous appendix at operation. After the initial rise of two or three degrees it may drop to ninety-nine or even normal where the appendix has become gangrenous: therefore, the temperature is not a reliable guide as to the condition of the patient.

As to pulse—it is generally increased in frequency, but it is of little or no value in making a diagnosis.

I would now like to make brief reference to some of my cases. I have operated on two-hundred cases in the interval without a death. In another two hundred cases the operation has been done during the acute attack and at periods varying from twelve hours from the beginning of the attack to three weeks and in one instance five months. In this series I have had in all fourteen deaths, *i. e.*, a mortality of seven per cent. In eleven of these cases there was general septic peritonitis, and one of them had been ailing for five months and was thought to be suffering from typhoid fever. When I operated on her, quite half the abdomen was filled with pus and she was suffering from septicemia. After the evacuation of four or five quarts of pus she improved somewhat, but lived only about a month. This case would probably have been saved if the diagnosis had been made even within the first month.

Case 2—The patient had been ailing for three weeks with what was supposed to be typhoid fever, but eventually a mass appeared in the abdomen. and he was sent into the hospital under my care. His tongue was dry, brown and thickly coated, and he had a very fetid breath, temperature 104, pulse 130, with a large swelling on the right side of abdomen. He was too weak to take a general anesthetic, so I opened with Schleich's solution of cocaine and evacuated about two quarts of pus. He

improved somewhat for two weeks and then developed a subphrenic abscess which I opened and drained. Later he developed an abscess of the lung and succumbed.

Case 3—The patient had been ailing for eighteen hours before the operation. He had intense pain, but his temperature at the time of operation was only one hundred, pulse ninety. I found a gangrenous appendix, perforated, and diffuse septic peritonitis. A portion of the omentum as large as one's hand was also gangrenous. He died in about three days.

Case 4—Patient ill thirty-six hours with usual acute symptoms. At operation found diffuse purulent peritonitis, with a gangrenous appendix. The peritoneum had a blistered appearance due to infection with the streptococcus. The cavity was flushed out and drained, and the patient did well for five days, then a misaarriage occurred of a two months pregnancy, and she died two days later.

Case 5—Had been ill three days with a severe attack resulting in a localized abscess, the abscess was opened and a gangrenous appendix removed, by simply throwing a ligature around its base where it was healthy. Four days later the patient became jaundiced and died in three weeks from pyle-phlebitis. A post-mortem showed multiple abscesses in the liver.

Case 6—The patient had been ill eight days; there was a large localized mass with severe symptoms of septicemia. The pus was evacuated and drainage provided, but the patient died of septicemia in about a week.

The eight remaining cases had been ill with general purulent peritonitis for from seven to ten days before operation. Of the cases which recovered I have had ten cases of general purulent peritonitis, and in one a septic thrombosis of the femoral vein followed by pulmonary embolism with recovery.

I would like to refer to one of these cases of recovery, after diffuse purulent peritonitis—a boy of fourteen years of age. He had been ill for a week, with high temperature and rapid pulse. When I saw him, the abdomen was distended, hard, and tender all over; temperature 103½, pulse 160, and very weak, with constant vomiting. I told the friends that I would not advise an operation, as he seemed to be in a dying condition. At their urgent request and that of the attending physician, an operation was done during the night in a farm house. There was a large quantity of pus evacuated, and a gangrenous appendix removed. The cavity was washed out with saline and drained with iodoform gauze. Exclusive saline enemata were used for three days. He made a perfect recovery.

Of all the fatal cases only two were operated upon within the first forty-eight hours, one of them within twenty-four hours. A large number of these successful cases were operated upon within the first two days.

As to time for operative intervention: There is no question in my mind that the most favorable time for operation is within the first twenty-four hours of the attack, or if this is not possible, within the first forty-eight hours, that is to say, before perforation occurs and infection of the tissues around the appendix. In some cases perforation has occurred earlier than this, but in the majority of cases it will not. The danger of operation prior to perforation or infection of the tissues and peritoneum is practically no more than that of an exploratory laparotomy. Drainage would not be required, and the abdomen would be closed and the patient well within two or three weeks. I think the majority of surgeons now agree with the early operation. There is a difference of opinion, however, about the operation during the spreading inflammatory process, say from the second to fifth day. My opinion is that it is wise to operate at this time, but the operation must be a limited one, that is, simply opening the abdomen, letting out the pus, removing the appendix, if it be accessible, and drainage. We find in many cases in this stage a localized mass containing pus. An incision can be made over this mass, and if the abscess is parietal, that is, adherent to the parietal peritoneum, it can be opened without opening the general peritoneal cavity. If, on the other hand, the mass is not adherent to the parietal peritoneum and the general cavity has to be opened to reach it, the latter can be completely shut off by using gauze sponges or strips of iodoform gauze before opening the abscess. The abscess can then be opened by breaking through the exudate which forms its outer wall, with the finger. When pus is reached it should be mopped out with gauze. Very frequently then the appendix can be found, a ligature thrown around its base and removed. If it is not easily found it should not be too vigorously searched for, as this might cause the breaking down of adhesions and carrying infection into the general peritoneal cavity. An experienced operator will usually without danger be able to find and remove the appendix. A perforated rubber tube and iodoform gauze should be placed in the abscess cavity, and the gauze which was used for walling off the general peritoneal cavity left in situ for several days.

As to operation in the period of subsidence of the inflammatory process from the fifth to seventh day on, I think, undoubtedly that here an operation should be done, the pus evacuated, and the appendix removed where it can be reached, and drainage provided. Operation in this stage is not so urgent as in the first and second, but by retaining the products of infection there is always an element of danger. Lastly, if an operation has not been done during the attack, it should certainly be done during the interval to prevent recurrence of the attack and relieve the patient of the effects of the pathological changes which have

occurred. The appendix can be removed in this stage without danger.

The suppurative cases might be divided as follows:

1. Gangrenous or perforated appendix with a small amount of pus lying free in the cavity.

2. An abscess below or to the outer side of the cæcum and beneath the anterior parietal peritoneum.

3. An abscess circumscribed around the cæcum either below or to the inner side.

4. Pus diffused through the general peritoneal cavity.

All of these cases will require drainage, and in the first three the general cavity can be thoroughly walled off without any fear of infection.

In cases of appendicitis, associated with diffuse purulent peritonitis, the question of flushing out the abdomen is an important one. Murphy and Deaver hold that it should never be done, while Kelly and others describe complicated technique for its performance. Personally, I have had successful results from both plans of treatment, and do not feel in a position to state which is the correct treatment. In cases where there is a large amount of pus without any lymph or limiting adhesions, I would wash out with normal saline solution. In cases where there are one or more collections of pus more or less walled off, mopping out with sponges and drainage is all that should be done; or where the patient is suffering intensely and showing marked constitutional depression, I would simply open and drain without washing out the cavity. There is no doubt that in many cases where there is a large collection of pus, and it would seem that there was general peritonitis, that really the whole cavity is not involved, especially if the pus is thick, and in these cases washing out would be injurious by spreading infection to the healthy peritoneum.

To sum up then, I have arrived at the following conclusions:

1. In every case of acute appendicitis it is the duty of the physician who first sees the case to ask for a consultation with a surgeon. The responsibility of saying when the operation should be done should rest with the surgeon.

2. Until a positive diagnosis is made and the surgeon sees the case, opium should not be given for the relief of pain.

3. If a surgeon can be had at the beginning of the attack so much the better for the patient, and the operation should be done then. In other words, I very strongly advise in all cases of acute appendicitis immediate operation as soon as the diagnosis is made, unless there is some complication contra indicating it.

4. That in the event of not being able to secure a competent surgeon the patient should be treated by exclusive rectal alimentation. The stomach should first be washed out so as to remove all decomposing matter, then absolutely nothing should

be given by the mouth. From one-half ounce to one ounce of some concentrated pre-digested meat extracts, with six ounces of salt solution every four hours, given by the bowel. An ice bag or leaches applied over the appendix to relieve the pain.

This treatment can also be given in cases where the patient is too ill to give any promise of relief by operation.

5. While making a diagnosis and after it is made, until a surgeon can be had, exclusive rectal feeding should be resorted to.

After the operation, in all these acute cases, I am in the habit of using exclusive rectal feeding for at least two days and often for a longer period. In most cases only normal saline is used, but if the patient is very exhausted, feeding with meat extract added to the saline is used. The patient will complain very little of thirst after the first twenty-four hours.

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ABNORMAL REFRACTION AND EYE-STRAIN.

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The emmetropic, that is, the normal eye, produces a distinct image of external objects on the retina, particularly that portion of it situated at the posterior extremity of the visual axis, *i.e.*, the yellow spot region.

The formation of the image is accomplished by the cornea, crystalline lens, aqueous and vitreous humors. The cornea is the principal lens when the eye is at rest, as it separates two media with the greatest difference in density, and therefore has a higher refractory power than the crystalline lens. But the crystalline lens possesses the important function of accommodation, and approaches during the maximum of this function to the refractive power of the cornea. In order to form a distinct retinal image it is necessary that the curvature of the meridians should be symmetrical. Any departure from this produces variations in their refractive power.

The emmetropic eye has a range of vision from infinity to its near point. No glass improves distant vision, and spectacles are not required for reading until the age of forty-five or fifty years is reached.

Emmetropia, in the strict sense of the term, is the condition midway between hyperopia and myopia; and its title of normal refraction is denied, as it is not common to find people absolutely emmetropic.

One of the most important points in the treatment of eye diseases is to restore the eye to a condition of emmetropia by suitable glasses.

Errors of refraction lie at the root of 50 per cent. or more of all *diseases* of the eye.

Ametropia is any departure from emmetropia or perfect focussing. The principal focus is not a point, nor does it lie in the retina.

Ametropia is of three kinds. In the first class the eye is too weak or the axis is too short, so that the principal focus of the eye falls beyond, *i.e.*, behind the retina. This is termed hyperopia or far-sightedness.

In the second class, the refractive power of the eye is too strong or the axis of the eye is too long, causing the principal focus to fall in front of the retina. This is termed myopia, or near-sightedness.

The third class comprises astigmatism.

Hyperopia is nearly always congenital, and nearly all eyes are hyperopic at birth. The eyeball increases in length with the development of the rest of the body, and hyperopia diminishes with emmetropia, or more rarely into myopia.

Myopia is that form of ametropia in which the retina lies back of the principal focus of the eye, and only those rays from some points nearer than infinity can come to a focus upon the retina. This is the far point of the myopic eye.

Myopia may be produced by increased refraction of the cornea or crystalline lens, curvature myopia, or by too great a length of the optic axis, axial myopia.

In many cases myopia is due to elongation of the optic axis, the result of pathological changes in the coats of the eye.

Myopia is frequently progressive, and the increased convergence rendered necessary by the near position of the far point is a significant factor in the production of myopia on account of the distension backwards, which results from the compression of the ball between the external and internal rectus muscles.

Myopia does not usually decrease with age, but, on the contrary, tends to increase up to adult life or later.

The term astigmatism is applied to that refractive condition of the eye in which a luminous point forms an image upon the retina, the shape of which image is a line, an oval, or a circle, according to the situation of the retina; but never a point, that is, the object is never accurately focussed. Hence there is a circle of diffusion.

In regular astigmatism there are simple hyperopic and myopic astigmatism, compound hyperopic and myopic astigmatism, and mixed astigmatism, *i.e.*, hyperopia and myopia combined.

Simple astigmatism means that one meridian of the cornea is normal and the other hyperopic or myopic. The normal meridian for the hyperopic is the vertical, and for the myopic is the horizontal.

Compound hyperopic or compound myopic astigmatism is that a plus or minus spherical is needed for both meridians; but that, in addition, one meridian is stronger than the other, and hence a + or — cylinder has to be added in order accurately to focus an object upon the retina.

Mixed astigmatism means that one meridian is hyperopic and the other myopic.

Simple astigmatism of a small amount, or a small grade of

compound hyperopic or myopic astigmatism, is always associated with normal or nearly normal vision; and also with the greatest functional disturbance of the nervous system.

The greater the variation of the axis of a cylinder from its physiological position the greater the disturbance of the nerve centres; and also it is as marked if the deviation in one eye is exactly opposite to the deviation in the other.

In cases where the vision is normal, which, of course, does not imply a normally refracting eye, the nerve-centre disturbances are often very pronounced. This is due to the fact that, as by an exertion the eye can focus well, and as it abhors any approach to a circle of diffusion, it always strives to overcome it. Especially is this the case where it can almost or completely accomplish it. Hence the reply, "I can see well," is only often a sign that the eye may be the origin of acute suffering.

Now, as to the disturbances affecting many parts of the body, I shall mention some of them. Of headaches, 60 to 80 per cent. are due to eye-strain. Again, the only complaint may be a languid, listless state of the nervous system, unassociated with any other symptoms, and the statement that the eyes are always quite easy. It is in this type that the true cause, viz., eye-strain, is often completely overlooked. Even when it is found out and demonstrated, very difficult is it to convince the physician that such passive lethargy and weakness of the whole nervous system can be due to this cause; for, as he remarks, the eyes and head do not, by their symptoms, as is the usual rule, draw any attention to eye-strain as a cause.

Marked digestive disturbances of the stomach, associated with pain, vomiting; disorders of the bowels of various kinds, as pain, constipation, diarrhea; great mental depression, leading up to threats of suicide even; severe and agonizing pain in one part of the head like the most intense neuralgia, even requiring hypodermic injections of morphia to allay; ringing in the ears; great dizziness; inability to fix one's mind on any subject; epileptic fits; a condition of optic neuritis in hyperopic eyes; all these, and more, may arise from eye-strain. In regard to the testing of eyes for glasses, it is a fact that the more experienced the oculist is, the more careful is he, for he realizes how difficult it often is to make an eye take the proper glass.

It must be thoroughly understood that because an eye can be made to see normally 6-6 or 20-20, therefore the glass with

which this is done must necessarily be the correct one, is an entirely wrong conception.

It is the knowledge of this fact which often calls into action all the skill of an oculist; for he must find out which of all the things an eye will do with a glass or glasses, is the correct one, and also if that glass which seems to be most suitable can, from its nature, be a sufficient cause for the disturbance complained of.

In hyperopia with astigmatism, a variation from the normal standard being present, which as a rule causes nerve-centre explosions, may not in any way give rise to these explosions, is an exception which proves the rule.

In this form, *i.e.*, in hyperopic astigmatism, we have to deal with great irritability of the eye due in greatest measure to the spasm of the ciliary muscle and secondary to irritation of the retina, and hence may sometimes even simulate myopia.

In myopic astigmatism we have chiefly to deal with retinal irritation, and in the second place with spasm.

As to the mydriatics used, two are the favorites, viz., atropine and homatropin. Sometimes others are used, but not frequently.

Several years ago homatropin was highly lauded. As the dilatation of the pupil and the paresis of the ciliary muscle quickly passed away, compared with atropine, it was hailed with relief. However, this quality of evanescence is its weakness and the cause of its non-use or limited use by a great many, if not a majority, of oculists at the present time.

That the great and marked spasm of the eye-muscles, especially the ciliary, cannot be overcome by a few hours' instillation of homatropin is now an acknowledged fact, and hence, I feel, when used in such cases it only renders the confusion worse and makes accurate correction an impossibility almost.

