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VOL. X. HALIFAX, N. S., AUGUST, 1898. No. 8.

Presidential Address.

RECIPROCAL REGISTRATION.*

By D. A. CAMPBELL, M. D., C. M., Halifax, N. S.

Gentlemen :—

Before beginning my address, allow me to thank you for the honour you have conferred by electing me to the position of President of this association. It is a distinction highly appreciated, but entirely undeserved, as my interest and work on behalf of the association has been of a very ordinary character. With your generous co-operation, I trust to merit to some extent the confidence which you have placed in me.

As the subject of my address I have chosen Reciprocal Registration, because it is one in which this association has taken a deep interest since its organization seven years ago, and also one in which I have been more or less personally interested for many years past. The present time seems appropriate to mark the progress made to secure reciprocity of licensure between the provinces of Canada, to determine what remains to be done, and to consider the best means of attaining the desired ends. Competent critics affirm that the position of the medical profession in Canada is good, that the standard of medical education compares favourably with that of other countries, that the average practitioner is generally well qualified, and that even in the most sparsely settled districts of the country the services of a competent physician are usually available. Such advantages have been secured to the people of Canada by well directed efforts in the sphere of medical education in the several

* Delivered before Meeting of Maritime Medical Association, at Halifax, July, 1898.

provinces. Various influences have helped to keep the standard of medical education in Canada in touch with the rapid advance of medical knowledge elsewhere. Probably the most influential factors have been the laws enacted from time to time in each of the provinces, regulating the practice of medicine, and the administration of those laws by representatives of the profession. In every province of the Dominion the profession possesses the inestimable privilege of self-government, being entrusted by the legislatures with full control of medical education, registration and many other matters affecting their interests. Nowhere else, so far as I know, has the profession been accorded similar privileges.

The most serious defect of the medical legislation of Canada is that, being strictly provincial in its scope, no provision can be made for a national license, or its equivalent, except through the roundabout way of a mutual agreement between the provinces respecting the requirements for registration and subsequent reciprocity of licensure. The necessity for a national qualification was not fully realized formerly, and consequently the profession in each of the provinces followed the course which they thought best to obtain legislation locally satisfactory without much regard to the necessity and advantages of uniformity. Hence, as might be naturally expected in a country so extensive as Canada, made up of provinces differing in age, population, wealth and educational advancement, there is considerable diversity in the medical legislation of the provinces. During recent years the inconvenience of a merely provincial qualification has been more keenly felt, hence there has been a steady and fairly rapid growth of opinion in the profession in favour of inter-provincial reciprocity, a policy which if universally adopted would make a provincial qualification for all practical purposes equivalent to a national license. Thus far there has been no outspoken opposition to the scheme, a fact which speaks well for the popularity of the proposal. To many, therefore, it seems surprising that the progress of negotiations has been so slow.

Before relating the progress of the movement towards reciprocity, I wish to call your attention briefly to one or two generally overlooked features of the difficulties which lie in the way. The only serious obstacle retarding reciprocity in licensing is the diversity of the provincial requirements touching the right to practice. A careful study of these requirements will, I think, convince any fair-minded person that such differences as arise from the unequal condition of the provinces in respect to age, population, wealth and educational status, admit of being

easily harmonized; but apart from this natural diversity, a diversity has been created and taken advantage of in some provinces to promote objects foreign to the intention of medical legislation. It is this artifical diversity which so effectually blocks the pathway of reciprocity. A desire to foster medical schools, and possibly a wish to diminish competition, have unquestionably brought about a needless amount of diversity in the requirements of registration. Suspicion of a desire to lessen competition should be aroused where a province with a lower standard of requirements absolutely refuses to recognize the license of provinces with higher standards.

The influence of medical schools is clearly traceable in the legislation of some of the provinces. Many of the requirements of the Medical Boards of Ontario and Quebec bear the impress of a design to promote the interests of their own medical schools; in fact the rivalry of medical schools has affected the regulations of these provinces considerably. The requirements of Ontario seem as if designed to make it very inconvenient for men to obtain a license if they have prosecuted their studies outside of that province. The requirements of Quebec discriminate in favour of the schools of that province by granting a license to their graduates without further examination.

To put the matter as plainly as possible without further details of evidence to support the assertion, the medical schools of Ontario and Quebec have taken advantage of the legislation of the respective provinces relating to medicine to advance the interests of such schools, and in doing so have created a want of uniformity in the requirements for registration—requirements of no benefit to the public and injurious to the profession, and it is this needless diversity which is the most formidable obstacle to the forward movement of reciprocity.

Permit me now to refer briefly to the various efforts which have been made to secure reciprocity of registration.

The policy of reciprocity suggested itself when the strenuous efforts of the Canadian Medical Association to obtain a central examination board for Canada ended in failure. The meetings of that association, held from time to time in different sections of the country, have done good work in the direction of unifying the profession, and have served as a useful medium for diffusing information respecting the status and requirements of medical education in each province. The desirability and advantages of reciprocity have been pointed out from year to year in the address of the President, and the subject has been frequently

referred to committee. The enactment of laws, generally based on the Ontario act, by the provinces previously without regulations, widened the interest in the subject. The adoption of a treaty of reciprocity between the Medical Boards of the three maritime provinces in 1894 gave a strong impetus to the movement, and I think you will pardon me if I dwell for a moment on some of the features of that agreement.

One of the main objects for which this association was formed was to unify and advance the interests of the profession in the maritime provinces. Consequently reciprocity of registration was the chief concern of the association from the first, and the scheme was pushed to completion as rapidly as possible. As a preliminary step satisfactory legislation had to be obtained in Prince Edward Island. When this was secured no further difficulty was anticipated, as the legislation of the three provinces was nearly uniform, and the profession was found to be almost unanimously in favor of the scheme, all of the provincial societies having adopted resolutions supporting it. At the Charlottetown meeting of this association in 1893 a resolution was unanimously adopted asking the Medical Boards of the three provinces to take action in the matter. This was done, and a conjoint committee representing the three provinces gave the subject careful consideration. This committee submitted a report providing a uniform standard of requirements for registration, which was subsequently adopted by the Medical Board of each province, and the necessary authority to complete the treaty was secured from the several legislatures. All this work, greatly enhancing the value of a medical license obtained in any of these three provinces, was accomplished by the efforts of this association within three years after its organization, and it is matter for still further satisfaction that these provinces secured their reciprocal agreement not by any of them lowering its previous requirements, but by all of them advancing to a uniformly higher standard. The matriculating requirements were increased and the passing of this examination made obligatory before commencing study. The period of study is to be four collegiate years. Private tuition with a preceptor is no longer recognized. The curriculum is adequate and adapted to the wants of the provinces. It permits a student to study where he pleases, and it has been arranged to give full recognition to graded course of study. Applicants having diplomas from colleges requiring a four years' graded course may be registered without examination, otherwise any deficiency in the curriculum is to be made good and an examination is to be passed before examiners appointed by the Boards.

The agreement for reciprocity did not commit the Medical Boards to the principle of a central examining body, as it was thought better, for a time at least, to discriminate against colleges which do not require a four years' graded course of study for graduation than to make examination obligatory in all cases. It is well to remember that at the time of the treaty the Prince Edward Island Medical Board had obtained authority to appoint a central board of examiners. The Medical Board of New Brunswick also, when asking for authority from the legislature to carry out the reciprocity, obtained power to appoint a central board of examiners. The Medical Board of Nova Scotia very unwisely, I think, did not take advantage of this opportunity to ask the legislature for similar powers. This reciprocity has been in operation for only four years—rather too short a period to test the scheme.

Some questions which have cropped up suggest the desirability of a speedy and more direct plan of discussing them than by correspondence. This could easily be secured by an annual conference of representatives of the board, at or about the date of the meeting of this association. The measure of reciprocity already secured has given a powerful stimulus to a movement for a wider reciprocity, and this may be regarded as one of its most valuable results. If I mistake not, at the meeting of the conjoint committee of the boards a resolution was adopted instructing the secretary to communicate with the other boards of Canada, stating what had been done in the maritime provinces, and asking them to discuss the question and to send delegates to be present at the meeting of the Canadian Medical Association at St. John, N. B., in 1894. A determination was arrived at by the maritime men to give the question prominence at that meeting. The President of the Canadian Association, Dr. Harrison, of Selkirk, Ont., made a reference to the subject in his address, and the report of the committee on the address gave an opportunity for discussion. A resolution appointing a committee to report upon the best means of obtaining a uniform standard of requirements for Canada was adopted, and the committee instructed to report at the next annual meeting at Kingston in 1895. At the Kingston meeting the committee submitted a report, which was substantially as follows:—

The secretary was instructed to communicate with the various Medical Boards asking them to discuss the question, and appoint delegates to co-operate with a committee of the association in framing a uniform standard of requirements.