Atropin, however, is much more powerful. If in any case of hyperopic astigmatism I am unable to get a satisfactory result without a mydriatic, I always use atropine; for I consider that with homatropin any effect will be too superficial and short-lived to be of any benefit.

I shall narrate an exaggerated case to show you what I mean. A man, aged thirty years, came to me with a history of severe headaches for ten years or so. During this time he had given him, by oculists, twenty-five to thirty prescriptions for glasses. I examined and found he had simple hyperopic astigmatism of a small amount. I could easily make him read 6-6 or 20-20 with a + .50 cyl, but I could not

make the eye decide upon an angle. It would give them, varying 50 deg. between the extremes. This showed great ciliary spasm and retinal irritation. I used a four-grain solution of atropine, putting a few drops into each eye thrice daily, and kept it up uninterruptedly for four months before I could get the eyes to take a cylinder without variation of angle.

Finally each eye did, and then I ceased the atropine. My result was satisfactory, as he informed me one year later. No longer did he suffer from blinding headaches, as had been his lot for ten years. I also gave prisms to exercise the external ocular muscles.

Here my good results were due to the soothing effect of the atropine upon the ciliary muscle and retina by preventing any work being done by the eyes, and this action aided by the iodide and bromide of potassium internally.

When these structures became quite quiet, then the retina could recognize accurately the proper position of the axis, and hence could finally name it correctly every time.

In myopic astigmatism the same treatment has to be pursued, but not so often. Here, however, the pain and uneasiness are at the back of the eye and are due to long-standing irritation of the retina, a form of inflammation not visible to the opthalmoscope, not gauged by it.

Now, another cause of trouble arising from the eyes is that the external ocular muscles do not act normally. The normal action is called orthophoria, and the abnormal heterophoria. ,

There is an undoubted substratum of truth in connection with this, but not nearly as much as has been stated. It is indeed putting the cart before the horse, when you see these muscle enthusiasts cutting and readjusting muscles, and at the same time giving to the errors of refraction a very perfunctory test, and hence oftentimes a wrong correction, that is, the glasses ordered and worn are incorrect.

Accurate correction is always a *sine qua non*, of prime importance in these cases, and operation upon the muscles of secondary importance. However, a reversal is wrong and non-scientific treatment. This, however, is too often done.

No eye can, as a rule, be properly corrected at one sitting, and it is this procedure of one sitting which so often eventuates in the ordering of wrong glasses and hence non-relief.

If the medical profession but once accepted two facts, one that so very many improper functional activities of various organs of the body often give rise to nerve-storms, simulating

every known phase of abnormal nerve-centre conditions, structural and non-structural; and that very many varieties of these storms are due to improper activity of the eye, it would then surely act as if it were weighted with this responsibility. If it did, then it should give its exclusive support to eye specialists belonging to the profession, and not as it now so often does to all kinds and varieties of irregulars and hangers-on. We oculists do wish that the general profession would bestir itself and learn to test eyes for errors of refraction. In this way could it inculcate the lay mind with a true conception of the prescribing of glasses. It could select the cases that should be sent on to the oculist and prescribe for the others, and thus prevent much harm now being done.

In this way could it gradually drive out of the field a class of men which has no right in it, and which the commercial instincts and greed of the manufacturing companies of optical goods have wrongly forced into existence.

This class, devoid of any knowledge of the eye, except the most rudimentary, is thus dealing in a thoroughly commercial way with one of the most important and difficult branches of eye work.

This branch of eye work, *i.e.*, errors of refraction, ought surely to receive your careful attention, when, as I have already mentioned, it is at the root of 50 per cent. of all diseases of the eye.

THE AMERICAN DISEASE: AN INTERPRETATION.*

By WILLIAM BROADDUS PRITCHARD, M.D., (PHILADELPHIA).

Medical nomenclature, certainly as regards names for many diseases, stands to-day the most neglected, the most incongruous, the least rational and the least progressive of all the minor divisions of the subject. Many of those most familiar justify a continued existence solely through the fallacious law of traditional custom. In some instances, both name and disease being inelastic—typhoid fever or epilepsy, for example—no special harm is done. In others, as hysteria and chorea, we continue to insult intelligence apparently without either conciousness of shame or hope or desire for reform. There is something of promise in the tuberculosis of to-day rather than the consumption of our fathers, but much remains to be done, the work having scarcely begun. The field of neurology, perhaps, more than any other, needs the scythe and pruning hook. The latter instrument could, in my judgment, be used with particularly beneficial effect if employed vigorously and with discriminating judgment in neurological nosology. Its first work, if in my hands, would be to clip and trim and shape into at least some semblance of definite form and substance that phantom, once a tree, now a forest and rapidly becoming a wilderness, so rank and riotous is its growth, neurasthenia. No shorter road to nervous prostration exists than along the route of present interpretation and mental comprehension of the term as generally understood or misunderstood. I confess to an antipathy—I think rational though amounting almost to an obsession—for the word. Originally intended to possess a definite significance, its field of application has been so elaborated and broadened and abused that to-day it means almost anything, and with equal truth almost nothing. The inspiration which gave it birth marked the genius, but the child has grown a monster, fattening upon the flesh of hundreds of brothers and sisters, and even its cousins. It is still from custom classed among the neuroses or psycho-neuroses and thus the special property of the neurologist, but like its twin sister—the only sister left, by the way—hysteria, it has wandered afar with an omniverous appetite and is known to-day and claimed in some one of its hydra-headed forms in every field of medicine. To the stomach specialists belong the gastric and lithemic types, to the surgeon the post-operative and some of the traumatic cases. The sexual neurasthenic is the property of the genito-urinary specialists, the reflex cases are almost equally distributed to those who know the eye, the ear, the nose and throat, while the neurolo-

*Read before the Ontario Medical Association, June, 1905.

gists divide the remainder with the gynecologists, or play battledore or shuttlecock with all. The general practitioner alone is counted an invader in this field, and he, wise man that he is, with appreciative philosophy rarely feels himself aggrieved.

My criticism is not of the term etymologically. On the contrary, properly restricted in interpretation, it is an excellent example of word-making. It should stand, however, for either fish, flesh or fowl—for a definite entity or syndrome—if retained in our nosology. If discarded in this field, by all means keep it, but restrict it to the broad, descriptive significance of a generic term alone. I am not yet willing to accept the dictum embodied in the recent paper of an eminent American writer who, with a stroke of the pen, announces the passing of neurasthenia, for which he would substitute a group of pure psychoses, if for no other reason than that he leaves us none the better off for such a begging of the question; and yet one is almost tempted to let it pass away into final oblivion and without a protest on reading a serious thesis by another recent writer upon neurasthenia in babes. If it is to continue a neurological and general medical waste-basket into which we are to dump all forms and degrees of illness associated with irritable, nervous weakness to which we cannot attach a standard label, *then it cannot be lost too quickly. It means to-day* to the student mind mystery, confusion, chaos and correllated aversion, curiously mixed with a contradictory fascination; to the patient it has become a term full of suspicion; to the medical teacher it is a term of reproach. No observation or experience during my fifteen years of post-graduate teaching has been more emphasized than this attitude or mind of the student body. Year after year and many times a year, the cry has been the same from all my classes: "What is neurasthenia?" I think you will agree with me that something should be done. The solution of the problem to me seems relatively simple. Let us stop running after strange gods and the making of false idols and return to the worship of our fathers and to one faith. There *is* a nervous affection—the very same which originally inspired Dr. Beard to coin the word, with a broadly constant symptom picture, a more constant etiology, a conjectural pathology, a fairly certain prognosis and a definite plan, in principles at least, of treatment, the chief and essential symptomatic manifestation of which is an irritable, quick exhaustion of nervous function in many or all directions. It has become almost lost, it has suffered degradation, it has fallen from the genus to the species in the literature of the subject, not so much through intrinsic conditions, but because of the confusion and chaos of interpretation. The dignity and importance of this subtype, its rapid and progressive increase, the charm and fascination of its study

and of its remedial and curative treatment are such as justify and, indeed, demand that it be taken from this chaotic mass and be given a distant identity. Let *this* be neurasthenia. We shall simply give back to Cæsar what was his, lost property to the original owner. It is but the restoration of the birthright. How the thief will cover his nakedness is his problem, not ours.

I have but borrowed for a purpose my title, and having explained my motive, I discard it. And yet it is not altogether bad. That it has the ring of cheap sensationalism is a just criticism, though nothing was further from my mind, a disavowal which I hope has been anticipated and is accepted. In much that the condition that I have in mind represents, in much that is peculiar to this affection—to neurasthenia—the term, the American disease, is both accurate and appropriate. As I conceive it, it *is* an American disease indigenous to this soil and essentially a product of causative conditions peculiar to this country. That it now exists elsewhere, and probably always did in sporadic form I do not doubt, but this is its home, this its soil, this the atmosphere in which it luxuriates. What is this disease? What are its symptoms? How differentiate it? What is its etiology and prognosis, and how is it to be treated? My limit of time will permit me to create the scheme of the picture only, but if the viewpoint be the proper one and the perspective liberal in breadth, any one of my audience will, I am sure, be able to do the filling in. I would count my work well done and a good end accomplished if I did no more than infect you with the enthusiastic interest with which the subject inspires me. In the effort to do so I shall create part of the perspective referred to. First as to your material: Neurasthenia never occurs in fools. The idea constitutes a paradox. Neurasthenia may make a fool, but you cannot make a fool a neurasthenic. It is a disease of bright intellects, its victims are leaders and masters of men, each one a captain of industry. Each case is unique as a study if you are to study helpfully. There are no arbitrary limits to the horizon of studious effort. The political history of the world has been made largely by paranoiacs. Mahomet, Peter the Hermit and Oliver Cromwell are examples in point, to go back no farther. In each there was an imperative and an impelling monomania. The world of literature, of art and of science, of fruitful endeavor in all higher fields, is indebted in an analogous degree to the neurasthenic, analogously endowed with an imperative and an impelling energy. Dr. Gould's list includes such names as Carlyle, Wagner, Huxley, Spencer and many others. The confidence, the faith of patients of this type, is to be classed as an inspiring stimulus in itself and is well worth the struggle to grasp understandingly this subject. That yours is the helping hand depen-

ded upon by such men—such giants—whom you may lead as little children; the knowledge that you, and sometimes you alone, may bring back into the world's arena of action and into the old supremacy, such factors in the world's work, represents to my mind an objective, a purpose, a sphere of usefulness second to none of the many laudable ambitions along the highest planes of medicine.

In painting the clinical picture it would mar my scheme to paint an individual likeness. I shall give you first the basis for a composite photograph, made up of the case histories of fifty selected patients from private practice. Forty-two of these were American born, the remainder, 8, with two exceptions, had been residents more than fifteen years; 22 were from New York City, 4 from Connecticut, 3 from Massachusetts, 5 from Pennsylvania, 2 from New Jersey, 5 from as many different Southern States, 1 from Canada, and the remaining 8 from as many different sections. Forty-three were from cities of more than 100,000 inhabitants, although only 21 were city born. The average age was 37, the oldest 62, the youngest 26. Without a single exception all were brain workers. Sixteen of these fifty had been makers of history in different spheres, some large, some small; mercantile, literary, religious, scientific, political or economic. Two of the number were among the hundred captains of industry assembled in a list made to commemorate a national function celebrated a few years ago. By occupation 13 were financiers, in multiple mercantile lines, really better described as promoters; 6 were lawyers, 3 clergymen, 2 merchants, 5 physicians, 5 brokers, 4 school teachers. Of the remaining twelve, 2 were professional politicians, 2 corporation officials, and 4 managers of large industrial plants. Four of the fifty were men of independent, self-acquired means, who described themselves as having no occupation at the time of record. They have been included in the groups mentioned according to previous occupation. Four of this series were women, 1 a journalist, 1 an actress, and 2 of them teachers. Fourteen of the fifty were unmarried, the age average of this series of fourteen being relatively high, forty-four. The four females were all childless, though two of them were married.

Instead of an analytical elaboration of individual symptoms, let me give you a standard clinical history selected from the series of fifty as a type portrait.

M., aged 33, male, born of healthy good stock, American parentage, the only handicap being parental poverty. Driven by necessity and by that subtle factor, temperament, to early effort in extraordinary degree, he acquired the strenuous, ambitious, high tension, keenly sensitive habit. He could not afford a liberal or broadening education because his own dollars paid

for it. At 19 he was in business as apprentice in a large establishment manufacturing mechanical engineering appliances. At 26, with a capital of $500, he organized a company, had it incorporated, was president, secretary, treasurer, superintendent, salesman and chief stockholder, entering into competition with established and lavishly capitalized rival corporations. Awake at 7, he hurried through breakfast a few minutes later, mixing an omelet with an order or a countermand, assimilable sometimes with the former, always incompatible with the latter, taking in with his coffee the London market or the Paris bourse, dividing the steam supply between brain and stomach when it should have been all turned on at the point of physiological demand. A hurried walk to the train, possibly a delusional constitutional in this very walk, the steam being still turned on to the top floor. In the office a pile of mail, interviews with clerks, orders, directions, instructions, detail work in every department. Just here *en passant* is laid the immediate foundation of the breakdown. It is the man of detail, the man great in everything except the qualities which make the general, who becomes the neurasthenic. It is the crime of attending to minutiæ which makes the nervous derelict. The general is never a neurasthenic. It is the one flaw in the statue of true greatness. That quality, the highest which helps us to select our lieutenants, is always lacking. The neurasthenic is the archetype of the poohbah. He is not only general, but also colonel, major, captain and private. The penalty is inevitable. No man can do the work of four along higher lines without paying for it.

After four hours in the office this man goes to lunch, tired nervous and with preoccupied mind. He takes his secretary or manager, and again the attempt is made to mix a steak or an omelet with a business problem. The steam is still turned on at the top, our patient eats fast and drinks a lot of water or other fluid, prematurely flushing the contents of the stomach into the intestine. Already by nervous inhibition he has interfered with biliary and other secretions The intestine, the duodenum, cannot take care of the albumenoids—the proteids—properly. It cannot take care of its own. The alkaline reaction of duodenal secretion has been upset by the flushed overflow of acid gastric juice. the secretion of bile has been inhibited by the state of mental tension and the diversion of energising agencies from digestive viscera to brain. Fermentative decomposition with resulting ptomaine and toxine formation follows, deficient nutritional assimilation plus chemical irritation are added to cell fatigue along a routine line without rotation. Notices of protest begin to come into first subconscious recognition, but are disregarded. They may come from any one or many sources. Headache of the cincture or helmet type, vertigo a

sense of irritable weakness, mental and physical follows; vague, mysterious messages in a strange language, never heard before, are received but not understood. This patient has always been well and has had no training along the lines of familiarity with symptoms. These messages at first ignored, sometimes hushed with a cocktail or a highball, or many of both, become more and more continuous and imperative. The habit of almost mechanical activity of mind projects itself into the hours for sleep. Insomnia develops, at first as dreamful, anxious sleep, then with fitful, broken sleep, and later with an allowance cut by more than half from the normal. He wakes tired, irritable. The pneumogastric is one of the first and often the most emphatic of the aggrieved protestants. Palpitations, over-action, an irregularity partly toxic, lay the foundation for what later has become an obsession of fear of sudden death —heart anguish. He fears to be alone, to walk alone, to sleep alone. To this other fears have been added. A perfectly legitimate dizziness has laid the foundation for an almost hallucinatory persistence of this impression. Rapid motion, as in the cars or a carriage, high places, sudden changes in the visual perspective, originate as many phobiæ. Every nerve gets on edge and this hyperesthesia of auditory, or visual, or olfactory, or gustatory, or pneumogastric nerve, varying, as it necessarily does, in degree, gives explanation for the proteon system picture. It is the mystery of it all which leads to introspection in attempts at explanation, and finally to an exquisite exaltation of subject consciousness, a veritable delirium of anguish.

Neurasthenia is essentially a recoverable affection. In a majority the recovery is complete and final. In a few, usually neglected or mismanaged cases, the recovery is imperfect, relapses are common and the neurasthenic habit becomes almost a part of the individual. Even in these cases a steadily progressive tendency to recovery and to a normal poise as the final fixed habit may be established by persistent effort based upon an intelligent understanding of the general principles of treatment plus an appropriate application of such principles to the personal equation of the particular patient. Neurasthenia carries with it no penalty to succeeding generations. This statement is contrary to *a priori* reasoning, and also contrary to routine teaching and unthinking or ignorant belief. It is a statement based, however, upon careful observations in an extended experience, and I believe it to be absolutely true. The victim pays the whole penalty; the disease is free from the law of entail. The high average standard of good health and nervous poise in the children of neurasthenic fathers has been a frequent personal observation.

I do not believe that any individual case of neurasthenia

ever originated in a single cause. The very essence of the affection makes such an hypothesis a paradox. Equally true is it that no single agency is sufficient to explain the prolonged maintenance of this condition. Any one of many causes may appear to dominate in a given case and for a given time, but the carefully studied etiology will prove a complex one in every instance. The list of stereotyped and empirically accepted causes is a long one and undergoes a progressive expansion from year to year. Overwork, worry, prolonged mental tension and anxiety, malnutrition from deprivation of food, sleep and rest, toxemia of autogenous and heterogenous sources, shock, trauma, reflex irritation, and as many more are on the list. Most of these are contributory factors only, and some are effects which are essentially secondary, being part of a vicious cycle, vicious in fact and even more so in interpretation. The insufficiency alone of any of these factors is tacitly admitted in the usual statement that an hereditary predisposition is fundamentally necessary, a proposition not sustained in my own experience, though carefully investigated always. Neurasthenia is, I believe, essentially an acquired state and heredity, except of temperament, and a high grade cortex is an almost negligible equation. My chief criticism of the ordinary etiology as outlined is the narrow viewpoint with resulting technical limitation in treatment. What is the cause of these causes? *The* factor in neurasthenia in the American disease—the factor common to all cases—is, broadly, that of atmosphere—the atmosphere peculiar to this country, the atmosphere of limitless possibilities, not in one field, but in all; in commerce, in art, in literature, in every field of intellectual accomplishment. It is this ether of limitless possibilities which stimulates the individual to a degree of effort, of tension, of strain, of superstrenuous endeavor, impossible and unknown, except by the infectiousness of example elsewhere. There is no limit to the game, and anybody may sit in. America is the only country in which you can go in with one white chip and have a chance to quit the biggest winner. It is this atmosphere which is the incentive to overwork. It is the anxiety, the tension, the strain of the game, which brings worry, loss of sleep and all the rest; and even here the penalty comes indirectly. The intoxication of endeavor, the delirium of effort, is at the expense of all conservatism. The laws of nature—inexorable as fate—fate itself in fact, are violated not daily, but every hour. The hygiene of life is set aside. All kinds and degrees of insult are offered to brain, stomach, heart and every other organ. Day after day the steam is kept turned on and at full pressure to the one floor, and, worse still, often to the one room. Is it any wonder that all the rest of the house grows cold, or that, the power being insufficient, the machinery of the lower floors

works poorly and makes poor goods? Every function suffers sooner or later. One after another, and sometimes several together, they protest, then openly rebel and finally go on strike. Indigestion, toxin and ptomaine formation, torpor of sewerage function and resultant, defective elimination add the element of chemical irritation, or autoxemia, or lithemia, to the situation. The tired brain cell gives way under this added handicap and goes out on sympathetic strike.

The accident of dominating symptoms in a given case is but rarely of any value in determining the etiology. Gastric and lithemic and other types may be recognized and distinguished symptomatically with some minor advantage, but no more serious error of interpretation exists than to conceive of them as primary etiological types with a correllated therapeusis. Anti-lithemic drugging will not cure a lithemic neurasthenia nor will lavage make well your so-called gastric cases.

I have again and again noted a urine with specific gravity above 1,030 with 14, 16, 18 and even 20 grains of urea per ounce, with lime oxalate and urates in abundance, all these conditions giving way to the normal under direct treatment, the neurasthenia remaining essentially unchanged. I never knew a sexual neurasthenic, so called, to be cured by any plan of direct genito-urinary treatment, and this statement applies with equal truth and force to all efforts (and I have seen many) to cure the reflex cases by removal of a supposed cause in any peripheral irritant.

I know of no condition in medicine which demands more exactingly of the physician all the diagnostic resources of the profession, and yet mistakes in diagnosis should be rare. The symptomatic semblance of neurasthenia—the pseudo forms—which may sometimes present much of the picture, but will always show a radical omission or addition somewhere, should always be in mind and should be excluded carefully seriatim. More than one patient referred to me as a neurasthenic has been found to be the real victim of tuberculosis, of malaria, of Bright's disease, of gastric ulcer or some other similar affection. Anomalous forms of Basedow's disease in women and various toxic states among men have represented especially common mistakes in diagnosis. Paretic dementia in its incipient stages and some forms of melancholia, particularly the affective types, demand special mention. A guarantee of escape from the opprobrium of error as to the pseudo types is possible only through an exhaustive recourse to all measures and methods of accurate information. Elaborate urinalysis, blood examinations and often examinations of the sputum is a routine procedure with me. In any case in which the dominant symptoms are referable to a particular function or organ persistently, I am proportionately suspicious of a local disease at

least complicating the general state. It should not be forgotten that a neurasthenic may have a coexistent Bright's. In Basedow's disease which, as we know, may utterly lack the spectacular symptoms, the absence of goitre and of exophthalmos may easily lead us to interpret the nervous irritability, the quick exhaustion, the fears, the digestive and other functional disturbances, the loss of sleep and the widespread vasomotor symptoms as due to a neurasthenia, but the habitual quick pulse, the shallow respiratory action, the diarrhea and the *tout ensemble* of constancy in the picture will always give rise to doubts which will be converted into negative certainty when the etiology is considered. From paretic dementia we can distinguish neurasthenia by the presence in the former and the absence in the latter of organic signs. No matter what the degree of incipiency, if the disease has advanced to the point of inducing symptoms, we shall find in paresis somewhere some of the physical signs. Special care should be observed in the melancholic (by the way, the majority type) forms of paresis. In melancholia we have, no matter what the subtype, a constant syndrome; a characteristic facies, a post-cervical ache, a shortened sleep, an irrational melancholy and a tendency to suicide. In neurasthenia this facies is absent and the tendency to suicide is rare. Melancholiacs get to sleep as a rule with but little difficulty, but wake too soon, at 2, or 3, or 4, and sleep no more. In neurasthenia they sleep lightly, dream much and wake often. The post-cervical ache may belong to both, but in neurasthenia it is often a cincture or helmet headache, quickly dissipated by mental diversion. The neurasthenic can laugh, the melancholiac cannot. For a melancholiac to laugh is to refute the diagnosis. From myasthenia gravis it is to be distinguished chiefly by the absence of dominant bulbar symptoms.

What is the pathology of neurasthenia? The answer is almost anyone's guess, and yet to know the lines of experimental research and investigation already established is a long step in the direction of what will finally prove the correct guess. The work of Hodge, familiar to you all, was a far call in the right direction, and while it has given us no final solution, it probably paved the way to the yet to be demonstrated pathological explanation of these cases. The effects of fatigue, of worry, of irritation, upon the brain cell structure was proven to be actual and demonstrably so, by his work. Barrows has added observations which demonstrate with equal positiveness, the structural and sometimes actually organic changes and results which follow to the cell from malnutrition. All neurasthenics, it should be remembered, are examples of malnutrition from faulty assimilation and metabolism, usually secondary. The work along chemical lines with a final explanation in states of auto-intoxication promises much, but that which

appeals most strongly, even though as yet it offers least in a tangible, material way, is a combination of the others with an imaginative elaboration of the ion theory. The analogy of the highest governing nervous system with a telephone service in a large city has occurred to many, appeals to most of us and is familiar to you all. We have all been able to grasp mentally some conception of the power plant, the conducting wires, the receiving and transmitting station of the subscriber and a central, but the plan of a central switchboard is where we stop. The hello girl of the central station will not do. She is too unreliable; she goes to sleep on post; she talks distracting gossip; she has no sense of duty at times. Her sole stimulus to duty well done is often the approval of the inspector only and the $10 per week. Neurasthenics don't gossip, they don't go to sleep—more's the pity—and yet the switch gets out of gear and you cannot get a connection, or if you do there is a buzz and you can't understand which stands for the weakness; to which we might add in carrying out the analogy, the usual profanity, to represent the irritability. Mendelssohn, Frankhouser and others, in attempts to give a tangible, graspable explanation of electrical action upon nervous function, have advanced and elaborated what might be called the theory of wandering ions. You will recall that, when first announced, the neuron theory, in addition to facts proven, claimed, but did *not* prove a distinct individuality for each neuron, with no anastomosis anatomically with our neurons. This undemonstrated claim was unaccepted for the reason that it left less explained than before the observed and familiar facts of concert of action and synergistic relationship of nervous function which seemed to demand some anatomical connection. Imagine bodies endowed with autogenous mobile life, which stretch an arm from 1 to 5, or A to G, wandering about with a restless usefulness, connecting two separate souls who want to get in touch in the same way but with infinitely more of reliability, as the central hello girl connects you up with the number you send in from the transmitting phone. Imagine these little bodies goaded day after day to extraordinary effort, allowed no rest, no sleep, whipped by alcohol, or tobacco, or coffee, suffering from deprivation and irritation in every way, rations served foul, working for a thoughtless, selfish, utterly inconsiderate master. Do you wonder that they get discouraged, tired, exhausted and confused, taking messages wrong, turning in a fire alarm here, calling in the police there, doing many things which they should not do and leaving undone those things which they should do? Very pretty, you will say, but fanciful. I admit it, but I deny any more of fact in any other theory.

The first step—the essential foundation of any plan of successful treatment in neurasthenia—is the establishment of a

proper relation between physician and patient. The status of the physician should be firmly established before the question of treatment is considered at all. He will have laid the foundation of any plan of successful treatment well in a direct ratio with the thoroughness, the exhaustiveness of his diagnostic examination of the patient. Nothing should be taken for granted—no second-hand information should be accepted. At the risk of being tedious, examine for yourself. Five minutes or less is often more than sufficient time for a final diagnosis in paresis or tabes—two hours is often time well spent in the first examination of a neurasthenic, and this is true even in the instances in which as many minutes only have been necessary to convince you of the nature of the case. Remember there are two parties to the transaction. Your own enlightenment is not the only requisite. The neurasthenic always takes himself and, at least, some of his symptoms seriously. To tell him abruptly that this or that means nothing is not convincing to him, however true to you. No obvious foundation has been laid for so positive a statement in so short and superficial an examination. To you many of the symptoms are distorted by exaggeration, to him they are real. Do not forget the axiomatic fact that neurasthenia does not develop in a fool, and as corollary to this fact make your appeal to the intelligence of your patient. Explain things; give the patient something tangible to grasp, some explanation which appeals to reason. He will leave the ether of imagination and come down to the terra firma of fact gladly. The effect at first may be upon the subconscious ego only, but the leaven of action will later rise into controlling consciousness. The physician, by the way, should never think, or believe, or guess; he should know. Therefore, he should lay at least a plausible foundation for such knowledge in a patient examination at the first interview. It is just as important that a reverse attitude should be the rule thereafter. Discuss with your patient in subsequent interviews every topic conceivable except his ills. At stated intervals go over the case objectively, taking an account of stock. Where favorable progress is noted, not only mention it—prove it; if still *in statu quo*, explain the delay in results. Silence is rarely golden in such situations. Equally important with this factor or proper relationship between doctor and subject is the control of the patient's environment. Just which is proper varies with different cases, but once settled, it should rarely vary with the case. Compromises and concessions are always dangerous. The patient's hand should never touch the tiller, once you have taken charge of the ship. First, place him so as to minimize the influence of all adverse factors, domestic, financial or otherwise. Break up, as far as possible, all subtle or obvious factors which contribute to a morbid

introspection by conscious or subconscious association. Encourage objective consciousness by a change in the physical and mental atmosphere. Sometimes this must be done radically, and the patient cut out from the family or from his business. Never leave him alone, and never leave him idle. Put with him a tactful, resourceful, sensible, attendant—train your own nurse, by the way—train him over again, if a hospital graduate. Don't call him a nurse in any event—neurasthenics resent trained nurses. Give all your instructions to this nurse-companion—never to the patient, who should have nothing whatever to do with his case. Arrange all details of diet, of exercise, medicines, baths, diversion, etc., with the nurse. Give your patient a chance to escape from a knowledge every hour of the day that he is a patient. Keep him busy, fill in every minute of the day. A salt rub in the morning, the patient standing in eighteen or twenty inches of hot water, three minutes of practice in deep breathing exercises, after which comes breakfast. All meals should gradually be made as full and as nutritious as possible. I observe idiosyncrasies, but no other law of special diet. After each meal from twenty to thirty minutes of recumbent rest is insisted upon—a habit observed by nearly every carnivorous animal, except man. Next comes the daily visit to my office, with treatment by the galvanic current, one electrode back of the neck, the other over the forehead, both as large as possible, in order to get the utmost diffusion at the point of contact and thus a maximum of electricity with a minimum of discomfort from local action. A steady battery, a rheostat, a meter, and proper electrodes are absolutely essential. Part of the benefit is undoubtedly due to suggestion. This is a small part, however, by comparison with what I am firmly convinced by years of careful observation to be an intrinsically dynamic effect of sometimes striking benefit from electricity thus administered in these cases. I never exceed five milliamperes in amount, or half an hour for the seance. Usually I begin with one milliampere and a five-minute seance. On leaving my office, my patient goes direct, riding or walking, according to circumstances, to a gymnasium, the director of which, Dr. Watson L. Savage, is a medical graduate, whose life-work has been given with enthusiasm to the co-operation, elaboration and perfection of a plan, which we both believe will, when perfected, prove a specific, curative treatment for these cases, a proper environment and control being the only other essentials. By this plan of psycho-physical, educational control, we secure, by the indirect method, what is always difficult, and often impossible, by any direct plan—a lowering of tension, a mental relaxation, a return to rational inhibition, to order from chaos. These patients are taught the lesson of physical, muscular relaxation—how to lie

down, how to go through the mattress to the bottom, how to turn loose physically. That the muscular system is energized and overkeyed into states of hypertension through sympathy with states of mento-nervous exaltation is familiar to us all in the tense mouth, the corrugated brow, the clenched hand, the restless walk. We simply start at the other end, and re-educate the higher through the lower. The quickest, the surest, the most rational way to key-down a man mentally, is first to key him down motorially. I have waited for ten years of results to accumulate before announcing publically, except in the lecture room, the value of this procedure. I give you no experimental theory. My unqualified endorsement is based not only upon a rational conception but many confirmations in experience. I count this part of the plan of treatment in neurâsthenia one of the most positively helpful and essential of all the major details. The afternoon, following lunch and another half-hour of rest, is spent out of doors—a drive, a horse-back ride, golf, tennis, a walk, a visit to some museum or place of public interest: a shifting from one to another of these various diversions, largely based upon the personal equation of temperament and aptitude in your patient, fills up the afternoons. In suitable cases part of the evening must be filled, and occasionally the theatre or a concert can be utilized, but never at the expense of sleep, if insomnia be present. A half-hour of massage at bedtime closes the day's work.