At the Montreal meeting in 1896 the committee and a strong delegation representing all the Medical Boards of Canada, except British

Columbia and the North West Territories, met immediately after the session was formally opened. An admirable discussion, in which nearly all present took part, was followed by the appointment of a sub-committee composed of one representative from each province to prepare a uniform standard of requirements. The report prepared by this sub-committee was accepted and subsequently adopted by that association with the following proviso:—

"The committee make these resolutions merely as suggestions for the consideration of the councils of the several provinces as a mutual basis of agreement, and request that each report thereon to the next meeting of the association, and also send one or more delegates to represent them at that meeting."

In 1897 the association met again in Montreal and the committee on reciprocity reported finally as follows:—

"The committee beg leave to report that the Medical Councils of Quebec, Prince Edward Island, Nova Scotia, New Brunswick and Manitoba have signified by resolution their approval of the resolutions of the committee of 1896, and have accepted them as a basis of agreement for inter-provincial registration. We therefore recommend that the matter be referred to the councils mentioned to formulate an agreement and to carry it into effect."

The discussion which followed disclosed an unwillingness on the part of the Ontario Council to accept the proposed standard of requirements, inasmuch as without an alteration of the law that province could not concede reciprocity to a province which permitted registration without an examination by a central examining board or a similar body constituted by law to carry out that purpose, and that any attempt to secure an alteration of the law so as to accept the proposed standard might result in more extensive alterations of the act than was contemplated.

The announcement was a great disappointment and provoked some hostile criticisms. At first glance the refusal of the Ontario Council to accept the proposed standard does seem somewhat unreasonable. But let us consider the facts before coming to any conclusion. Ontario has for more than a quarter of a century steadily adhered to the principle of a central examining board, believing it to be the only way by which the state or the profession can have complete control of the licensing power, and the only way by which the evil results which arise from keen competition between medical schools can be effectually restrained. The feature objectionable to the Ontario Council of the proposed standard of

requirements is contained in the third section, the whole of which I will read :—

"III. *Examination.*—All candidates for registration in the various provinces (in addition to having fulfilled the foregoing requirements) shall be required to undergo examination, before examiners to be appointed in each of the provinces by their respective councils, or by means of assessors, as in the province of Quebec, or by delegating their authority to one central body, as has been done in Manitoba."

It is the proviso about Quebec that is the stumbling block. The terms of the proviso are somewhat ambiguous, as they may convey the impression that the examinations are conducted by means of assessors in that province. The intention of the proviso is that graduates of the medical schools of Quebec shall be admitted to registration without further examination if assessors representing the Medical Board are present at such examination. Such being the intention of the proviso, is it not clearly inconsistent with the principle of a central examining board as understood in Ontario and the other provinces, and in the event of the proposed standard being accepted, it would give the students of the Quebec schools the privilege of license to practise in Canada, after passing one examination conducted by their teachers, whereas graduates from other schools in all the provinces must undergo a second examination before an independent board of examiners to entitle them to the license.

Assuming that the Ontario Council agreed to the Quebec proviso and approached the legislature to obtain the power of making the necessary change in the statute respecting reciprocity, how could they, with any show of reason, resist the appeal of the Ontario medical schools to be placed on the same footing as Quebec schools? This is precisely what would happen if the Ontario Council accepted the proviso of Quebec. The schools of that province would demand the same privileges as had been allowed in Quebec. The Council of Ontario would at once lose that complete control of the licensing power which they have always regarded as the most essential feature of their legislation.

Assuming that both Ontario and Quebec permitted the alumni of their schools respectively to obtain registration without further examination, how long could the principle of a central examining board be maintained in the other provinces? The provinces with medical schools would have to concede similar privileges to their graduates, and the other provinces could not successfully maintain a law which compelled

those who had the energy and enterprise to obtain their diplomas in other than Canadian schools to submit to the additional expense and ordeal of examination before receiving registration. It seems to me that a treaty of reciprocity with the proviso respecting Quebec would not be permanent, containing as it does the seeds of speedy dissolution.

You will naturally infer, then, that I am in sympathy with the stand taken by the Ontario Council. In taking this view I may perhaps be in a small minority, nevertheless I hold strongly to the conviction that it would be infinitely preferable in the interests of reciprocity for the universities of Quebec to relinquish a privilege than for the Medical Council of Ontario to sacrifice a vital principle. A permanent treaty of reciprocity, one that will be beneficial at home by effectually placing a restraint upon the downward tendency of competing medical schools, one also that will secure to us advantages abroad, must be based on complete control of the licensing power by the Medical Board of each province. Without central examining boards this power cannot be effectually exercised with such certainty and uniformity as would be satisfactory to the Medical Boards of other provinces, and in such a manner as to be accepted by the licensing authorities of other countries.

The unsuccessful issue of negotiations last year should not be regarded as an indefinite postponement of the question. The matter is of so much importance, and the progress towards its solution so far advanced, that to give it up now ought not to be dreamed of. The adjustment of the differences between Ontario and Quebec must be effected in some way, and this may require some time. Meanwhile the maritime boards could put into operation central examining boards, so as to become familiarized with their working, and better prepared to enter into a larger reciprocal union. New Brunswick and Prince Edward Island are now ready, but the Medical Board of Nova Scotia has been backward, perhaps somewhat unwilling to adopt the policy. The opinion of this meeting, together with the combined influence of the Medical Boards of the sister provinces, should have some weight in overcoming the hesitancy of Nova Scotia's representatives.

Time will not permit me to discuss at any length the merits or demerits of a central examining board. Nor is there any occasion for doing so, because the question is one of expediency. If reciprocity in Canada is thought desirable, and such is the general conviction, if it can only be obtained through the universal adoption by the provinces of central examining boards, about which there can be no reasonable doubt,

then the Medical Board of Nova Scotia should no longer be satisfied with being at the tail end of a procession of provinces moving forward to accomplish a useful purpose. There is no doubt whatever the operation of central examining boards will occasion with us, as they have done elsewhere, considerable irritation for a time, which will increase to some extent the prejudices of the public against medical legislation. Difficulties will be met with in arranging the details of these boards, such as the selection of suitable examiners, particularly for the scientific subjects of the curriculum, and provisions will have to be made for practical examinations in these subjects. These difficulties can be overcome in time, and the irritation and discontent will gradually cease as the advantages of the system are better understood.

So far, I have only referred to the advantages of a national qualification for Canada, but there is another phase of this reciprocity question which must be considered. Just as soon as a uniform system of requirements for registration is adopted by all the provinces, the privileges of British registration are open to Canadian licentiates. Some doubt has been expressed about this, but there is no ground for it. The British Medical Council, by amendments to their Act, in 1888, obtained authority to recognize colonial qualifications, and the Australian colonies have enjoyed the privilege for some years.

The reply of the British Medical Council to the provinces and universities of Canada which have applied for recognition of their qualifications has been: "We cannot be expected to inquire into the various qualifications that obtain in the different provinces of the Dominion. Adopt a common inter-provincial standard and we will gladly admit you to registration."

There is yet another phase of the reciprocity question that must not be lost sight of. The progress of medical education in the United States during recent years has been remarkably rapid. Medical legislation is passing through the same phases of development as in Canada, inter-state reciprocity of registration is already a live question, and the day is not far distant when it will be accomplished. When that time comes, is it not reasonable to hope that reciprocity of practice can be established between the two countries?

Now that the college diploma has practically ceased to confer the privileges it formerly ensured, and is being steadily superceded everywhere by state licenses, is it not our duty earnestly to maintain the standard of the state qualification and widen the bounds of its recog-

nition? To those of the profession who have secured a goodly heritage, the advantage of reciprocity in registration may have no present attraction; but we should remember that most of the privileges which we now enjoy have been secured to us by the labour of those who have gone before, and therefore it becomes our duty in turn to be mindful of our successors and to strive to secure for future members of the profession, once duly licensed, all that is practicable, including the great advantage of being able to practice the sacred art of healing wherever the English tongue is spoken.

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Original Communications.