This one symptom, insomnia, must be controlled always. Make your patient sleep—count a dreamful night insomnia. Veronal, trional, sulfonal, in 5, 10 and 15-grain doses, are effective and satisfactory. I often shift them. All should be given in some hot menstruum. No nervous patient should ever know his drugs—send the prescription yourself, and always mark it, "No copy. Do not repeat." Fifteen years ago a few neurasthenics under my care came back to health and nervous poise in spite of the drugs which I employed in treating them. For five years past, using less than half the drugs, my percentage of recoveries has increased fourfold. Drugs play a varying part—sometimes no role at all, again a vital one. Some patients demand them, others are indifferent, and still others need them neither mentally nor physically. Sleep must be secured and maintained, elimination and prompt sewage function regulated and complicating accidents combated. For temporary use, until the regime outlined becomes effective in lessening it, the mental state of unrest and hyper-psychical esthesia should be controlled, and the drug which most effectively accomplishes this purpose is opium in the form of the denarcotized, aqueous extract in doses from one-tenth to quarter-grain three or four times daily. Free water drinking between meals is a desirable habit to encourage and a positive water,

always symptomatically remedial in cases in which lithemia is an aggravating factor, is the Royal Fachingen. I do not believe in the sanatorium treatment of these cases as I know sanatoria. If the ideal sanatorium existed, the sanatorium plan would be ideal. I add nothing to your personal knowledge, when I tell you that such an ideal does not exist. I can conceive of no more fitting nor important statement in conclusion than one of condemnatory criticism of the misapplication of the Weir-Mitchell plan of rest and isolation in these cases. It is to be condemned first, as involving the conception of a *routine system or plan* of treatment; second, as encouraging introspection; and third, as violating in principle all intelligent interpretation of the whole subject. For women and feminine males it will do no harm; for men and masculine women it is an insult to intelligence.

Editorials.

ONTARIO MEDICAL COUNCIL.

There is a wondrous change in the atmosphere of the Medical Council since the cessation of the bitter war between the Old Guard and the Defence Association. Without any reference to the questions then in dispute it strikes the onlooker now that the methods of conducting the proceedings at present are much more dignified than those in vogue a few years ago. Our genial friend, the Honorable Senator Sullivan, the President of last year, retired gracefully, and the newly elected President, Dr. Albert A. McDonald, took his place in a quiet and unostentatious way, and during the meeting was a very acceptable chairman.

One of the most important questions considered by the members was that connected with certain proposed changes in the Medical Act, which would add to the efficiency of the law officers in putting a stop to crooks and quackery. As the proposed amendments are especially in the interests of the public it is hoped that they will be passed at the next meeting of the Ontario Legislature.

A great deal has been said during the last ten years as to the advisability of selling the present building and erecting a new one for the exclusive use of the Council. Two years ago there appeared to be a consensus of opinion that the building should be sold as soon as possible. The matter was put in the hands of a committee, fortunately possessed of considerable business ability, and it was found that the building could not be sold at a paying price, from the Council's standpoint. The committee had much pleasure in reporting that the revenues derived from the portions of the building have been greatly increased during the last two years. It has been decided that for some time at least the building will be retained in its present shape, because it will "pay better to keep it than sell it."

As usual, considerable time was taken in the consideration of certain petitions in connection with the report of the Complaints Committee. As a matter of fact, too many of the complaints of rejected students have been received and considered during

recent years. We may sympathise with the rejected student, but we have a firm conviction that the decision of the examiners should in all cases be final. We presume, of course, that the examiners are men of ordinary honesty and decency. Experience in the past has shown that any departure from such a rule is apt to lead to confusion.

One of the most important duties of the Council is the selection of a Board of Examiners. We have given on another page a list of the examiners for next year and are happy to say that we consider it in all respects satisfactory.

TUBERCULOSIS.

We have heard much about tuberculosis in recent years, but unfortunately the amount of work done this far to prevent its spread and to cure its victims has been comparatively small. Many think that the dangers of infection and contagion have been somewhat exaggerated. The opinion expressed in our medical parliament at the last meeting that tuberculosis was quite as contagious as small-pox will hardly be accepted by all. However, there is a general consensus of opinion that the disease is more or less contagious.

We are inclined to think that too little attention has been paid to the great dangers from eating impure foods. There has lately, however, been a great scare in London, England, about certain poisonous matters lurking in ordinary foods. Last year the fated oyster came into disrepute; this year tuberculous poultry came to the fore. It is stated that 30 per cent. of the poultry raised in England, and subsequently served at the table, has suffered from some form of tuberculosis. This startling statement was made by a poultry expert with reference to the rumor that the Royal Commission is now considering the question of tuberculosis in poultry.

This is by no means a new suggestion, and has been referred to in numerous meetings of medical societies. The statements, however, of medical experts did not appear to create as much interest as those of an ordinary breeder. The latter seems to have "got ahead" of the practising physician by telling the public that such diseases as roup, wet-roup, swelled head,

dropsy of the wattles, gapes, liver disease, pip and pit—all of which are the bane of the poultry farmer—are merely different forms of tuberculosis.

We are told by a prominent official of the British National Poultry Organization Society that there are districts in England where it is impossible to carry on poultry farming owing to the presence of germs of tuberculosis in the soil. The same party says that he considers that there is great danger to public health in the thousands of yards, where poultry is raised under most filthy conditions.

MEDICAL COUNCIL REGISTRARSHIP.

We think that all who have watched carefully the workings of the Ontario Medical Council during the last twenty-five years will agree that the all-important officer of that body has been its Registrar. It seems hard to realize that Hon. Dr. Pyne, who is still recognized as one of the Boys, should have been Registrar for 27 years. His position during that time has been unique. It was well expressed the other night by certain members of the Council that Dr. Pyne has always shown marvellously good judgment. We quite agree with the views thus expressed, and firmly believe that Dr. Pyne has shown himself to be in all respects "a level headed" physician. His manner has always been particularly quiet and unostentatious, but in many of the storms that have arisen he has been the most important factor in the interests of conciliation and peace. What he has accomplished in this respect will, perhaps, be more fully appreciated in the future than it has been in the past by the general public, although it is now well known to those who have watched provincial medical politics.

When the Registrar was asked to enter politics he refused to do so until he consulted with members of the Council on both sides of politics. One and all said: Yes, by all means go into the Legislature; it wants just such men as you, and as many of them as possible, both in the interests of the public and the profession. Just exactly how a red hot Tory can satisfy both the lion and the lamb to such a remarkable extent is one of Dr. Pyne's secrets, which we understand he will disclose on some future occasion.

When he became the Honorable Minister of Education it was thought by a few that his appointment as a minister might interfere with his work as Registrar of the Council. Since it was learned, however, that the Premier and other members of the Government were quite willing and even desired Dr. Pyne to be guided entirely by the wishes of the Council, there was a unanimous wish that he should be re-elected Registar. This conclusion is a most satisfactory one to the profession of Ontario.

NEED FOR THE NEW HOSPITAL.

Mr. J. W. Flavelle, chairman of the Board of Trustees of the Toronto General Hospital has written the following letter to *The News*:

"My attention has been directed to a letter in *The Globe* of July 4th, signed 'A Careful Observer,' and to reports of meetings held by physicians identified with other hospitals than the Toronto General, for the purpose of organizing opposition to the proposal that the city grant $200,000 to a reorganized Toronto General Hospital.

"The statement made by 'A Careful Observer,' 'The present movement is set on foot solely in the interests of the medical college,' is wholly mistaken. The movement originated entirely with the Board of Trustees of the Toronto General Hospital. It was conceived with two ideas: (1) To give to the sick and suffering the benefit of a modern hospital establishment, a benefit which will be denied them if the hospitals in the city continue as at present, or are improved only by the patchwork methods hitherto adopted by every hospital except the Sick Children's; (2) to assist in the educational work—medical and surgical—performed in connection with the Provincial University situated in Toronto.

"The urgent need of such a hospital, I venture to say, is felt by many citizens, and by every doctor in Toronto, whether unattached or identified with the General or any other hospital.

"The need of such a hospital, the need of added facilities for the medical and surgical educational work in the Province, and the magnitude of the undertaking, seemed to the trustees to establish a field for co-operation between the Government of the Province, the citizen body and municipality of Toronto and the present trustees of the General Hospital.

"Actuated by these feelings, the Board of the hospital waited upon the University authorities and the Government, and stated: 'If you feel warranted in granting a substantial sum

towards a new hospital establishment in Toronto in return for added hospital facilities for your educational work we, as trustees of the present Toronto General Hospital, suggest that we be given permission to hand back our trust to the Government that the resources of the trust, amounting to an annual rental of $25,000 upon properties held by it, may be available for the maintenance of such a new hospital establishment created through co-operation as above.' The response on the part of the Government and the University has been to promise, unconditionally, $300,000 to aid in the consummation of such a plan, with the understanding, however, that added facilities will be given for the medical and surgical educational work at Toronto University.

"The petition for co-operation by the city to the extent of $200,000 has received the favorable consideration of the Board of Control, and goes to the Council for action on Monday next. The agitation against the grant is conceived with the idea of defeating the measure in Council.

"Is the proposal that the Council approve of the plan and co-operate to the extent of $200,000 for the purpose of securing such service for the citizen body a reasonable one? Is the opposition actuated by a desire to render large public service or to proteet personal interests? I believe the proposal is reasonable. I know it has been made with no ulterior motive, and that the trustees of the Toronto General Hospital are possessed of the single and simple purpose to render to the citizens of Toronto a service which, from their acquaintance with hospital work, they believe essential. They do not believe the opposition is actuated by a desire to render public service, and I desire to say that the benefit to be secured to the whole community by such a hospital in every respect outweighs the personal ambition or the desire for hospital association on the part of any or all the physicians and surgeons of the City of Toronto.

"If the Council decides favorably and the grant of $200,000 is made at an early date there will be representatives of the Council, of the Government, of the University, and of the present trustees of the Toronto General Hospital; and at such conference a decision will doubtless be reached as to what will be the character of the new trust to be formed; what will be the basis of repre entation on the board, and all such detail for the operation of the hospital as may be worked out by the co-operating bodies. Then will naturally follow an appeal to the citizen body for subscriptions for a sum which will give the necessary moneys to complete the enterprise.

"If any agitation organized by interested persons is successful in interfering with the consummation of the proposal outlined, I can only say that the burden of such a grievous wrong will be borne by the sick and suffering of Toronto."—*Toronto News.*

THE NEW HOSPITAL FOR TORONTO.

A public meeting of physicians was held in St. George's Hall, Toronto, to discuss a scheme for the building of a new hospital. Dr. John Hunter was elected chairman, and Dr. W. F. Bryans, secretary.

The subject we have for discussion is one of intense interest to citizens of Toronto and to all classes of citizens, for it touches all citizens some way or other, was the brief prologue of the chairman.

There should be a limit to the speaking, said the secretary, rising, with an eye single to accomplishment. There are some men here so enthusiastic that they will talk all afternoon; and the late adjournment proved the wisdom of his caution.

Five minutes for movers of a resolution, three minutes for others, and three minutes for the mover's reply were agreed upon.

The chairman then made a bid for resolutions, and Dr. James Spence was the first to respond.

I might say, in introducing this resolution, he said, that I have no antagonism to any private individual or any private corporation that wishes to endow an institution for the teaching of medicine, theology, dentistry or any branch of science.

We are all interested in one thing, the alleviation of suffering and the prolongation of life, each in his own way. Those who do their work by the bedsides have to use their judgments rather than the laboratories, but we appreciate the value of the laboratory work and desire to further it, and I wish to make it clear that I am not opposed to the generosity of the province in making so large a grant to medical education. But I want to say that the institutions that have served the people so long should not be moved at the whim of any Board of Trustees.

He then made the following resolution:—

"Whereas the Board of Trustees of the Toronto General Hospital contemplates the destruction of that venerable institution with its accommodation for 400 patients, and

"Whereas, the cost of a similar institution would approximate $200,000 to $300,000 to-day, and.

"Whereas the said hospital is not only an historic institution, in connection with which much of the history of medical progress in this province and especially of this city is associated, but it is to-day the best-equipped general hospital, not only of this city, but perhaps of the whole province.

"Whereas, if the said hospital ever was a necessity where it now stands; to take care of the eastern half of the city—while the western half can be served by St. Michael's, the Emergency, Grace and the Western—it is more necessary now on account of

the great expansion of the city eastward, as well as in every other direction; and

"Whereas, if the General Hospital were removed to the site contemplated at Queen's Park, the whole of the eastern half of the city would be deprived of near hospital accommodation, entailing great suffering to patients meeting with accidents in the east and in transporting to the west, and as the lives of many of these depend on the promptness of the medical attention given after accidents, many deaths would be caused indirectly at least by this change.

"Therefore, resolved, that in the opinion of the medical men of the city of Toronto, here assembled, it would be a crime against the citizens of this city, and the taxpayers especially, to permit the trustees of the General Hospital to lay a guilty hand upon that institution and carry out the scheme outlined before the Board of Control.

"I don't think I need say anything more," continued the doctor. "It is not long since some of us had something to do with the birth of an institution in the west end. I am not speaking for any particular institution. I am speaking as a ratepayer, not as a medical man. We had some difficulty in getting that hospital established in the west end, and the chief difficulty was with our able Medical Health Officer. We had a great deal of difficulty, and it was only overcome through the efforts of the late James Scott, in condemning the very thing for the west end that this scheme proposes for the east—forcing people who met with injury to be carried from the Junction and the western portion of the city to the General Hospital. Mr. Scott pointed out that lives were being lost—that in the interests of humanity a hospital was needed in the west end.

"This scheme would deprive the whole of the east end of hospital accommodation. I think it is a crime, and one we, as medical men, should see does not occur. My opinion is that that hospital should never be touched. If any should go, let it be one of those that need improvement."

It was decided, upon the suggestion of Dean Reeve, to hear all the resolutions before discussing them.

Regarding Dr. Spence's motion, however, Dr. McPhedran remarked: "The hospital belongs to the trustees and the citizens have nothing to say about where it is to be situated. The trustees can place it where they like."

Dr. Palmer—"But they are asking the citizens for $200,000."

Dr. C. E. Stacey said: "We very often come across patients who are able to pay a medical man, but whose surroundings are such that they should be removed to a hospital. Suppose a man who is boarding is taken with typhoid fever or pneumonia; it is quite necessary that he have proper nursing, which he

cannot get in a boarding-house. He cannot afford to pay prices for a private ward. His first question is, 'Will you attend me if I go to the hospital?' Under the régime of the new hospital that will not be allowed.

"Therefore, in the interests of the public as well as of the medical men outside the hospital staff, I move, that "In the opinion of this meeting of the medical men of Toronto, every patient who is treated in the proposed new hospital, receiving such a large sum from the public treasury, should have the right to select his or her medical attendant, and that this should apply to all wards and all classes of patients, except city order patients." Dr. J. W. Johnston seconded the resolution.

Dr. Palmer then submitted the following resolution: "That municipal grants to hospitals and charitable institutions are right and proper because it is the easiest and most equitable means of raising money for such purposes. The poor and those of moderate means being inappreciably assessed and the rich paying all the large sums. But in all cases no one hospital should be specialized for civic forms, the grant should be equally distributed among all the hospitals equally worthy.

"That it would be unjust to vote $200,000 of the people's money without submitting the same to a vote of the people, notwithstanding the fact that the recent University Act gives the Council of Toronto the power to do so without reference to the ratepayers, thus depriving the people of their right to use their franchise."

In supporting the resolution, Dr. Palmer spoke pretty warmly regarding what he considered the aspersion cast by Flavelle upon the medical men associated with the other hospitals.

"These hospitals," he said, "have been built up with a struggle. They have filled a long-felt want. That requires no argument for its justification is evidenced by the fact that they give attention to from fifty to sixty per cent. of the city order patients. They have been built at great cost by private contributions entirely.

"I am not aware that there is an individual associated with any one of these hospitals who has a personal interest in it. The insinuation is made by Mr. Flavelle in a letter to the press published to-day, that those who are opposing this scheme are actuated by personal and selfish motives. It is a false insinuation, and if there is a personal and selfish interest, I say it lies in the hands of Mr. Flavelle himself. He is a great schemer. No doubt his scheme is wise from his standpoint and everything else that comes in his way must be crushed.

"His scheme alone concerns the interests of the suffering. It is a violation of those interests to move the General Hospital

to the centre of the city, already well provided with. hospital accommodation, and leave the east end without any. It is a violation of the duty of the civic government to specialize one institution for such a grant to the detriment of the others."

Dr. Spence seconded the resolution.

The resolutions seemed to come tardily, and as no more offered at the chairman's repeated call, Dr. Sheard rose to speak. He was frequently applauded, and as he proceeded a change seemed to come over the sentiment of the gathering.

I did not come with the intention of moving any resolution, he said, but I would like to make a few remarks regarding this hospital proposition, which is very imperfectly and improperly comprehended.

I am associated with the medical faculty of the University of Toronto, but my interest has not up to the present become very great, and you will not ascribe to me a bias particularly in favor of that institution.

I have been in close touch with the city authorities, have discussed the scheme with many of them, and have been over the ground with the trustees of the General Hospital. I wou'd like to point out what this opportunity really means.

There are many features which are highly commendable in this scheme. This city has not a thoroughly up-to-date and moderately equipped General Hospital. Such an institution can only be built from the ground up. Dr. Osler was right when he said such institutions should be burned every ten years. Dr. Spence's application of the word 'venerable' to the General Hospital furnished the measure of its senility.

This movement was started by the magnificent gift of Mr. Cawthra Mulock of $100,000 for an out-patient department. It set the Board of Trustees thinking whether it was wise to spend that amount of money on the present site. The establishment of the Emergency was because of the increasing number of cases going to St. Michael's, and the conclusion that if the hospital was to continue its work it must get into closer touch with the manufacturing centre of the city. Similar considerations weighed again. The trustees approached the Government, who incorporated in the scheme something for the educational interests of this province.

The doctor warmly commended the Government's broad view and wise action, and pointed out the need for the co-operation of private wealth in carrying out such a plan. It would be an opportunity to secure for Toronto a great modern hospital, a benefit to and pride of the medical profession, and a blessing to poor and rich, unfortunate enough to need hospital treatment. Combined with the scheme was a far-seeing plan for a magnificent avenue and park in the centre of the city, embellished

with great public buildings, beginning with the City Hall and Osgoode Hall.

Dr. Palmer has put forward some things that are absolutely just and right, and regarding which I have heard nothing to the contrary. There must be conditions attached to the municipal grant. The Council is simply discussing the matter. If it goes to the people, well, they take very little interest. They are not capable of judging about it. I think it would have a good chance of being defeated. The new institution would be lost to us as medical men. I am not here as a ratepayer; I am here as a doctor.

As far as I know then, the conditions likely to be attached to the civil grant are these—

1. That public ward cases shall be available exclusively for the Faculty of Medicine the Toronto University, but all other accommodation in the hospital shall be equally available to all other practitioners in the city.

2. That what is to constitute a public ward patient is one who is unable to pay for his medical attendance.

3. That the municipality of the city of Toronto have a representation upon the Board of Hospital Trustees equal to that of the Ontario Government.

4. That in the new institution accommodation is to be afforded as far as possible to patients sent in upon the city's order.

That, said the doctor, referring to the conditions, will give each of you access to every private and semi-private ward. The public ward patients give a *quid pro quo* for their medical attendance in submitting themselves for clinical examinations.

What constitutes a private patient? Dr. Sheared was asked.

If he pays his doctor he is a private patient," he replied.

Would all patients who go into a public ward, asked Dr. Ferguson, "be entitled to free medical attendance because they go into a public ward?

"If they submit to clinical examination," replied Dr. Sheard.

He proposed a separate building to give accommodation to $3.50 a week pay patients who had their own doctors. Dr. Ferguson asked for a guarantee, and Dr. Sheard made a plea for reasonableness.

The city itself cannot demand a guarantee, he said, that there will always be accommodation for its patients. It may be overtaken by an epidemic.

Will the right be taken from city order patients to select the hospital they will go to? was another question.

Dr. Sheard replied in the negative emphatically, and

promised absolutely fair and equitable treatment for all hospitals, as far as the health Department was concerned.

Council, continued the doctor, must be represented on that Board of Trustees. I'm not prepared to say to what extent, but I think with a numerical equality with the Government. The bodies to be represented will be the Government, the University, the city and the private benefactors. I think that will be a fair representation.

In the new institution, accommodation will be asked, as far as possible, for patients sent in on city order. That, of course, must be largely theoretical, but we don't propose to give them money and have no return.

In conclusion, the doctor appealed to the medical men for unity. Nearly $1,300,000 was required for the new hospital, and what chance was there of getting the $700,000 required by private subscription, if it went forth that a large body of medical men were opposed to it? It would be a hospital to compare favorably with any in Montreal and many in the States. He urged the profession to assist this great philanthropic work in a city whose philanthropic efforts had too long lain dormant.

Dr. Sheard then moved "that in the opinion of this meeting the proposal to establish a new hospital be approved, with certain conditions," and quoted the conditions given above.

It was seconded by Dean Reeve.

Dr. Spence was not quite sure about that part of Dr. Palmer's motion calling for a vote of the people, and submitted the following:

"That before $200,000 be granted by the City Council, the opinion of the people be secured by submitting the same to the people."

"As a representative of the east end, it is the intention to cut off our hospital facilities or not?" asked Dr. Fraser.

"I am not prepared to say what the purpose of the trustees is," replied Dr. Sheard, "but so far as I know their intention is to sell out the present hospital ground; but there are some new buildings, and I don't think it would be at all difficult to have a small hospital there for the east end."

Dr. Sheared here submitted a statement showing the amounts received by the various hospitals for city patients during 1903-4-5:

	1903	1904	5 mths. 1905.
General	$11,723	$12,937	$8,010
St. Michael's	10,316	11,500	6,075
Grace	3,046	3,816	2,024
Western	3,357	3,713	2,101
St. John's	132	189	124

Dr. Sheard drew attention to the fact that Grace and Western combined secured about half as much as the General.

As no other resolutions were offered the chairman called for discussion of the resolution of Dr. Spence.

I agree it would be criminal to lay guilty hands on the General, commented Dr. Oldright.

Dr. F. N. G. Starr submitted as an amendment to Dr. Spence's motion, "that it would be in the best interest of the public and profession to establish the proposed new hospital." He thought a branch of the old General might be retained in the east end. There did not seem to be any doubt that a new hospital was needed. Certainly there was none in the mind of the inspector of hospitals. All knew that in some wards of the General the conditions were almost nauseating.

The motion was ruled out of order.

Dean Reeve then resumed the discussion.

The trustees have realized from their experience in hospital work that they will be guilty of crime if they do not lay hands upon the General in its present condition and secure at as early a date as possible a thoroughly modern institution.

This movement did not originate with the medical faculty of the University, but with the trustees of the hospital. Their action commended itself to a large number of practitioners.

I am sorry that strong language has been used this afternoon. I was pained to hear one member of our profession attributing motives to one member of the Hospital Board, which would be unworthy a man who stood much lower in the community, socially and commercially.

I think it would be a great mistake to pass this resolution, he said. We all think it most desirable to have our hospital in the highest state of efficiency.

Dr. Palmer—Our hospital!

I would be sorry to see any man so narrow as to confine his sympathies to one hospital, replied Dr. Reeve This scheme was not undertaken with any selfish motive. Mr. Flavelle and his assistants deserve the gratitude of the profession for their work since they took charge of the General Hospital. This motion would condemn the profession to the present hospital as it is. That would be a great calamity.

The great bulk of the city patients, said Dr. McPhedran, come from the west or central parts of the city. Regarding the need for a new hospital there cannot be two views on that question. The present one is anything but a credit to the city of Toronto.

It is said that this new hospital would retard the development of the other hospitals. It would not. The establishment of the Johns Hopkins Hospital in Baltimore was strongly opposed on that very ground by the hospitals of the city. Now

they are all proud of it because it has done more for Baltimore than any dozen ordinary hospitals would have done. It has stimulated the others to improvement. So would this; all others would benefit. Therefore it should receive the co-operation of the practitioners in the city most heartily.

He urged their co-operation for the sake of the good name of the profession, for the University and for the poor.

Dr. Wishart found in Montreal an example for the encouragement of those who favored the hospital scheme. He and Dr. Palmer, who had come from Montreal, could remember when the Montreal General Hospital was no better than Toronto's. Then the Royal Victoria Hospital was built. The General had put on wings, and anyone belonging to it would say it was because the Royal Victoria Hospital was built that the General is in its present condition to-day.

If you stop this new hospital, he said, you will put a fatal obstacle in the way of every other hospital in the city being improved.

Dr. Oldright agreed with the two former speakers. The fact that some people had come forward to help our hospital will induce others to help other hospitals. The effect of the new hospital upon medical education throughout the province had not been touched upon. A man from the Southern States had said to him, "Why do we hear nothing about Toronto and all about Montreal?"

We should not have to feel that Ontario stands behind in the matter of medical education. We all know the General is not what we should have for medical education. St Michael's is erecting a new wing, and that doesn't look as if they were afraid of the new scheme.

Dr. Ferguson said, I do not object to men of wealth being generous to such institutions, but when it comes to asking a large donation from the public treasury and one institution is singled out, I object I don't object to the city giving $200,000 for hospital work if it is distributed among the several hospitals.

I assure you the smaller hospitals meet a felt want in furnishing skilled nurses for the medical profession. My own cousin was taken ill with typhoid when in a boarding-house. He was taken to the General Hospital and I was not allowed to attend him. When I called one day I was told by the porter at the door that it was not visitor's day. The medical profession felt they were up against it until other hospitals were started.

Nearly twenty years ago I urged upon the trustees of the General Hospital to open a branch in the west end, and put upon the staff medical men of the west part of the city. Had they done that the present feeling would not have existed.

The one solution for medical teaching in this city is getting

an affiliation with the various hospitals. Dr. Osler, when here recently, said no one hospital in Toronto could do it. The only way to get all the clinical material is to have the students go to all the hospitals, as is done in other cities. If you are going to give, give to all. I speak in the general interest of the medical profession in the city.

Dr. Palmer—It has been said that the probabilities are that the General Hospital will have a branch in its present position. That will meet with hearty endorsation, and I venture to say no one will object to that if it is properly maintained.

He then returned to Mr. Flavelle's allegation that the opponents of the scheme were actuated by selfish ambition.

It is a slur upon the profession of this city. He openly says they are actuated by personal interest.

If Dr. Sheard will assure me that I can attend my patients in the hospital, said Dr. Johnson, I think the best we can do is to fall into accord with him and follow his leadership, for he will get what he wants in the long run.

Dr. Sheard has practically admitted, said Dr. Spence, the nece-sity of retaining the hospital in some form where it is. There has not been a soul who has said one solitary word against the statement that that is the best equipped general hospital in Toronto.

Dr. Starr—Yes, but it's very bad.

Dr. Sheard—It can be made better.

The vote was taken on Dr. Spence's motion and it stood 12 for and 21 against.

Then Dr. Stacey's motion was debated, and therein lay the real interest of the profession generally, the right to follow their patient into the hospital and attend him there.

Dr. Stacey's motion is all right as far as it goes, said Dr. Sheard, but it doesn't go far enough. Why differentiate between one the city pays for, and one a generous minister pays for?

Patients who pay only $3.50 a week are not semi-private, said Dr. Reeve. The trustees cannot afford to treat as semi-private those who pay only city order rates. It is a pity that during the last two weeks stress has been laid upon the statement that the new hospital intended to take all the charity patients. Dr. Sheard will be fair in his distribution of them.

Is he a pauper who pays only $3.50 a week? asked Dr. Wishart.

He is, because the government grant pays the other half of his cost. I have seen government grants for patients in private wards, said Dr. Sheard. A man is a pauper patient when he gets his medical attendance for nothing.

There was some discussion of the assertion that the new

hospital would give free medical attendance to pay patients who would submit themselves for clinical examination.

It is pauperizing them, declared Dr. Palmer. It is unethical to bribe them in that way.

I repudiate the statement that we give a bonus of any kind to get patients to come into the hospital for clinical purposes, said Dr. Reeve.

Dr. Sheard finally made it clear that the patient who did not pay his doctor was the pauper. The patient who did have a right to his own medical attendant, and a separate building, he thought, should be provided for that class of patient.

Dr. Stacey then agreed to the substitution for his motion of the following by Dr. Sheard, and it was carried without a division:

"That public ward cases shall be available exclusively for the Faculty of Medicine of the Toronto University, but all other accomodation in the hospital shall be equally available to all other practitioners of good standing in the city.

"That what is to constitute a public ward patient is one who is unable to pay for his medical attendance. In the new institution accommodation is to be afforded, as far as possible, to patients sent in upon the city's order."

Dr. Palmer's motion for an equitable distribution of the grant, for the submission of the question, was discussed briefly and defeated by a vote of 10 to 21.

Dr. Spence's motion for a popular vote was then ruled out of order and the discussion was on Dr. Sheard's motion to append the scheme with conditions. The vote on that was 25 for and 3 against.

The meeting then adjourned.

TORONTO CITY COUNCIL.

Great interest was taken in the meeting of the Toronto City Council, July 10th, when after a discussion lasting five hours, a grant of $200,000 toward the proposed new hospital was decided on. There were present during the discussion Messrs. Flavelle, Larkin, Haney, Cawthra Mulock, the Mayor (in the chair), trustees, and a large number of physicians.