MEDICAL EVIDENCE BEFORE THE LAW COURTS.*

By Wm. Bayard, M. D., St. John, N. B.

The human mind is so constituted that all do not believe or see alike upon the same subject. In the selection of a wife each does, or should, think his own the best, though the difference may be great indeed. Bulwer has truly said that "people differ in taste as in opinion; some like an apple and some an inion."

Recognizing this peculiar feature of our nature, the question may be asked why our noble profession receives the lion's share of the opprobrium attached to that characteristic? So much so, that the remark "doctors differ" has become a by-word.

It is for the purpose of directing your attention to that subject I address you this morning. Do we deserve the character given us? Certainly not more than the sister professions. The members of the bar, from the bench down, have their differences, so have those of the church, from the bishop to the curate. At our society meetings, at our social gatherings, and, happily, at our clinical consultations, difference of opinion seldom exists. Then have we not obtained the character in consequence of the discreditable wranglings too often exhibited when we appear on the witness stand, placed there for the purpose of contradicting each other, a degrading position, and one which every man who respects himself, or his profession, should avoid when possible?

Medicine is not an exact science, but that does not justify such great divergence of opinion as often is observed. It is true ridiculous statements will be made by those who enter the witness box, ignorant of the subject upon which they are to be examined, and who endeavor to appear learned before court and jury. Of these I do not speak; it is of those who should know better, though I have seen such exhibitions as made me blush for my profession. On one occasion I heard a man of twenty-five years' practical experience say in a case of mortification from frostbite that to add yeast and charcoal to an oatmeal poultice and to give quinine internally was just what he would do to create mortification. Again it is recorded that a medical man, when questioned regarding antisepsis in the treatment of wounds, "indignant-

*Read at meeting of Maritime Medical Association, Halifax, July, 1898.

ly scouted the idea of making use of corrosive sublimate in his practice, but triumphantly declared that he did use the bichloride of mercury."

Other illustrations may be mentioned—the Maybrick case in Liverpool, the Carlyle Harris case in New York, and the recent Leutgert case in Chicago. In each we have some of the most prominent medical men in their respective cities going on the witness stand and flatly contradicting each other about scientific questions. In the Leutgert case a small fragment of the upper extremity of a femur was presented. One gentleman swore positively it was his opinion that the bone was that of a human female; another was equally certain that it was the femur of a hog. On the day following the attorney produced in court bones known to have been obtained from a chimpanzee, which bones were identified by the experts as human. A humiliating position indeed! How much better would it have been had they candidly acknowledged their ignorance.

With such exhibitions before us, can we feel surprised when we find Lord Campbell saying: "Skilled witnesses come with such bias on their minds to support the cause in which they are embarked that no weight should be given to their evidence." Again, Judge Davis, of the United States, says: "If there is any kind of testimony that is not only of no value, but even worse than that, it is that of medical experts." Another judge has spoken almost as strongly. He says: "There seems but one opinion as to the fact that medical testimony is extremely unsatisfactory. We are more and more confirmed in an opinion that the difficulty comes largely from the manner in which the witnesses are selected."

Can any body of men be placed in a more unenviable position than to be forced into court—for we must obey the subpœna—to give evidence before men who value our opinions so little? We are not told that we lie, but the same meaning is expressed in polite terms. Does not the position we occupy imperatively demand that steps should be taken to place us in a better one? Many of the leading medical men in the adjoining republic, appreciating the position, have instituted a movement in favor of legislative action to forbid the selection of expert witnesses by litigants and placing it in the hands of judges and others. If this can be accomplished it will have the effect of preventing the odious spectacle of experts being placed on the stand to contradict each other. But, as every medical practitioner is liable to be called as a witness, legislation will not protect him. He must understand medical jurisprudence and *never* appear in the witness box without having made the

case upon which he is to be examined his special study. He is not supposed to be so profoundly versed in all the principles of medicine and medical jurisprudence as to be able to solve every medical difficulty that may occur during the trial of a civil or criminal case, but he is expected to possess an average knowledge of his profession and of the duties and responsibilities of a medical witness. The position is an unpleasant one, and often a trying one, inasmuch as the guilt or innocence of the accused may rest upon his evidence. Barristers are entrusted with almost unlimited powers of interrogation; they may insist upon answers to the most painful questioning. There are no medical secrets in a court of law; the medical witness must answer every question that is relevant to the case, and its relevancy is a matter to be decided by the judge. But no man is bound to answer a question that would in any way criminate himself. Oftentimes the privilege allowed the barrister is abused by irrelevant questions being put in a rude and dictatorial manner, justifying the severe rebuke given to a learned sergeant by Chief Justice Earle, who said: "The freedom of question allowed by the bar was a public nuisance, and the barrister who made use of such an imputation ought to be prosecuted. If a question had relation to the truth he was most anxious that it should be put, but to cast haphazard imputations at the suggestion of a person who might have no scruples as to what he did, was a degree of mischief that made him wish that the party should be prosecuted."

But, gentlemen, while we justly condemn such conduct in the barrister, may we not ask ourselves the question, Does not the medical witness sometimes call forth such questioning by the character of his answers? Does he always go upon the stand possessing a thorough knowledge of the subject upon which he is to be examined? Is his judgment never warped by prejudice for or against one side or the other, or in favor of some hastily formed theory? That he speaks the truth according to his judgment there is not a doubt, but may not his mind receive an unintentional bias with the *retainer?* This bias may be produced by the attorney who calls upon him and reports the case from his own standpoint; the medical man forms and gives a hurried opinion, based, perhaps, on partial information. It suits the ideas or the interest of the attorney, who books him as a witness, and when on the stand he finds himself led by subtle questioning to make unguarded statements, which, upon mature reflection and further information, he would wish unsaid. Another medical man is called, who, having made himself

master of the subject, in the interest of truth and justice finds himself in the unpleasant position of being compelled to expose errors of opinion. Hence doctors get the credit of differing where no difference of opinion should exist. But the court and jury, from their want of knowledge of medical subjects, are incapable of judging who is right and who is wrong, and the defendant's barrister does not forget to play upon this difference of opinion. This mode of procedure largely accounts for the character we have obtained.

The motto of the general practitioner, "semper paratus," applies with force to this branch of his profession, for whether he resides in town or country he cannot escape the risk of being suddenly called upon to give evidence. He may argue that a little time will be afforded him to look at his books; but let me assure him that a hurried glance at them, unless he has previously made medical jurisprudence his study, will not protect him from embarassment when in the witness box. The accuracy of his statements may, and probably will, be tested by the strictest cross-examination. Let us suppose him summoned to attend a person laboring under the effects of poison. At the time he has no suspicion of the symptoms; but as the case progresses suspicion is aroused of poison having been given with criminal intent. In spite of treatment, death ensues. Here the functions of the medical man end and those of the medical witness begin. He cannot now avoid giving evidence, nor can he shift the responsibility on another. The law will insist upon his appearance at the coroner's court and at the subsequent trial.

Therefore, knowing that he must attend as a medical witness, he cannot be too particular in his observation of everything that can throw light upon the subject. Circumstances of no interest in a medical or surgical point of view are often of the greatest importance in legal medicine. To enable him to meet questions that must arise during the progress of the examination his observation must not be confined to the recognition and treatment of the case; it should take a wider range and embrace all the surrounding facts and incidences which may, in aid of his memory, be reduced to writing. But to make his notes or memoranda admissible in court they should be taken on the spot and at the time the observations are made, and with accuracy, as they will be subject to the scrutiny of the court.

Before any suspicious circumstances have come to light the witness may be summoned to a person dying from the effects of a wound or poison, who may make a "dying declaration" of the circumstances. This

declaration should be taken in writing on the spot at the time, and in the exact words made use of by the person. It has been thought necessary to prove that the person making the declaration had lost all hope of recovery; but under the difficulty of forming an opinion as to when the feeling of hope completely deserts a man, it is considered sufficient for all purposes—the man being dangerously ill—if he expresses his belief that he is dying. Such declarations are only admissible as evidence in cases of homicide, not in civil cases.

A privilege has been claimed by medical men that they should not divulge statements made to them in confidence by patients. This is recognized in some of the states in the adjoining confederacy. But under the English law this privilege is not acknowledged. The propriety of the English decision may be questioned, inasmuch as the patient, knowing that his confidential statements may be retailed in court, might withhold information necessary for the proper treatment of his disease.