Dr. Barrick spoke at some length and protested against the Council making the grant without submitting the question to the ratepayers.

Dr. John Ferguson supported Dr. Barrick's protest; he also thought that each pay patient, whether a public ward, a semi-private, or a private ward patient should be allowed to choose

his own hospital and physician. He said that such custom and such tendency was becoming more prevalent. With such conditions he favored the grant, provided it was distributed to the various hospitals throughout the city.

Dr. R. A. Reeve, in reply, said that Dr. Ferguson, was quite mistaken with regard to the practice of allowing the profession generally to take advantage of hospital facilities, and attend cases particularly those of charity or public ward patients. That practice is being restricted more and more by the best hospitals in America and Europe, and the cases are attended by those who are responsible to the trustees. It is felt that in this way you can fasten the responsibility upon the respective members of the staff, which would not otherwise be possible. It appears to us that it would be a great mistake to oppose this generous offer and this movement which has been initiated, and so far brought to a successful issue by a few public-spirited men, to whom the profession of Toronto is greatly indebted, and to whom the citizens will be much more indebted in the near future. It is desirable that we should have a modern hospital, fully equipped in all its departments.

In regard to certain conditions which are proposed in the new institution. By vitue of the gift directly and indirectly, of $300,000 from the Government, there is the condition that public ward patients should be under the care of the medical faculty of the University of Toronto. There is a double object in this: First, the case of the sick under conditions most effectual, and, secondly, the promotion of the education of young men, the better to fit them to discharge their duty as members of the medical profession. It is recognized all the world over that hospitals have a double function to discharge, and I am sure this will not be controverted by those who are opposing this movement to-day.

It is contended by those opposed to this movement that it is unjust to the general profession not to allow them to attend patients in the public wards—those paying only $3.50 per week, or those admitted on civic orders. Every patient of that sort costs the trustees of the hospital at least $3.50 per week, in addition to the civic grant of fifty cents per day, and it is hardly fair to consider him in the light of a private ward patient.

Gentlemen who have spoken to-day contend that the profession at large should be allowed to attend these patients without reference to whether they have positions on the staff. I take issue with them. The members of the profession are qualified, but I maintain in the interest of the public, and particularly in the interest of the poorer classes, that results are better where the staff are responsible, directly to the authorities of the institution.

In reply to Dr. Noble, Dr. Reeve said it was never intended to prevent private or semi-private ward patients from having their own doctors; to allow this had always been the rule at the General Hospital.

Mr. J W. Flavelle explained the position of the Hospital Board. He said: "This movement did not arise from any feeling of antagonism toward any medical men, nor because the Board of the Toronto General Hospital are desirous of having some favors for that hospital. It arose from their belief that all the hospitals of the city, with the exception of the Sick Children's Hospital, should be rebuilt. They believed that the Toronto General Hospital, as it is at present, has done what Dr. Reeve claims for it, efficient and good service. They believed, however, that the conditions which are present in modern surgical and modern hospital work require altogether better buildings and better equipment than any hospital the city has at present. I may say of our friends of St. Michael's, Grace, or the Western Hospitals, that if it happened to be their fortune to present proposals to this Council, whereby they would secure new buildings, I would help them by personal subscription, and by effort before this Council. Not because it was for this hospital or that hospital, but because it would be for the benefit of the whole body of citizens."

After the delivery of these four excellent addresses, of which we have given only brief abstracts, the question was discussed in all its aspects by the Mayor, Controllers and members. We hope we shall give no offence to the Council when we say that we were surprised at the ability shown by the members in the discussion, and the very intelligent conception they evidently had respecting all matters pertaining to hospitals. Apart from the professional aspects we were delighted with their prompt and snappy method of conducting the routine business. We believe the citizens of Toronto have reason to be proud of their City Council, which, as a deliberative and administrative body, is, in our opinion, second to none in Canada. We think that even Osler would decide that no chloroform is necessary at the present time. In fact, a large proportion of the members look like boys, but, at the same time, very *intelligent* boys.

We have always felt that the firm of Messrs. Parke, Davis & Company spared no pains to entertain members of the medical profession whenever they visited Detroit or Walkerville, but the writer is desirous of expressing his appreciation of the attention shown him on a recent visit to London, England. The genial Manager of their English branch, Mr. F. M. Fisk and Mr. W. B. Whalen certainly helped to make our stay in London most enjoyable, and we fully appreciated the tention.

KOCHER'S CLINIC.

The following is extracted from a letter received by a relative in Toronto:

Bern I am beginning to like very much, and, strange as it may seem, from the first I have felt more at home than I did in London. It is a pretty little place and the people one meets seem very nice. My German I find is not of much use, as the language here is a sort of combination of German, French and Italian, and usually when I go to a place and ask for anything I am answered in English, though we don't hear as much of our own language here as we did around the Lake of Geneva.

My boon companion is an Irishman who is doing three months' work on the continent on a travelling scholarship he won at Dublin University. He is a very decent chap, and like myself only intends to stay here about three weeks longer. From here he goes to Vienna and Breslau. There are a few more English-speaking people at the clinic than when I wrote before, and altogether we form a small colony of our own.

The hospital is situated on a hill with a beautiful view of the Alps, and lots of good fresh air. It is composed of separate buildings so that each man has his patients all in one part and does his operating in the one room. Professor Kocher himself has a clinic every day from eight till ten, and operates at the hospital at ten o'clock on Mondays, Tuesdays, Fridays and Saturdays. His class, I should say, contains one hundred students, and at least half of them are women, ninety-five per cent. of whom, I am told, come from Russia. He usually begins by showing specimens which he has collected since his last clinic, and then gives demonstrations on his patients which are brought down from the wards. The first two cases he usually lectures on, and then calls two of his class down and gives a grind on the next. When that is finished he usually brings in a number of patients for the purpose of teaching the art of diagnosis. It is at his clinics that we get an idea of what care he takes to keep his hands aseptic between operations. He uses rubber gloves in making any examination of the mouth, rectum or vagina, and when there is any chance of his fingers coming into contact with a septic wound, claiming that it is better to use gloves between the operations and take them off if considered advisable at the time of operating. At the end of his clinics a list of twelve names is posted, and these people together with any graduates who are present and have sent in their cards are allowed to be present at the operations. Usually in about twenty minutes the door of the operating room is opened and we are admitted to the room. He takes great care in washing his hands in warm running water using soap and a scrubbing brush, and when that is finished they are well scrubbed in

eighty-five per cent. alcohol and then washed in salt solution. You will see that even in cleansing his hands he refrains from using antiseptics, which I believe he gave up primarily because he found them so hard on his hands, and he says that he has had no cause to regret this step since.

The operating outfit consists of a small white coat with very short sleeves, a large rubber apron outside this, and this in turn is covered by a sterilized gown, and all his assistants wear white caps. Kocher and all who assist him wear two pairs of gloves, a pair of rubber ones, and a pair of cotton ones over them. The latter are changed frequently during the operation.

The patients sometimes walk in, get up on the table, and have a chance to see what is going to happen to them, as they often are brought in and prepared before the last operation is finished. The parts operated on are prepared with ether and alcohol, and then the whole patient, except the field of operation, is covered with aseptic clothes. In practically all his operations after the administration of the anesthetic is commenced the skin incision is marked out by drawing the knife across the surface very lightly, and then a one per cent. solution of cocaine is injected under this, and he is in this way able to proceed with very light anesthesia. To-day, for instance, I saw him remove a sarcoma from the cerebellum of a young man, and he and the patient were conversing during a g eater part of the operation. During his operations he uses a great many artery forceps, as he practically catches all bleeding points, and has no blood at all in his wounds. If the wound needs to be cleaned it is done with salt solution, no antiseptics being brought into contact with the tissues at all. The tissues are torn as little as possible, and most of his dissecting is done with the point of the knife, though his blunt dissector appears to be quite useful in his thyroid operations. When the operation is finished he puts on a clean pair of gloves and applies ligatures to all the vessels upon which he has placed clamps, and after the approximation of the deeper parts closes the skin with a continuous suture and applies a xeroform dressing, Drainage tubes made of glass are used in a majority of cases, and these are removed in twenty-four hours. The only suture material I have seen him use has been silk, and this always of the same size. When he uses it in such a place as the isthmus of the thyroid he doubles it twice. His septic patients are operated on by his second assistant in a separate room. These patients are kept in a building altogether distinct from the one in which the clean patients are.

One is struck by the short time he keeps his patients in bed after operations, as we often see them walking about in a little over a week, and none of them are kept so absolutely flat on their backs, as I have been taught they should be. They are generally well propped up with pillows. At the end of

forty-eight hours the stitches are removed in thyroid cases; at the end of eight days in others and then a dressing of xeroform gauze and collodion is applied. He has in his wards ninety-five beds, but I understood he usually has more than one hundred patients under treaiment.

On Thursday night a few of us had the honor of dining with Professor and Mrs. Kocher. There were only ten people present including his own family of four. Amongst these we had one Irishman, one Italian, one man from Holland, one American, one Swede, four Swiss and one Canadian. I sat on his left and had a very pleasant talk with him, and can assure you he is a most delightful man.

ARTHUR B. WRIGHT.

Bern, Switzerland, June 20th, 1905.

THE ONTARIO MEDICAL COUNCIL.

The annual meeting of the Ontario Medical Council was held, July 4th to 8th, inclusive. The first order of business was the election of officers for the coming year with the following result: President, Dr. Albert A. Macdonald, of Toronto: Vice-President, Dr. W. H. Moorehouse, of London; Registrar, Hon. Dr. R. A. Pyne; Treasurer, Dr. H. Wilberforce Aikins; Solicitor, Mr. Christopher Robinson, K.C.; Prosecutor, Mr. Charles Rose; Auditor, Dr. J. C. Patton: Reporter, Mr. John Downey.

Before the installation of the new President the retiring President, Hon. Dr. Sullivan, of Kingston, delivered a brief address. He stated that he bore a message of greeting from the Senate of the Dominion of Canada, requesting them to aid in formulating some means which would apply to all Canada in the arresting and prevention of that widespread disease called consumption. Dr. Edwards, the Chairman of the National Association in Ottawa, was throwing his whole powers in this great work, Dr. Sullivan stated, and would gladly receive any aid from whatever source it came.

He suggested that the Public School text-books should have a space set aside for the education of the pupils in the proper methods of cleanliness and sanitary science in general.

It was announced that a large number of doctors throughout the province were behind in their fees, and it was recommended that a notice should be sent out to the delinquents that unless the amounts owing were paid their licenses as practitioners would be revoked. The fee is $2 per year. This matter was also referred to a committee.

The report of the official prosecutor, Mr. Charles Rose, was

submitted. It foreshadows an appeal to the Legislature to amend the code so as to expedite the prosecution of Christian Scientists, who are not particularly vulnerable under the existing Act. Dealing with this branch, Mr. Rose, in his report, says:—

"Year after year I have drawn your attention to the need of a small amendment to the penal clause of the Medical Act, as from the decisions rendered by judges of our higher courts it is impossible to secure a conviction as the Act now stands against many persons who, I consider, practise medicine; but from the fact that they do not prescribe drugs, the higher court judges have decided that they do not practise medicine. Many of those who do not give medicine, although practising the art of healing, are more dangerous to the public than he who prescribes medicine. I think it is time for the Ontario Medical Council to lay the facts before the Attorney-General, and I feel sure that if this were done he would see to it that such an amendment was passed, not in the interest of the medical profession, but to protect the public from this class of healing."

Mr. Rose refers to the Goodfellow Christian Science case in Toronto, and Sir John Boyd's remarks on the subject. Then he adds:

"During the past year we have had a number of such cases cropping up in our Police Courts in different parts of the province, and in every instance the judge before whom the case was brought spoke strongly against this class of practitioner. There are many other kinds of sick healers of the same nature throughout the province who give no medicine, but undertake to cure diseases in a somewhat similar manner to the Christian Scientists, and it is to such as these that the Government's attention should be directed in any amendment made."

Mr. Rose states that during the year complaints were registered against about fifty persons for practising medicine illegally. He also complains that a number of licensed practitioners throughout the province employ unqualified men, and that in many cases the unqualified man is left in charge of the physician's practice. If an example of some of them were made by the Discipline Committee investigating their conduct Mr. Rose thinks it might put a stop to this kind of "unprofessional work."

It is hinted that several charges of a graver nature will be considered by the council.

Dr. W. H. Moorehouse, of London, moved a resolution providing for the appointment of a committee to interview the Ontario Government, and endeavor to secure a liberal grant to assist in preventing the spread of tuberculosis. The resolution met with the cordial support of the members, and the opinion was expressed that the province should lay aside a specified um annually for this purpose.

Dr. Elliott, of Gravenhurst, stated that the sanitarium at Gravenhurst was filled to its utmost capacity, and in consequence he had been unable to find suitable quarters for several consumptive patients he had under his charge.

It was shown that with the gain in knowledge as to the contagious character of the disease people had come to regard persons affected with tuberculosis with alarm. General hospitals were enjoined under pain of forfeiture of Government and municipal grants from receiving consumptive patients, and this was a wise precaution, as it was a highly dangerous thing for sick people to be thrown in contact with persons suffering from tuberculosis.

Dr. T. H. Thornton, of Consecon, regarded the malady as contagious as small-pox, and in order to stamp it out, or at least prevent its spread, provision should be made so that consumptives could be isolated and at the same time given the treatment necessary to their recovery. The Medical Association were the proper body to take charge, and the Province should bear the expense of such a movement. Dr. Mearns, of Woodstock, spoke along the same lines.

The financial statement showed a reduction on mortgage loan of $5,000, with a revenue of about $35,000, and a balance on hand of $5,764.92.

The first order of business on Thursday, July 6th, was consideration of certain amendments to the Medical Act which will preclude the probability of Christian Scientists and other "faith healers" evading the provisions of the law on technicalities.

Dr. Robertson presented the report of the committee on the matter, and after several changes had been made in the wording of the amendments, the report was adopted and referred to the solicitor, with instructions to frame a bill for presentation to the Legislature at its next session.

The clause bearing on the question sets forth that it shall not be lawful for any person not registered as a qualified practitioner to practise medicine, surgery, midwifery, or any other method of healing, or to attend upon or attempt to attend upon any person the subject of, or supposed to be the subject of, illness or disease, for hire, gain, or hope of reward. Any person so offending, on a summary conviction before a magistrate, will be liable to a penalty not exceeding $100 and not less than $25.

The words added, and which it is believed will prove effective, so far as Christian Scientists are concerned, are: "or any other method of healing."

When the report was brought down the words "medicine, surgery and midwifery" were eliminated, and the "art of healing" substituted.

Dr. Ryan, Dr. Arthur Jukes Johnson and others strongly

objected to the dropping of those traditional and classic names. Objection was also made to the term "art of healing." After a lengthy debate the clause was adopted as stated. Dr. Britton advised leaving the whole matter over for another year, claiming that it was such a critical subject that it behooved them to proceed carefully. The experience in the past had been that when medical men applied to the Legislature for amendments they usually received more than they asked for or desired. The report also provided for the holding of examinations at London, Ont.