This question of privilege has presented itself in another form. A medical man may be in attendance upon a patient, and from the nature of the symptoms and the absence of any natural cause for the illness, he suspects that poison is being administered. Should he remain silent, or make his suspicions known? While his first and paramount duty is to his patient, he should be very careful not to make so grave a charge upon loose suspicion. Before he acts, he should, without delay, have his suspicions confirmed by the most careful chemical tests on the food and drinks and on the urine and other excreta of the patient. I may observe that all tests should be made in the presence of a witness. If his charge should not be sustained he would render himself liable to prosecution Having discovered the existence of poison in them he should, as Sir Robert Christison advises, communicate his conviction to his patient, or place the matter in the hands of a magistrate.

A medical witness should always avoid giving an opinion as to the cause of death, without a post mortem inspection of the body. Such an opinion, given as it must be on insufficient data, is conjectural and of little value.

A physician may appear before the courts in a two-fold capacity, as an *ordinary witness*, to state the facts within his knowledge, or as a *skilled witness*, to interpret facts,—though both capacities are occasionally so blended that it is difficult to draw the line between them.

An ordinary witness stands in the same position as all others, and is bound, when called upon, to testify before a court of law, to what he sees and what he does. Therefore before entering the witness box he should clearly understand in what capacity he is called. If he gives his opinion on facts placed before him, he then becomes an expert witness.

But his position is quite different when he appears as a *skilled* or *expert* witness. The character and value of his testimony is hereby entirely changed. He should bear in mind that he has no proper concern in the issue of the trial,—that while he may be called by the plaintiff or defendant he is in no wise the witness of either side. Being there, like a faithful microscope to enlarge the field of vision of others and to enlighten the minds of the court and jury upon points requiring his special knowledge, and having no concern whatever in the issue, his brain is being consulted, not his heart.

He is expected to explain the relations of cause and effect in certain facts placed before him by the court—hypothetically, or, possibly, by evidence—which relations require professional explanation, in order that due weight may be given to the facts out of which they arise. The truth of the facts placed before him are not for his consideration. It is therefore necessary that he should possess the greatest amount of proficiency in those matters about which he is called to testify. When giving his opinion, it is the duty of the expert to state the data upon which it is formed; by doing so he places court and jury in a position to judge whether all the facts before him have been taken into consideration. But he should studiously avoid giving a positive opinion upon a debatable theory without explaining that it is debatable. By adhering to recognized facts he will largely prevent controversy. If a doubt exists in his mind it would be better to give the court the benefit of it than place himself in a false position.

As I have already said, a medical witness may stand in a two-fold capacity. As an *ordinary* witness, and as an *expert* witness. The question for consideration is, Is he bound to obey the subpœna? A subpœna being a peremptory command from the sovereign authority to attend before a court cannot be disobeyed with impunity. As an ordinary witness he must obey it. But as an expert witness it has been contended that he need not obey it. Lord Campbell is reported to have said that "A scientific witness was not bound to attend upon being served with a subpœna, and he ought not to be subpœnaed." This dictum has been disputed and I think properly so, as it ignores the fact that the sub-

pœna is a command not to be construed by the expert. It is an order for a personal attendance at the court, and must be obeyed if possible.

Can a *skilled* or *expert* witness refuse to give his evidence without remuneration? Professor Odronaux observes upon this point: "Once put upon the stand as a skilled witness, his obligation to the public ceases, and he stands in the position of any professional man consulted in relation to a subject upon which his opinion is sought. It is evident that the skill and professional experience of a man are so far his individual capital and property that he cannot be compelled to bestow it gratuitously upon any party. Neither the public, any more than a private person, have a right to extort services from him in the line of his profession, without adequate compensation. On the witness stand, precisely as in his office, his opinions may be given or withheld at pleasure, for a skilled witness cannot be compelled to give an opinion, or be committed for contempt if he refuses to do so."

An expert should make his claim for compensation *after* having been sworn, but *before* the opening of the examination *in chief*; it will not avail if delayed until the cross-examination.

In connection with this subject, Maule said: "There is a distinction between the case of a man who sees a fact and is called to prove it in a court of justice, and that of a man who is selected by a party to give his opinion on a matter with which he is peculiarly conversant from the nature and employment of his life. The former is bound, as a matter of public duty, to speak to a fact which happened to have fallen within his knowledge; without such testimony the course of justice must be stopped. The latter is under no such obligation. There is no such necessity for his evidence, and the party who selects him must pay him."

The next question for consideration is the deportment of the medical man in the witness-box.

His demeanor should be that of an educated gentleman, understanding his subject and the responsibility of his position, ever keeping in his mind the fact that he has no concern whatever in the issue of the case.

A barrister, in his zeal for his clients, makes use of all fair means, and sometimes means not quite fair, to destroy the value of testimony that may be adverse to his allegation or theory; consequently the medical witness may expect to have his professional qualifications, his means of knowledge, his experience, the accuracy of his judgment, the time during which he has been in practice, or the grounds of his opinion, closely investigated. He should be on his guard and never allow him-

self to be irritated by such questioning. Better meet any attempt to involve him in contradiction with good humour, and disarm his questioner by shewing that he understands his subject, that his opinion is not given without due consideration, and that his only object is to tell the truth regardless of consequences.

To convince those who listen to him that he is master of his subject, he must make his opinion clear and give satisfactory reasons for that opinion. This can only be accomplished when he understands the subject thoroughly. A man, whether learned or not, whether in court or out, will talk clearly upon a subject he well understands, but unless he is clear in his own mind, his account of it will be confused and unsatisfactory.

I need not say that straightforward answers should invariably be given to all questions. His replies should be made audibly, concisely, without hesitation, and with as *few technicalities as possible*, for counsel, as a rule, are unacquainted with medical terms, and often misapply them. He should also avoid being drawn into argument by counsel.

Categorical replies are often insisted upon by counsel to questions that cannot be properly answered in the affirmative or negative. If, from the mode in which the question is framed, the witness should feel that the simple answer, "yes" or "no," would not convey his meaning, or might mislead the court, he should appeal to the judge to allow him to explain his views more correctly. Few judges will refuse such a request.

Counsel during the examination of a medical witness often refer to the writings of professional men. The authority and passage being quoted, the witness may be asked whether he agrees or differs with the opinion of the author. Before giving his answer, he should examine the book and see that the passage is correctly quoted. While he cannot read from professional books in court, he may refer to them.

A medical witness cannot express opinions upon the opinions of others, nor upon the merits of the case, nor upon the facts that are controverted. He may, and often is, required to express an opinion upon a hypothetical statement of facts.

Now gentlemen, it must be acknowledged that the expert enters the witness-box with the sympathy of the court against him. This position is caused by the divergent opinions often exhibited by men, who, unintentionally—like arbitrators—attach weight to the evidence on the side of the case on which they are retained. It is not claimed that they

intend to speak incorrectly, but the human mind is so constituted that it will receive a bias without knowing it. Hence he should *never* allow himself to be placed in such a position when it can be avoided. Properly speaking, he is not there as a witness, but for the purpose of explaining to the court points within his special knowledge.

Such being the degrading position of the expert witness, does it not imperatively call for a remedy? Justice to the accused in a criminal case demands it. A poor man, though innocent, may be unable to provide such an array of experts as his wealthy accuser. And the judge, who, as a rule, is not versed in medical subjects, is left to guess which of the contending experts is right.

What is the remedy for this state of things? Regarding the *ordinary* witness I have nothing to offer, beyond urging him *never* to appear upon the witness-stand without a thorough knowledge of the subject upon which he is to be examined, and to avoid giving an opinion unless he is summoned as an expert.

Regarding the *expert* witness, the litigant should not have the power of selecting him, and he should ever bear in mind that he is not there to support plaintiff or defendant, but to enlighten the court upon points that come within his special knowledge.

This power cannot be abrogated without legislation. Here a difficulty confronts us. It cannot be obtained without the united action of the entire profession, and let me hope that our body may be a unit upon that demand. Legislators are but human and hard to convince, some are governed by prejudice, some by interest, and others by patriotic motives. We must appeal to their interest. There are hundreds of medical men in each province, and if every one exercises with determination the influence he possesses, it will create a power that could not be ignored.

I would suggest that the power to select an expert witness be taken from the litigant and be placed in the hands of the bench of judges. As judges are not supposed, from their want of knowledge of medical subjects, to be able to make the best selection, I would also suggest that the Medical Council, or the Medical Society, of each province, have the power to nominate twelve persons, from whom five may be appointed by the judges for that purpose, and who shall be paid in criminal cases from the provincial chest, and in civil cases by the losing litigant.

GYNÆCOLOGICAL NOTES FROM PARIS.

By A. Lapthorn Smith, B. A., M. D., M. R. C. S., Montreal, Canada

Apostoli.—As chance would have it, I found myself first at the clinic of Apostoli, who has attained such world wide celebrity by his successful application of electricity to gynæcological therapeutics. Although his office is still at 5 Rue Moliere near the Avenue de l'Opera, he has removed his clinic from its former dingy surroundings in the Rue des Pais to a much larger and more suitable place at 15 Rue Montmartre. Since my last visit here twelve years ago, his views have changed but little. Most of what I wrote in my letters from Paris at that time, is still true. I was greatly interested to see his splendid outfit of instruments and apparatus, and the honest and painstaking manner in which the records of his cases are kept: and I could not but be impressed each time that I visited his magnificent waiting rooms by seeing them filled with the highest class of patients from so many different countries. His method must have some virtue in it to have stood the test of so many years. At his clinic he has three salaried assistants constanly taking histories and giving treatment, so that now he has more than five thousand cases, all carefully, and many of them minutely recorded. His clinic costs him personally over three thousand dollars a year. Although he still uses the constant galvanic current for the symptomatic cure of fibroids and the fine Faradic current for pelvic pain, he has added two other important elements to his installation: One, the static current obtained from a Holtz machine, and the other the Tesla current of very high tension and high frequency. The static is given in the form of showers or sparks, while the Tesla current is applied as the patient is reclining on a sofa or sitting within a solenoid or cage, the current passing all around him. Want of space prevents me from describing these currents more fully, so I must be content with a summary of my observations:

1st. Apostoli does not treat surgical cases with electricity. Each time that I attended his clinic I saw case after case sent to the surgeon, because these cases had either disease of the appendages or cancer of the uterus, neither of which he claims to cure by electricity. He wishes it to be distinctly understood, therefore, that electricity is an ally and not a rival of surgical treatment.

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2nd. If I had any doubt, which I have not, as to the great value of electricity as a diagnostic agent in gynæcology, it would have been dissipated by what I saw at Apostoli's clinic. As the cases were brought before him, the assistants reported that in several of them there was intolerance of even small doses of 40 or 50 milliamperes. Apostoli invited me to investigate them carefully with him, and by the aid of the clinical history and the physical examination I would have suspected diseased appendages in some and cancer in others. With the intolerance of electricity added, Apostoli felt so certain of the diagnosis that he then and there sent them to the surgeon for operation. He was much interested in a case of my own bearing upon the diagnostic value of electricity. A young woman who had been treated by three physicians with electricity for a large fibroid tumor of the uterus, was rendered worse each time. Guided by Apostoli's advice I suspected pus tubes, and on performing laparotomy I found that what was thought to be a fibroid was a collection of four enormous abscesses of the two tubes and ovaries.

3rd. I saw demonstrated the important place occupied by the electrical treatment of ovarian pain, for which, so far, neither medicine nor surgery have proven very effective. And yet no other word than magical would express the offset of the *static* spark on tender ovaries. Cases which could not endure firm pressure on the ovarian region without crying out, declared after two or three minutes of application of the static sparks, that the same pressure caused them no discomfort whatever. Some of these patients were seen for the first time while I was there, and did not leave my sight for a moment, nor was a word spoken to them until the effect was produced; so that they did not know what was being done, nor what was the effect expected. I cannot say how long the relief lasted, but Apostoli assured me that many cases, even including those suffering from ovarian pain after removal of the ovaries, had been completely cured by this treatment, which he tells me, has taken the place of the current from the long fine faradic coil.

Pozzi, with whom I had the pleasure of spending a morning at the Broca Hospital, is one of the most striking figures of the profession in Paris. Like our own Sir William Hingston, he is a Senator and a Knight (of the Legion of Honor), and he is also a full professor of the University. He is a tremendous worker, his book on gynæcology being one of the most complete that has ever appeared. I was always puzzled to know how he managed to find the time to write such a work, and on expressing my curiosity, he told me that he obtained leave of absence

from the University and from the Hospital, and, taking many cases of note books and monographs with him, went to Montpellier, where he shut himself up like a hermit for two years, writing for fifteen hours a day. I saw him do an abdominal hysterectomy, during which, in order to give himself more room to work, he first split open the fundus and enucleated a large hard fibroid by screwing a specially made corkscrew into it. The remainder of the operation was exceedingly simple, because relieved of its load, the uterus was easily lifted out, including the cervix, and the six arteries ligatured individually with catgut, and the peritoneum closed. As far as I could learn, vaginal hysterectomy is gradually being abandoned in France, where it had its greatest stronghold; and Howard Kelly's method of abdominal hysterectomy is gradually taking its place. Pozzi is getting the city council of Paris to build a one hundred thousand dollar operating theatre and laparotomy pavillion. It will be without wood—marble and cement throughout, so that each day it may be washed with a stream of bichloride solution with the hose.

SEGOND is next in seniority to Pozzi, and is about forty-eight years of age. He is a man of great force of character and is making a marked impression on the progress of gynæcology in France. He was a strong advocate of vaginal morcellement of the uterus for pus tubes, fibroid tumors and all conditions in which both tubes and ovaries had to be removed. While visiting America a year ago he performed this operation eleven times before large assemblages of gynæcologists, and he did them so elegantly and quickly that he elicited the admiration of all who saw him operate. But though he came to show American surgeons what could be done with vaginal hysterectomy, they in turn showed him what they could do by the abdominal method, with the result that Segond became converted by those whom he came to convert, and ever since his return he has become so strong in his advocacy of Kelly's method as to carry all before him. They all, however, still remove the cervix, even when there is no suspicion of malignancy, their sole object being to obtain vaginal drainage which they think was the strong point leading to their great success in the vaginal method. In this I think they are mistaken, as it adds very much to the time required for the operation, several whom I saw doing it taking more time to arrest the vaginal hæmorrhage than was required for the ligature of the six arteries and the removal of the tumor. Moreover, I think it important to leave the *healthy* cervix to avoid shortening of the vagina, and there is so little to drain as a rule that it hardly justifies the opening of the vagina. Segond

is a great admirer of everything American, and he told the large staff present that the finest hospital he had ever seen was the Royal Victoria at Montreal, and in his writings, which are very forcible and convincing in their style, he loses no opportunity of praising the skill of American gynæcologists. I saw him doing an abdominal hysterectomy for cancer of the uterus, in which he also removed the upper part of the vagina which was affected; he had great difficulty in stopping the bleeding. He admitted on my inquiring, that his experience with hysterectomy for cancer was very discouraging; so I suppose they have the same difficulty to contend with in France as we have, namely, the cases come to us too late. The above case was at the Salpetriere: the next one was at the Baudeloque, where I saw him remove a papilloma of the ovary, with secondary grafts on the peritoneum, and ascites. After removing the disease he placed a drainage tube and gauze packing, on account of the profuse oozing. He recognized the fact that gauze packing keeps in secretions but does not drain them. The third case I saw Segond doing was at a private hospital kept by the nuns, where he removed one tube and ovary from a young lady; but he admitted that it did not give very satisfactory results as he had often to operate on them again later.

RICHELOT, as far as I could learn, comes next to Segond. I saw him operating at the St. Louis Hospital, the dirtiest looking old barracks, internally, that I have ever seen. As this was probably not his fault, I felt sorry for him. I called upon him at his elegant private house 32 Rue Pauthievre and although he was crowded with patients, he received me most kindly and made an appointment for the next day. Everything during the operation was rigorously aseptic, which of course is the principal thing; but any stranger seeing *only* that hospital would have a very bad opinion of French hospitals. I was glad that it happened to be a vaginal hysterectomy for disease of both appendages, pus tubes, for that is his forte. He performed the operation beautifully, in about the same time as we would take to remove them by the abdomen. They claim here that the uterus should always be removed when both ovaries are taken away. I also saw him perform a Schroeder operation, using a needle on a handle to pass the sutures. He did not, like Martin, of Berlin, pass a preliminary suture on each side to control hæmorrhage. At all the hospitals the feet and legs of the patient are bandaged up in a thick layer of cotton well sterilized, an example worth following as it helps to keep up the bodily temperature. To close the abdomen Segond uses through and through silver wire; Bouilly, through and through silkworm gut and Pozzi three layers, two of buried catgut and one of superficial silkworm gut.