Another amendment recommended was that in cases where a suit is brought against a doctor for malpractice, the party so proceeding must first pay the doctor the full amount owing for medical attendance.

Hon. Dr. Sullivan made application on behalf of John A. Reid, of Prescott, to permit that gentleman to take his examination before the Council to qualify him as a practitioner. Mr. Reid graduated at Queen's College in 1891, but owing to the death of his father did not appear before the Council for his final examination. The matter was referred to the Registration Committee.

It was decided to hold the examinations on the third Tuesday in November, and the third Tuesday in May next. The first Tuesday in July next was fixed upon as the date of the next annual meeting.

The Medical Building on Bay St., will probably remain in the possession of the Medical Council for some time to come. The report of the Property Committee, presented by Dr. Johnson, said that in pursuance of the instructions given to the committee last year, tenders for the sale of the building had been asked, but nothing further was done. The year, however, had been a satisfactory one. The building was in good condition, all the offices were taken, some of them at an increased rental, and about $10,000 had been paid on the mortgage held by the Canada Life.

Hon. Dr. Sullivan made a motion that a committee be appointed to consult with the Dominion Government and through them to devise some scheme by which to deal more effectively with consumptive patients, and to provide more places for their care. It was the opinion of the meeting that compulsory measures should be passed in each Province, as otherwise they would be neglected.

Several doctors deplored the way in which the public had come to look upon consumptives, shunning them and treating them with fear. The medical profession should do all that was possible to help these unfortunates.

A motion was made by Dr. Thornton to the effect that teachers should be appointed as examiners in anatomy, chemistry

and similar subjects, as they were better able to examine in them than ordinary practitioners who were not continually studying in these particular lines. The motion was referred to the Education Committee.

At the meeting of July 7th the reports of many committees were presented. Dr. Adam Wright's Text-book of Obstetrics was placed on the list of books recommended in the place of the American Text-book of Obstetrics. It was decided to accede to the request of Hon. Dr. Sullivan with reference to Mr. John A. Reid, of Prescott. The Committee on Education did not recommend any important changes in the curriculum.

The last item of business at the meeting of July 8th was the appointment of the following examiners: Anatomy, Descriptive—Dr. T. W. G. McKay, of Oshawa. Theory and Practice of Medicine—Dr. George Hodge, of London. Clinical Medicine—Dr. H. R. Duff, Kingston. Midwifery, Operative and other than Operative, and Puerperal Diseases—Dr. J. R. McCabe, Strathroy. Physiology and Histology—Dr. R. D. Rudolf, Toronto. Surgery, Operative and other than Operative—Dr. W. T. Parke, Woodstock. Clinical Surgery—Dr. J. S. McCullough, Alliston. Medical and Surgical Anatomy—Dr. T. H. Middleboro, Owen Sound. Chemistry, Theoretical and Practical, and Toxicology—Dr. A. R. Pyne, Toronto. Materia Medica and Pharmacology—James S. Sprague, Stirling. Medical Jurisprudence and Sanitary Science—Dr. D. J. Sinclair, Woodstock. Diseases of Women—Dr. R. E. Webster, Ottawa. Diseases of Children—Dr. James Newell, Watford. Pathology, Therapeutics and Bacteriology—Dr. Isaac Wood, Kingston. Homeopathic Examiner—Dr. W. A. McFall, Peterboro'.

Regarding the suggestion that an examiner may examine on the subject on which he lectures, the committee reported as follows:

"No teacher shall be eligible for appointment as examiner in the subject which he teaches, but this restriction shall not apply to teachers of Anatomy, Physiology, and Chemistry."

CANADIAN MEDICAL ASSOCIATION.

Halifax, N.S., August 22nd to 25th, 1905.

PRELIMINARY PROGRAMME.

President's Address—Dr. John Stewart, Halifax.

Address in Surgery—Dr. Francis M. Caird, Edinburgh, Scotland.

Address in Medicine—Dr. D. A. Campbell, Halifax.

Address in Gynecology—Dr. Howard A. Kelly, Baltimore.

Address in Ophthalmology—Dr. J. W. Stirling, Montreal.

Discussion—Renal and Ureteral Surgery. Introduced by Dr. A. Primrose, Toronto.

Two Cases of Retro Ocular Neuritis—Dr. Geo. H. Burnham, Toronto.

Paper (title to be announced)—Dr. H. A. Bruce, Toronto.

The Symptoms, Diagnosis, Prognosis and Treatment of Neoplasms Affecting the Central Nervous System.—Dr. D. A. Shirres, Montreal.

Chorea, with an Analysis of 130 Cases—Dr. Robert King, Halifax.

Rare Forms of Aneurysm—Dr. Maude E. Abbott, Montreal.

The Buried Suture—Dr. J. M. Elder, Montreal.

Dentigerous Cysts, or the Removal of the Inferior Dental Nerve for Tic—Dr. M. C. Smith, Lynn, Mass.

Combination Operation for the Radical Cure of Inguinal Hernia—Dr. F. N. G. Starr, Toronto.

Two Case Reports—(1) A Case of Chylo-Thorax; (2) Further Notes on a Case of Myelogenous Leukemia with Disappearance of the Splenomegaly and Myelocytes—Dr. D. G. J. Campbell, Halifax.

Physical and Clinical Researches of Radium—Dr. Myron Metzenbaum, Cleveland, Ohio.

Prostatectomy—Dr. E. W. Cushing, Boston, Mass.

The Surgery of the Stomach in Non-Malignant Conditions—Dr. Geo. E. Armstrong, Montreal.

Dislocations (with lantern demonstration)—Dr. J. Alex. Hutchison, Montreal.

The Fever of Late Syphilis—Dr. Arthur Birt, Berwick, N.S.

Postural Albuminuria of Children—Dr. W. H. Eagar, Halifax.

The Prodromata of Insanity—Dr. W. H. Hattie, Halifax.

The Treatment of Small-pox without Pitting—Dr. Archibald Leitch, St. Thomas, Ont.

Tracheotomy as a Remedy in Severe Whooping Cough—Dr. A. B Atherton, Fredericton, N.B.

Recent Fracture of the Clavicle, with Operative Treatment—Dr. J. W. T. Patton, Truro, N.S.

In addition to the foregoing, several have promised papers, but have not yet decided upon the title of same.

The thirty-first annual meeting of the Mississippi Valley Medical Association will be held at Indianapolis, Ind., October 10, 11, 12, under the Presidency of Dr. Bransford Lewis, of St. Louis, Mo. The annual address in medicine will be delivered by Dr. Arthur R. Edwards, of Chicago, Ill.; and the address in surgery by Dr. W. D Haggard, of Nashville, Tenn. The mere mention of these names is sufficient guarantee of the excellence of the principal addresses of the meeting.

RESULTS OF RECENT EXAMINATIONS.

Graduates in Medicine, University of Toronto.

The results of the fourth year examinations in medicine at the University of Toronto are as follows:

Medals—Faculty gold medal, W. S. Lemon; first faculty silver medal, G. Ford; second faculty silver medal, W. Merritt; third faculty silver medal, M. E. Gowland.

Scholarships: First year—I., J. G. Harkness; II., R. E. Davidson. Second year—I., G. C. Gray; II., W. C. Shier.

Post-graduate scholarship.

The George Brown Memorial Scholarship in Medical Science—For this scholarship W. S. Lemon, A. G. McPhedran, G. G. Little, S. R. Dalrymple, R. H. Bonnycastle, ranked in the order named.

Final examination—The following received degrees with honors: (1) W. S. Lemon, (2) G. Ford, (3) R. H. Bonnycastle, (4) S. R. Dalrymple and G. G. Little, (6) Miss McAlpine, (7) M. E. Gowland, (8) A. G. McPhedran, (9) W. Roberts, (10) C. Schlichter, (11) Miss M. E. Reid.

The following have completed the examination in the fourth year: W. H. F. Addison, Miss E. E. Bagshaw, Miss E. Beatty, J. C. Beatty, A. C. Bennet, G. I. Black, T. W. Blanchard, R. H. Bonnycastle, D. H. Boddington, G. Boyd, S J. Boyd, J. H. R. Brotrecht, F. J. Buller, R. B. Burwell, K. C. Cairns, Miss M. B. Callaghan, W. H. Cameron, M. H. V. Cameron, F. M. Campbell, J. A. Campbell, W. M. Carrick, J. D. Christie, R. L. Clark, H. B. Coleman, T. W. Collinson, F. H. Coone, H. H. G. Coulthard, H. D. Cowper, J. M. Dalrymple, S. R. Dalrymple, C. B. Eckel, W. G. Evans, G. Ford, A. J. Gilchrist, W. C. Gilday, E. A. Goode, M. E. Gowland, D. A. L. Graham, G. W. Graham, F. W. Hall, F. V. Hamlin, J. J. Hamilton, E. C. Hanna, E. B. Hardy, J. E. Knipfel, W. S. Laird, Mrs. L. C. Langstaff, W. S. Lemon, G. G. Little, R. C. Lowrey, E. J. Lyon, Miss M. McAlpine, J. McAndrew, E. A. McDonald, F. F. McEwen, J. A. McKenna, G. L. MacKinnon, F. D. McLachlan, G. D. MacLean, C. McMane, A. McNally, A. G. McPhedran, J. H. McPhedran, T. T. McRae, W. W. Medley, W. Merritt, E. M. Middleton, S. F. Millen, J. I. Morris, F. B. Mowbray, A. G. Munns, C. W. Murray, W. J. O'Hara, C. Powell, W. E. Procunier, J. A. Rae, Miss H. E. Reid, Miss M. E. Reid, W. Roberts, A. M. Rolls, C. Schlichter, J. A. Scratch, A. Sinclair, A. B. Smillie, W. J. Smith, F. J. Snelgrove, J. H. Soady, J. A. Speirs, C. E. Spence, A. M. Spohn, C. H. Stapleford, A. P. Stewart, A. W. Thomas, R. W. Tisdale, J. H. Todd, W. C Toll, S. Traynor, L. A. Trueman, R. M. Turner, F. Vanderlip, A. G. Wallis, F. J. Weidenhammer, J. L. Wilson, A. C. Woods.

MEDICAL GRADUATES, UNIVERSITY OF TRINITY COLLEGE.

Final M.D.C.M. Examination—Certificates of honor: W. J. Dobbie, (gold medallist), R. R. B. Fitzgerald, (silver medallist), E. F. Atkinson.

Class I—R. D. Orok, C. A. F. Caviller, W. J. Corrigan, J. A. Kinnear, W. Dales, H. C. Kindred, C. W. Field.

Class II—A. R. Curtis, H. W. Burgess, G. E. Seldon, T. C. Brereton, J. R. Serson, J. S. Springer, R. J. Carson, B. T. Davey (equal); E. C. A. Reynolds, W. H. Godfrey, G. H. Carlisle, F. W. Rolph (equal); J. A. Gallagher; Miss M. E. Donglan, G. W. Hall (equal); M. J. C. Naftel, H. M. East, J. A. Cullum, W. B. Cassels, J. S. Pritchard, J. Boyce, J. P. Campbell. A. J. Weart, R. M. Cumberland, E. J. Hagan.

Class III—H. Clendenning, T. H. Argue, F. W. McKee, S. J. Staples, G. S. Strathy, A. E. Murphy, J. G. Middlemas, C. A. McKay, Miss G. L. Urquhart, A. W. Keane, C. Howson; S. Blumberger, W. J. J. Brawley (equal); C. D. Lochead, W. A. Peart, H. A. Abraham, J. M. Dale, D. H. Gesner, B. E. Tughen, G. D. R. Black, W. E. Wallwin, G. F. Milne.

Certificates of Honor—W. J. Dobbie (gold medal), R. R. B. Fitzgerald (silver medal), E. F. Atkinson.

DEGREE OF M.D. AND C.M., QUEEN'S UNIVERSITY.

H. J. Bennett, Gananogue; Joseph Chant, Chantry; J. H. Code, Kingston; E. C. Consitt, Perth; J. A. Corrigan, Kingston; W. H. Dudley, Pembroke; J. G. Dwyer, M.A., Kingston; J. Y. Ferguson, B.A., Renfrew; E. A. Gaudet, B.A., Moncton, N.B.; A. W. Girvin, Stella; M. E. Grimshaw, Wolfe Island; R. W. Halladay, B.A., Elgin; J. T. Hogan, Perth; J. M. Hourigan, Smith's Falls; A. H. Hunt, Bridgetown, Barbadoes; M. Lesses, Kingston; M. Locke, Brinston's Corners, T. D. Macgillivray, B.A., Kingston; D. L. McKinnon, Lake Ainslie, N.S.; A. D. MacMillan, Finch; A. E. Mahood, B.A., Kingston; P. A. McIntosh, B.A., Dundela; C. R. Moxley; Kingston; G. R. Randall, Seeley's Bay; M. E. Reynolds, B.A., Athens; R. G. Reid, Kingston; J. J. Robb, B.A., Battersea; W. M. Robb, Lunenburg; B. A. Smith, Hartington; W. A. Smith, Kingston; J. F. Sparks, B.A., Kingston; A. C. Spooner, B.A., Latimer; E. W. Sproule, Harrowsmith; R. W. Tennent, Belleville; Jonn Turnbull, Lowville; C. M. Wagar, Enterprise; F. R. W. Warren, B.A., Balderson; J. W. Warren, Harper; H. J. Williamson, B.A., Kingston.

Medals and Prizes—Medal in Medicine. A. C. Spooner, B.A., Latimer; Medal in Surgery, M. Lesses, Kingston; Chancellor's

Scholarship, J. F. Sparks, B.A., Kingston; Dr. Clarke's Prize in Mental Diseases, equal, T. D. Macgillivray, B.A., Kingston, and E. W. Sproule, Harrowsmith; Dr. Mundell's Prize in Medical and Surgical Anatomy, J. G. Dwyer, M.A., Kingston; Dean Fowler Scholarship (third year), Elmer Bolton, Phillipsville; MacCabe Prize in Pathology, A. E. Baker, Osnabruck Centre; Faculty Prize (second year), F. H. Trousdale, Hartington; New York Alumnæ Association Prize in Physiology and Histology, J. P. Quigley, M.A., Kingston; Hayunga Prize in Pharmacology and Therapeutics, M. L. Burke, Port Antonio, Jamaica; Hayunga Prizes for best dissection made by two students, A. T. Spankie, Wolfe Island, and M. J. O. Walker, Kingston; Wm. K. Warner & Co. Prize for best examination in Anatomy of first year, C. T. C. Nurse, Georgetown, British Guiana; House Surgeons in General Hospital, A. C. Spooner, B. A., Latimer; M. Lesses, Kingston; H. J. Williamson, B.A., Kingston; and Next in order—J. F. Sparks, B.A., Kingston.

Graduates in Medicine, Manitoba University.

M.D.—William Wilson Amos, Robert Naismyth Burns, B.A., Frederick Todd Cadham, B.A., William Andrew Clark, Thomas Andrew Cohoe, George Hector Craig, B.A., Robert Edward Davis, James Duxbury, Albert Ernest Finley, William Jesse Grant, Benjamin Arthur Hopkins, Marsden Frank Ross Irwin, Robert Duncan Kippen, Arnot Leishman, David Park Miller, B.A., Harry Morton Murdoff, Harold Wigmore McGill, Charles James McKinnon, William John Mactavish, William C. Nickle, Richard R. Procter, George Walter Rogers, Albert Henry Rondeau, Herbert Samuel Sharpe, Harry Blackett Stacpoole, David Chester Thompson, Wilfrid Tucker, John Alexander Valens, Frederick Charles Walton, George Albert Woodruff, Joseph Theodore Wright.

C.M.—Willlam Andrew Clark, George Hector Craig, B.A., Albert Henry Rondeau, Herbert Samuel Sharpe.

Graduates in Medicine, Dalhousie University.

Edward Blackaddar, M.A., (Acad.); John Archibald Ferguson, B.Sc., (Dal.); Daniel Robert McDonald, George Gladstone MacDonald, George Arthur McIntosh, Victor Neil MacKay, Mary MacKenzie, Alexander W. Miller, B.A., (St. F. X.); James Alexander Murray, John Ignatius O'Connell, B.A., (St. F. X.); James Adam Proudfoot, Peter James Wallace.

College of Physicians and Surgeons of Ontario.

The following candidates passed the final examination of the College of Physicians and Surgeons of Ontario: J. H. Alford, G. B. Archer, P. Anderson, R. W. Anderson, W. G. Anderson, G. M. Biggs, H. R. Bright, E. C. Burson, J. H. Bennett, F. J. Buller, F. J. Brodie, H. R. Bryan, J. W. Brien, W. A. Burr, W. J. Barber, H. C. Church, W. W. Chipman, W. S. Coady, C. W. Clarke, J. C. Caskey, G. W. Crosby, A. H. Caulfield, W. K. Colbeck, T. A. Davies, E. C. Dixon, A. H. Davies, T. B. Edmison, F. J. Ellis, F. S. Eaton, P. J. Fleming, B. J. Ferguson, J. A. Faulkner, J. Graham, H. E. Gap, M. E. Gowland, Wm. Gibson, T. D. Gallivan, G. W. Graham, T. R. Henry, J. P. Houston, H. O. Howitt, R. W. Halladay, W. H. Harvey, A. L. Hore, G. O. Ireland, J. L. Kane, N. D. Kyle, A. Kinghorn, J. A. Kane, J. F. Killoran, W. H. Keen, E. J. Lyon, A. J. Lalonde, S. M. Lyon, B. M. Lancaster, Eleanor Lucas, A. J. Manard, A. T. Munroe, T. D. MacGillivray, W. E. Mason, A. F. Malloy, P. F. McCue, J. P. McKinnon, P. McGibbon, R. J. McCullough, R. A. McLurg, Geo. McGhie, A. G. McPhedran, D. F. McKinley, R. J. McComb, P. J. McCue, A. McNally, A. D. McClennan, C. C. McCullough, M. A. McQuade, W. E. McLaughlin, J. K. McGregor, A. G. McMillan, S. M. Nagle, J. S. Nelson, J. W. Presault, W. G. Reive, Wm. Reid, F. W. Rolph, G. H. Richards, A. L. Russell, A. B. Sutton, J. B. Stallwood, C. E. Spence, F. J. Snelgrove, A. W. Seighon, J. F. Sparks, E. Sheffield, W. A. Scanlon, G. M. Shaw, R. G. Snyder, A. E. Schulz, F. J. Sheahan, A. Turner, A. D. Unsworth, K. H. VanNorman, F. S. Vrooman, A. J. Williamson, F. C. S. Wilson, T. A. Watterson, B. C. Whyte, J. A. Wright, S. B. Walker.

McGill Medical Faculty.

The seventy-sixth convocation of McGill University for conferring degrees in the Faculty of Medicine was held on June 9th, 1905. The following is the list of names of those who secured the degrees of M.D.

Alguire, A. R., Cornwall; Briggs, J. A., New Westminster; Brown, F. F., Cornwall; Burgess, H. C., Sheffield Mills, N.S.; Chisholm, H. A., B.A., Lindwood, N.S.; Connor, E. L., Berlin; Costello, W. J. W., B.A., Montreal; Covernton, C. F., Montreal; Cumming, A., B.A., Scottsburg, N.S.; Dougan, B. H., Hampstead, N.B.; Dowler, W. H., Billings' Bridge, Ont.; Dykes, W., Nanaimo, B.C.; Finigan, J. F., Oshawa, Ont.; Geddes, R. W., B.A., Deseronto; Gillis, J. H., Metapedia; Grimmer, R. D., St. Andrews, N.B.; Hannington, J. W. R., Victoria; Heagerty, J. J., Montreal; Henderson, E. H., B.A., Franklin Centre; Henry, E. G., B.A., Lennoxville; Hume, G. M., Leeds Village; King, S. S.,

Albert, N.B.; Leslie, H. A., Souris, P.E.I.; Likely, D. S. B.A., St. John, N.B.; Loggei, W. S., Chatham, N.B.; McDermott, J. H., Gordontown, Jamaica; McKay, M. E., Whycocomagh, N. S.; McLean, J. D., Beaton's Mills, P.E.I.; McDonald, J. A., B.A., Valleyfield; McDonald, J. C., Peak's Station, P.E.I.; McIntosh, G. J., Dalkeith; McLeod, W. A., Finch; McMicking, A. E. T., Victoria; McMurty, S. O., B.A., Montreal; McMurthy, W. C., Port Hope; McNaughton, W. B., St. Raphael West, Ont.; Mason, J. H., Lachute Mills, Que.; Mersereau, H. C., Doaktown, N.B.; Miller, A. P., Chatham; Moffat, C. F., B.A., Montreal; Mohr, F. W. C., Arnprior; Muckleston, H. S., M.A., Perth; Mulligan, J. W., Omemee, Ont.; Munro, J. A., Pugwash, N.S.; Nelles, T. R. E., Simcoe; Prendergast, A. R., B.A., Montreal; Pruyn, W. G., B.A., Napanee; Richards, E. T. F., St. Vincent, B.W.I.; Robertson, A. R., Victoria; Robertson, B. W., St. John, N.B.; Rommel, E., Alma, N.B.; Ryan, L. McD., B.A., Newbury, Ont.; Sawyer, A. R., Roslindale, Mass.; Scott, W. J., B.A., Montreal; Scrimger, F. A. C., B.A., Montreal; Seifedt, F. W., B.A., Quebec; Sinclair, E. E., Summerside, P.E.I.; Styles, W. A. L., Montreal; Smith, W. A., Almonte; Sullivan, J. A., Arnprior; Tees, F. J., B.A., Montreal; Tull, J. A. C., Antigua, B.W.I.; Turnbull, E. G., Branchton, Ont.; Valin, R. E., Ottawa; Viner, N., B.A., Montreal; Waterman, C., Ogdensburg, N.Y.; White, P. G., Woodstock; Wigle. C. A., Wiarton; Wilkinson, W. M., Woodstock; Winder, J. B., B A., Compton; Winfrey, W. C., B.L., Sault Ste Marie, Mich.; Wood, G. O., Kenmore, Ont.; Wood, W. H., Montreal; Young, C. A., Ottawa.

Bishop's College.

The thirty-fourth annual convocation of Bishop's College for conferring degrees in the Faculty of Medicine was held on 31st May. Degrees were conferred upon the following graduates: F. W. Aris, C. S. Carmichael, R. B. Cunningham, G. W. Gallatly, F. D. Gill, E. H. Lawson, A. J. Moseley, H. G. MacKerrow, R. H. McRae, M. W. H. Pitman, N. Shacher, G. H. Silverman, H. M. Vartanian and P. Villard.

Obituary.

THOMAS GEORGE JOHNSTON, M.P.

Dr. Johnston, member of the Dominion Parliament for West Lambton, died in Ottawa, July 4th, aged 56. The cause of death is said to have been septicemia, following a scratch on his nose. He graduated from McGill University in 1871. He practised in Sarnia for many years and held many prominent offices in that town, including two terms as Mayor. He was elected to the House of Commons as a Liberal to represent West Lambton at a bye-election in 1898, and was re-elected at the subsequent general elections. He was extremely popular on both sides of the House at Ottawa.

DAVID LESLIE PHILLIP, M.D.

Dr. Phillip, of Brantford, died July 10th at the age of 69 years. He was a McGill graduate of 1861, and was one of the best known physicians in Western Ontario. He was a member of the Ontario Medical Council from 1885 to 1895.

Personals.

Dr. Edmund E. King spent a portion of the month of July in Winnipeg.

Dr. T. H. Bell, of Peterboro', was married June 1st to Miss Minnie Darling, of Toronto.

Dr. G. Sterling Ryerson returned from England on the Allan Line *SS. Bavarian*, and reached Toronto July 5th.

Dr. A. T. Rice, after practising in Woodstock for about twenty years, has removed to New Dundee, near Galt.

Dr. James Roberts has been appointed Medical Superintendent to the Hamilton City Hospital in the place of Dr. Freeman, resigned.

A large portion of the valuable medical library of the late Dr. James Thorburn has been donated to the University of Toronto.

We are pleased to be able to state that Dr. Brefney O'Reilly had quite recovered from his slight illness before reaching Father Point.

The meeting of the Fifth International Congress of Obstetrics and Gynecology, which was to have been held in September, 1905, has been postponed for a year.

Dr. A. B. McCallum left Toronto, July 7th, for Cape Town, South Africa, where he will attend the meeting of the British Medical Association for the advancement of Science.

In a letter received, posted at Father Point, by a friend in Toronto, Dr. Charles O'Reilly reports that he is well and delighted with the officers of the *SS. Montrose* upon which he sailed for England. He wished to be remembered to all the "boys," and expressed his great appreciation for their kindness to him before he left Toronto.

The following physicians have been appointed Associate Coroners by the Ontario Government, Dr. Wm. Arrell, of Cayuga, for the County of Haldimand; Dr. George Eric Chapman, of Sombra, for the County of Lambton; Dr. J. Lane, of North Williamsburg, for the united Counties of Stormount, Dundas and Glengarry; Dr. H. A. Minchin of the Township of Enniskillen, for the County of Lambton; Dr. W. J. McCollum, for the City of Toronto.

Correspondence.

MEDICAL THOUGHTS.

To the Editor of THE CANADIAN PRACTITIONER AND REVIEW.

DEAR SIR:

There is a name, dear to several thousand M.D.'s who, like myself, have no doubt wondered why our Provincial University has not honored with its LL.D. Need I say that this name is that of W. B. Geikie, whose reputation as an able Professor in Medicine for nearly forty, if not more years, and whose zeal for his students' welfare—"ever the students' friend"—have been confirmed and recognized by all true friends of medicine in this Canada of ours? Chauvinism being silenced.

When our universities shall exact for matriculants in medicine the qualifications of the degrees B.A. or the B.S. (in which degrees are embodied a thorough acquaintance with the classics of Greece and Rome), then medicine, and not until then, will have the honored place to which, among men, she is entitled. Why should not our Provincial University become the vexillary in these demands? Is it not to scholarly men most disheartening when the recent graduate says: "I have forgotten my Latin. I never studied Greek. I can not translate my diploma's Latin"?

Our studies go with us through life, and the dear people are expecting scholarship of the highest order among the youngest M.D.'s. Are our young men scholars, such as were Wm. Harvey or Oliver Goldsmith at graduation? History says, "No." Medicine invites and encourages the philomath —men of the type of I. B. Cameron—*inter sapientes medicus.*

Medical journalism is certainly debasing medicine, and an inspection will very easily confirm this assertion. Not only debasing and degrading in character, as relates to advertisements, but in many instances the texts have too often the almanac character, in which a proprietary medicine affords the object held in view. When medical journals are shorn of advertisements, of which two-thirds bear startling evidences of the fakir, the unrelenting parasite, and be even such as were our journals of twenty years ago, the better will

it be for our jealous mistress, medicine, and for our wrinkled purses.

When young M.D.'s possess greater, or equal, knowledge of pharmacy than is possessed by the ordinary druggist, more equal respect for each will be entertained, and Professor Chas. F. Heebner will not be prompted to write, as he most justly and honorably did, "The Dispenser's Difficulties," page 455 in *The Canadian Pharm. Journal.* To see ourselves as others see us, I wish every true M.D. would read this article, which in every sense I endorse and most humbly admit is lamentable for us—and I am neither a Zoilus or an Aristarchus—a very humble hewer to the line, letting the chips fall which way they may.

Have our best men, such of them as are associated with hospitals and are encouraging the trained nurse business, ever considered that much of the information or instruction given nurses is useless, and are arming them with much that they (the M.D.'s) purchased dearly with shekels and midnight oil, and which they (the nurses) will use to humiliate some faithful brother by lessening his prestige and income, without being a trusty aid and servant. The example set by Johns Hopkins Hospital in exacting materia medica, chemistry and anatomy of nurses is one which the enemies of medicine would most decidedly select and follow. Reader, this paragraph is introduced as a reminder, timely, it is hoped, and to illustrate that too many M.D.'s are easy marks and unmindful of the *Fidus in Arcanis* motto emblazoned on the seal of our College of Physicians and Surgeons.

When one, possessed of such distinguishing gifts as a writer and able scholar in the English classics, as is Dr. Fischer, Waterloo, Ont., the author of "Songs by the Way-Side," it is not necessary that one be waiting to get securely seated in the medical saddle; for such men like Weir Mitchell, Osler, Virchow, Paget, and others, even as Angelo, can be masters (even if medicine is a jealous mistress), in allied interests, for medical studies add encouragement, true insight, and awaken our heavenly thoughts in every noble study and research.

The first work placed in my hands for study by my preceptor was the history of medicine and its illustrious fathers. That such a study was beneficial, and is even encouraging, in the writing of these paragraphs, is evident in my thoughts; and why such delightful primary studies are not presented or

even mentioned in our universities has been, and is, to me an unsolved problem. If the history of the master-minds in medicine were taught (as should medical ethics be equally taught), professional respect and honor would be better respected and fakirism silenced.

From ten confréres I learn that six take one Canadian and two American medical journals; four take American journals only; only two of the above are taking the same Canadian journal. The American journals most preferred are those of the dollar-a-year order and monthly, have fifteen or more brief articles by correspondents. The American journal that advertises its own proprietary medicines and sends pin-cushions and cheap chromos to the doctors and vest-pocket samples to preachers and school-masters, and sends its journals to drug stores for sale, is an almanac of the worst kind, even if it has now and then some foolish doctor's photo and titles among its first pages; it is a wolf in sheep's clothing; no one among us takes it. I am brief.

These reflections are but thoughts, to which thoughts but briefly refer. For pointed and pithy paragraphs, or aphorisms, or brief articles, are such as we more especially admire, and such are more frequently read and arouse attention and comment generally benign and confirmatory, and the surprise is that so few among us, even the most scholarly and experienced, cannot find a leisure moment in the "swirl of time and tide" for the composition of an article which would possibly cheer some perplexed brother and otherwise enrich our journalistic literature, which in purity and freedom from licentious character is so markedly superior to many of the cheap American medical journals of medicine. Let the love of our profession, not self, wield your pen in the uplifting and maintenance of our interests, as have our enemies. And we M.D.'s have even been regarded as easy marks, even victims, for the collection-agency schemer and other countless frauds, and even for the traitors among our confréres.

Yours truly,

JAS. S. SPRAGUE.

Stirling, Ont.