DOYEN is said to be the equal of any, but he did not operate while I was in Paris. BOUILLY operates beautifully at the Cochin hospital. TUFFIER is a rising man. My next letter will be from Berlin.

THE
MARITIME MEDICAL NEWS.

VOL. X. AUGUST, 1898. No. 8.

Editorial.

THE MEETING OF THE MARITIME MEDICAL ASSOCIATION.

The visiting members of the Maritime Medical Association are under very great obligations to the profession of Halifax for their princely hospitality during the session. Halifax has the reputation of being very hospitable to strangers, and it has very many citizens who are not only well able to bestow their courtesies freely and graciously, but also know how to do it in such a way as to cause the recipients a pleasure in accepting them, but it is doubtful if any body of them can equal in this respect the members of its resident medical profession.

The social aspect of a meeting such as the one referred to, is only secondary to the professional, and the occasion is looked forward to as a holiday and a recreation by a number of gentlemen who get but little of either. It was the cause of much gratification, therefore, to the visitors, to find that the work of the committee who had charge of the arrangements was so successfully accomplished in every respect.

The sail on the magnificent harbour and up the Basin was delightful; the visit to the imposing battleship "Renown," a feature of great interest at any time, but rendered still more gratifying by the marked courtesies and attention of the officers on board, will be a pleasant memory for many a year; while we have no doubt that if several of the visitors were asked in what way they thought an afternoon should be spent so as to obtain the greatest amount of physical, mental and spiritual benefit, they would unhesitatingly answer—by a visit to the Studley Quoit Club grounds.

The dinner in the evening at the Hotel Florence, picturesquely situated near the head of the Basin, was a fitting windup to one of the most successful meetings the Association has ever held. The occasion

was graced by the presence of Dr. Russell M. P., Attorney-General Longley and several other eminent laymen who contributed by their happy speeches very much to the success of the function. It is only fitting that the Halifax profession should know how thoroughly their kindness and attention have been appreciated and how sincerely their visitors and guests wish them every personal and private success, as well as every civic and commercial prosperity to their beautiful and interesting city.

St. John, N. B. J. W. D.

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THE ANNUAL MEETING OF THE MARITIME MEDICAL ASSOCIATION.

In point of attendance, the eighth annual meeting was the most successful in the history of the association; the papers were excellent and led to entertaining and instructive discussions: the social part is the subject of an appreciative editorial in this issue by one of the St. John members of our staff.

The meeting was called to order by the president, Dr. D. A. Campbell, at 10.30 a. m. on Wednesday, July 6th. The president invited to platform seats Dr. Wm. Bayard, of St. John; Hon. Dr. Parker, of Halifax; and Dr. J. W. Daniel, of St. John—past presidents of the association; also Dr. G. E. Armstrong, of Montreal, and Dr. E. W. Cushing, of Boston.

After reading and confirmation of minutes of previous meeting, the secretary read letters of regret from several gentlemen who were unable to attend.

The president appointed the nominating committee as follows: Drs. M. MacLaren (St. John), W. H. Hattie (Halifax), Jas. Macleod (Charlottetown), R. MacNeill (Stanley, P. E. I.), G. A. B. Addy (St. John), E. Farrell (Halifax), T. D. Walker (St. John), Campbell (Northam, P. E. I.), and N. F. Cunningham, (Dartmouth).

The president then delivered his address, which appears elsewhere in this issue. On motion of Drs. Bayard and Daniel, a vote of thanks was tendered the president for his excellent address.

Papers were then read as follows:—By Dr. J. W. Daniel, of St. John, "Rupture of Vagina during Parturition;" by Dr. E. W. Cushing, of Boston, "Injuries resulting from Instrumental Delivery;" by Dr. W. S. Muir, of Truro, "Interesting notes on Midwifery Cases;" by Dr. M.

Chisholm, of Halifax, "Extra-uterine Pregnancy, with reports of Cases;" These papers, and all others read at the meeting, will appear in future issues. Each paper was of a high order and was well received and discussed.

The afternoon session was called to order at 2.45 p. m.

Dr. Kirkpatrick, of Halifax, presented two cataract cases, one a little girl of eight years of age born with partial cataract and the other a lady of forty years who had been blind with cataract since the age of two. Rapid absorption followed the discission operations performed on the little girl's eyes and good vision resulted. The lady who had been practically blind from birth has vision enough to enable her to go about alone and even to read large type. When performing the operation on the second eye of the little girl, the lens escaped into the anterior chamber; it was allowed to remain without producing the slightest irritation. Most authorities recommend immediate extraction of the cataract when such an accident happens, as severe inflammatory reaction is likely to happen. Free use of atropia was sufficient to prevent any further operative work necessary.

The secretary read a communication from the superintendent of the Victoria General Hospital inviting members to visit the hospital.

Dr. Bayard, of St. John, read a paper entitled, "Medical Evidence before the Law Courts," which appears elsewhere in this issue. A vote of thanks was extended to Dr. Bayard, upon motion of Drs. John Stewart and A. P. Reid.

Dr. Stewart referred to the long experience of Dr. Bayard who was thus particularly qualified to discuss the subject.

Dr. Reid spoke of the necessity for united action. He alluded to the manner in which the jury in the Buchanan case dealt with expert evidence. An important matter like this he considered ought to be brought to the attention of the local and Dominion parliaments.

Papers were also read by Dr. C. D. Murray, of Halifax, upon "A Fatal Case of Bradycardia occurring in a Young Man;" by Dr. W. D. Finn, of Halifax, upon "The Pathology and Treatment of Tetanus, with report of Two Cases:" by J. F. Macdonald, of Hopewell, on "Treatment of Acute Inflammatory Diseases of the Throat by the Hypodermatic Injections of Atropia." A discussion followed the reading of each paper.

Dr. C. D. Murray in discussing Dr. Finn's paper referred to the case of tetanus which had been sent to the V. G. Hospital by Dr. Finn.

Practically the same treatment had been carried out—chloral and the antitoxin serum of tetanus, recovery taking place.

Dr. Murray MacLaren alluded to an epidemic of tetanus neonatorum which was reported in the *British Medical Journal* about two years ago.

Dr. W. S. Muir stated that he had had four cases of tetanus in his practice, all mild, and all recovered under bromide and chloral.

Dr. G. E. Armstrong said there was tetanus and tetanus. In some cases the antitoxin serum is useless, particularly so in the very severe cases following external injury. A recent article urged the necessity of using the antitoxin as soon as the injury is received. This will be carried out in future in the Montreal General Hospital.

The members of the association were then driven to the grounds of the Studley Quoit Club, and enjoyed the hospitality of that historic organization. While there a very excellent group photo was taken by Notman.

The evening session was opened by the discussion on "Empyema."

Dr. Murray MacLaren was the first speaker and began his remarks by referring to the unavoidable absence of Dr. McLeod, of Charlottetown, which he regretted very much, as Dr. McLeod was to open the discussion.

Cases of empyema are often found to be tubercular, even though the accumulation of pus may be the first symptom. It was frequently associated with unresolved pneumonia. It was also sometimes seen with acute bronchitis, when the temperature will persist for a long time though the cough and expectoration may be diminished. A rarer cause is appendicitis, the pus spreading upwards. Empyema does not tend to spontaneous recovery. The removal of pus is imperative. It is wise to aspirate for diagnostic purposes Repeated aspirations are not often a successful treatment. The necessity of early incision and free drainage is important. Empyema often proceeds slowly and one feels like delaying but operation should be performed early. The site of incision varies —the sixth interspace in median line, or seventh or eighth more posteriorly, or where the pus points. A lower incision does not necessarily give better drainage and a higher incision affords more safety against injury to the diaphragm. He would excise a rib to ensure drainage. With care injury to the intercostal artery can be avoided. Washing out the pleural cavity is not now often pursued, and he has never done it himself. Fatal results have followed this procedure. Hemiplegia (Dennis says from shock) has followed washing out the cavity. The drains should be large. It is better to use two rubber tubes through a shield of

rubber tissue. When the lung does not fill the pleural cavity, portions of several ribs should be removed.

Dr. John Stewart in following, said that much depends on the variety of the organism present, whether it be the pneumococcus, streptococcus, staphylococcus, etc. In the diagnosis of empyema the layer of pus may be thin and be missed by the needle. The needle may puncture the lung itself and death has resulted from this cause. In referring to the treatment, Dr. Stewart said that few cases were cured by tapping and these were probably localized. Bulau's method by the continuous syphon drainage into an antiseptic reservoir was spoken of. For some cases it is useful, though not generally reliable. The best treatment is to remove part of rib so as to give plenty of room for drainage. He had done irrigation in two cases, one where the pus was fetid and considerable sloughing of the pleura took place and the patient recovered. Irrigation, however, is seldom required. The fluid used should be warm. The pressure used should be very little at first and gradually raised if thought necessary.

Dr. J. W. Daniel referring to empyema in children said it was frequently cured by simple incision and letting out the fluid. But if there is tubercular or streptococcic infection, then irrigation and constant drainage, with removal of a portion of rib may be required.

Dr. G. E. Armstrong said that aspiration was sometimes successful especially in pneumonic cases. If the case is tubercular, drainage is nearly always required, and excision of a rib is generally advisable. He was much pleased with the posterior incision. Of course the muscles here are thick and the operation bloody, but drainage is excellent. He thinks there is no advantage in low incisions, but get as nearly as possible over the centre of the empyema. He never washes, but wipes out the cavity gently with dry gauze and long forceps. When lung does not expand sometimes excision of a rib is enough, though at times many ribs should be removed. Next time he intends trying the suggestion of a French surgeon who incises the pleura.

Dr. A. S. Kendall said that in very young children empyema is commoner than is supposed, often following pneumonia. Nearly all pleuritic effusions in children end in empyema. Examine under chloroform and if necessary use a hypodermic syringe. To diagnose empyema from abscess of lung you will find in the latter symptoms of distress more marked. The expectoration of empyema is not often purulent while in abscess it is noticed to grow steadily more and more purulent.

Occasionally a flat note is replaced by a tympanitic note in empyema on account of the fluid forming a "solid" layer over a distended viscus.

Papers were read by Dr. G. E. Armstrong, of Montreal, on "Operative Treatment of Cancer of the Tongue," and by Dr. E. W. Cushing, of Boston, on "Hysterectomy." Each paper elicited discussion, and a vote of thanks was tendered to the author of each.

Papers were also read by Dr. Murray MacLaren, of St. John, on "Subcutaneous Fibrous Tumours" (illustrated by an immense specimen removed from the anterior abdominal wall), by W. B. Moore, of Kentville, on "A Peculiar Case of Gunshot Injury," by Dr. E. Farrell, of Halifax, on "Trephining for Epilepsy, with Report of a Case." Each paper was fully discussed.

Thursday morning's session was called to order at 9.30 o'clock, the president in the chair. The nominating committee brought in their report which, on motion, was received. The following officers were elected by ballot:—

President:—Dr. R. MacNeill, Stanley, P. E. I.

Vice-Presidents:—Dr. G. A. B. Addy, St. John, N. B.
Dr. W. B. Moore, Kentville, N. S.
Dr. S. R. Jenkins, Charlottetown, P. E. I.

Secretary:—Dr. Geo. M. Campbell, Halifax, N. S.

Treasurer:—Dr. T. D. Walker, St. John, N. B.

Committee on Arrangements:—Drs. Conroy, MacLeod, H. D. Johnson, Warburton and F. Kelly.

(To be concluded in our next issue.)

Matters Personal and Impersonal.

The July number of the *Canadian Journal of Medicine and Surgery* contains an illustrated report of the proceedings of the meeting of Ontario Medical Association, and a special greeting, including a three colored supplement introducing the Union Jack and Old Glory, and a poem of welcome by Dr. E. H. Stafford, to the International Association of Railroad Surgeons. The number is a highly creditable production.

The American Electro-therapeutic Association meets at Buffalo, N. Y., on September 13th, 14th and 15th. A very attractive programme is offered. All information will be furnished by the Secretary, Dr. John Gerin, 68 North Street, Auburn, N. Y.

The partnership hitherto existing between Presley Blakiston and Kenneth M. Blakiston, under the firm name of P. Blakiston, Son & Co., expired June 30, 1898, on account of the death of the senior member.

The business of publishing, importing, and dealing in medical and scientific books, as established in 1843, will be continued by Kenneth M. Blakiston, trading as P. Blakiston's Son & Co.

The July (1898) number of the *Alienist and Neurologist* contains: "Hysteria in Children," by Dr. L. Bruns; "Melancholia of Leprosy," by Albert S. Ashmead, M. D., New York; "Progress in Neurology," by Prof. C. H. Hughes, M. D., St. Louis; "Degeneracy Stigmata as Basis of Morbid Suspicion. A Study of Byron and Sir Walter Scott," by Jas. G. Kiernan, M. D., Chicago; "The Sanitary Salvage of Our Soldiers in Cuba," by Maj. Chas. H. Hughes; "Medical Service and Medical Fees; The Business Side of the Practice of Medicine," by Prof. C. H. Hughes, M. D.; besides the usual Selections, Editorials, Reviews, Book Notices, etc.

The Lambert Pharmacal Co., of St. Louis, have issued a neat little booklet on the treatment of Choleraic Diarrhœa. It includes several papers by eminent authorities, and contains a lot of very valuable information. Although in our favoured climate we are practically exempt from the summer diarrhœas which are so prevalent in warmer latitudes, we nevertheless have quite a sufficient experience to necessitate careful attention to the subject, and this little publication will be helpful to all who peruse it. It may be had *gratis* upon application to the publishers.

We are obliged to leave over, for our next issue, reports of the proceedings of the New Brunswick Medical Society, of the Medical Society of Nova Scotia, and of the St. John Medical Society.

ABBEY'S EFFERVESCENT SALT.

A pleasant effervescing aperient, taking the place of nauseating mineral waters.

Recognized and prescribed by eminent members of the profession in Great Britain, Europe and Canada.

Obituary.

Dr W. B. Slayter.—It is with very great regret that we chronicle the death of one of Halifax's most successful and most beloved physicians, Dr. W. B. Slayter, at the early age of 57 years. Although he had not been in his usual health for several years, he was able to look after his practice until six months ago, when he found the strain too great and he was obliged to retire from active life.

Dr. W. B. SLAYTER.

Dr. Slayter had the benefit of a liberal education. He held the M. D. degree of Trinity, of Rush, and of the University of Halifax, and was M. R. C. S., Eng., L. R. C. P., Lond., and F. O. S., Dublin. He served a term as house surgeon at Westminster Hospital, London, and afterwards was assistant to Forbes Winslow, the eminent English alienist. Later, while travelling with a wealthy British army officer who was the subject of circular insanity, he decided upon Chicago as a suitable place for location, and began practice there when he was freed of his charge. There he became assistant to Brainard on the surgical staff of Rush Medical College, and was successful in developing an excellent practice. In a few years, however, the death of his brother, Dr. John Slayter, the hero of the cholera epidemic of 1866, occurred, and at the urgent desire of his family the subject of our sketch returned to Halifax, and has ever since been intimately associated with the medical life of this city. He was

one of the original staff of the Halifax Medical College, and of the original staff of the Provincial and City (now Victoria General) Hospital.

Dr. Slayter always enjoyed a large and lucrative practice. His kindly and genial manner and generous disposition gained for him a host of friends, and his musical talents, which were of a high order, won him a still larger circle of admirers, He was a valued member of the Orpheus Club, and that organization attended his funeral in a body and aided in the beautiful and impressive burial service of the Church of England. He was buried from St. Luke's cathedral, the service being conducted by the Lord Bishop and the Rev. Mr. Crawford.

Dr. W. E. JENKINS.—The many friends of Dr. Wm. E. Jenkins, of Lunenburg, were shocked to hear of his unexpected death which occurred on the evening of July 4th. On the 25th of May he was attacked with tonsillitis followed by acute glossitis, remaining in this condition for about three weeks. He had hardly begun to recover when acute bronchitis supervened, the period of illness lasting about seven weeks. He, however, seemed to improve and he was removed to his father's residence at Conquerall Bank, on Sunday, July 3rd. The following day a sudden change for the worse took place and he died that evening from heart failure evidently from some obscure cause.

Dr. Jenkins was a young man of 36 years of age, graduated from McGill in 1890, and practised his profession with much success. His kindness of heart and genial manner won for him scores of friends who will mourn his demise with deep regret.

Dr. C. A. BLACK.—The report which spread through Amherst on the morning of the 10th of July that Dr. C. A. Black had suddenly died seemed to paralyze the whole community, as he had been in excellent health the previous night. During the morning he experienced severe pains in the region of his heart and thinking it due to indigestion, took a suitable dose to relieve that condition. He then lay down and in a few moments, without any struggle, turned over and expired. Dr. Black graduated from the University of Pennsylvania in 1867 and always practised his profession in Amherst and succeeded in working up a very large practice. He was a man of undoubted ability and was widely known, not only for his medical attainments, but on account of the deep interest he took in temperance and the public welfare.

Therapeutic Suggestions.

THE TREATMENT OF EXOPHTHALMIC GOITRE BY SECTION OF THE SYMPATHETIC NERVE.—By DR. JABOULAY (*Press. Med.*, No. 14, p. 81).

Up to the present time the author has treated eleven cases of Basedow's disease by section of the sympathetic nerve. His last case is described. The patient was a woman, thirty-seven years of age, cachectic, lower limbs œdematous; tachycardia was 160, neck 35 cm. Considerable exophthalmos. After section of the sympathetic, which consisted in the ablation of the superior cervical ganglion, the pulse fell to 100, then to 90; the neck diminished in size by 2 cm.; the exophthalmos disappeared. On the day following the operation the morning temperature was 40° C. (104° F.), the evening 38.5° C. (101.3° F.), falling still lower the next day. The stitches were removed on the third day and the patient appeared to be cured, when she began to cough and expectorate. She became more cachectic, and died on the tenth day. Nothing was found to explain the death except congestion at the base of the right lung. This congestion appeared to be accidental, and related in no way to the section of the nerve; for had it been due to vaso-motor trouble, the other lung would have been involved. The following high temperature was accounted for by the fact that the nurse thought that the goitre itself was to be operated on, and hence scrubbed it vigorously, in this way inducing absorption of the thyroid substance. The author is convinced that artificial paralysis of the cervical sympathetic is the treatment of choice in exophthalmic goitre, especially in the non-goitrous forms.—*Post-Graduate.*

TRIGEMINAL NEURALGIA.—At the meeting of the Union for Internal Medicine in Berlin, Franck *(Med. News)* presented two women whom he had cured of trigeminal neuralgia by injections of a watery solution of osmic acid, 1 to 1.5 per cent. Sometimes a single injection suffices; but if the nerve is not found by the first injection, it is necessary to repeat the attempt. The injection itself is painful, but it is followed by anæsthesia in the region of distribution of the nerve. Eulenberg endorsed this statement, cautioning the members always to have a freshly prepared solution on account of the readiness with which osmic acid decomposed.

NOSE BLEED.—The injection of a glass syringeful of lemon juice into the nose, after it has been cleansed of clots, will stop bleeding after everything else has failed.—*Med. Summary.*

NEW PATHOLOGY AND TREATMENT OF EXOPHTHALMIC GOITRE—Dr. Ch. Abadie, in *Presse medicale*, states that the disease is due to permanent excitation of the vaso-dilators of the cervical sympathetic nerve, and not to the hypertrophy of the thyroid gland, which is only secondary, and a symptom rather than a cause.

The dilatation of the retrobulbar vessels produces the protrusion of the eye-balls; irritation of the cardiac fibers results in tachycardia. The production of the broken forms is explained by the variability of localization and intensity of excitation. He recommends section of the sympathetic nerve, which has already proven to be of great value in several cases.

When the symptom of exophthalmos is greater than the thyroid hypertrophy, section of the nerve should be between the middle and superior cervical ganglia; when the goitre is the pronounced symptom, section should be below the middle ganglion; then when only tachycardia is extreme it is necessary to descend still lower and cut the efferent fibers of the inferior ganglion. Ablation and total extirpation (Jonnesco) presents some difficulties and seems to possess no advantage over simple section.—*Med. Council.*

TREATMENT OF THE INSOMNIA OF NEURASTHENIA.—First sponge off the patient with cool water; then quickly wrap him in a blanket which has been wrung out of hot water. Outside of this place a dry blanket, and about this hot bottles. In a few minutes the patient breaks out into a profuse sweat; when this has continued five or ten minutes, place the patient between warm blankets and rub him off with a towel and permit him then to go to sleep.—D'AULNAY.

TREATMENT OF COUGH IN PHTHISIS.—The following prescription is given by the *Journal de Medicine de Paris* of January 23, 1898.

℞—Fluid extract of hydrastis Canadensis, } of each 6 drachms.
Fluid extract of ergot..... }

Four or five times a day, after food, administer 30 to 40 drops of this solution in a little water.

It is asserted that Hydrastis Canadensis promptly checks the cough and that the muco-purulent expectoration is markedly diminished.—*Ther. Gazette.*

HEPATIC COLIC.—M. Fagio (*Progrès médical*, May 21st), recommends the following mixture:

℞ Chloroform water ..... 3 ounces.
Neutral glycerin } of each ..... 5 drachms.
Orange-flower water }

To be taken in three divided doses in the space of from two to three hours.—*N. Y. Med. Jour.*

ACUTE RHEUMATISM.—Strontium salicylate is less irritating to the stomach than the sodium salt, and it does not produce salicylism. Order it in powder form to be dissolved in hot water.—ESHNER.

CHELIDONIUM MAJUS IN CANCER.—M. Legrand (*Presse médicale*, May 28th), communicated to the *Société de therapeutique* of Paris, a case of cancer completely checked by the local application of extract of chelidonium majus after Denisensko's method.—*N. Y. Med. Jour.*

ICHTHYOL IN TUBERCULOSIS.—Fraenkel extends the use of ichthyol in tuberculosis, having employed the remedy in some thirty cases. In incipient stages the cough disappears in a few days. If the lesions are more extensive it may continue for some weeks or even months. Expectoration becomes more liquid and less abundant. All the symptoms are much improved. Twenty to forty drops of a mixture of equal parts of ichthyol and water should be taken four times daily. A little peppermint may be added to disguise the taste. In spite of its disagreeable odor and taste, the remedy produces no unpleasant gastric symptoms.—*Medical News.*

AMYLOLYTIC FERMENTS.—In an article on this important subject by Wyatt Wingrave, M. R. C. S. England, (Assistant Surgeon to the Central London Throat and Ear Hospital), in the London *Lancet*, May 7th, 1898, we are informed of a personal necessity that arose in the writer's experience for a reliable starch digestant. A crucial comparative examination was therefore made of many malt extracts and of taka-diastase, the tests being conducted both chemically and clinically.

He summarizes briefly. 1. That taka-diastase is the most powerful of the starch or diastatic ferments and the most reliable since it is more rapid in its action—*i. e.*, "it will convert a larger amount (of starch) in a given time than will any other amylolytic ferment." 2. That taka-diastase seems to be less retarded in its digestive action by the presence of the organic acids (butyric, lactic, acetic), and also by tea, coffee and alcohol, than are saliva and the

malt extracts. This is an important point in pyrosis. 3. That all mineral acids, hydrochloric, etc., quickly stop and permanently destroy all diastatic quantities. 4. That taka-diastase and malt diastase have, like ptyalin, no action upon cellulose (uncooked starch). All starch food should therefore be cooked to permit of starch ferment assisting Nature in this function.

SANMETTO IN GENITO-URINARY DISEASES.—I have used sanmetto in my practice for the last five years, and find it has no equal in diseases of the prostatic portion of the urethra, in pre-senility, in that peculiar condition existing in anæmic and chlorotic girls just entering womanhood, and all abnormal conditions of the reproductive organs, in either sex, depending on a debilitated condition of the general system. Sanmetto has never failed me in senile prostatitis, or enlargement of the prostate gland in aged men.

Durand, Mich. J. L. SMITH, M. D.

THE PROMPT SOLUTION OF TABLETS.—We are glad to know that the Antikamnia people take the precaution to state that when a prompt effect is desired the antikamnia tablets should be crushed. It so frequently happens that certain unfavorable influences in the stomach may prevent the prompt solution of tablets that this suggestion is well worth heeding. Antikamnia itself is tasteless, and the crushed tablet can be placed on the tongue and washed down with a swallow of water. Proprietors of other tablets would have had better success if they had given more thought to this question of prompt solubility. Antikamnia and its combination in tablet form are great favorites of ours, not because of their convenience alone, but also because of their therapeutic effects. —*The Journal of Practical Medicine.*

In this issue Messrs. Simson Bros. & Co., call attention to the merits of their Syrup Phos. Co. The reliable goods put out by this firm are becoming well known and appreciated, and this season they are having an immense sale for their own preparations.

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