

The Canada Lancet

VOL. XLIX.

TORONTO, MARCH, 1916

No. 7

EDITORIAL

ARMY MEDICAL MATTERS.

The following article in the *New York Medical Journal*, of recent date, sums up a number of important matters in the medical affairs of the European armies that we give it hear:—

“Colonel Hausen, surgeon in chief of the Swiss army, in a recent important address before the Central Medical Society of Switzerland, put forth his observations made in many visits paid by him in recent months to the French and German military hospitals.

“A well known fact is that for some months at the beginning of the war emphysematous gangrene and tetanus were prevalent, but these infections are much less common now. Prophylactic vaccination for tetanus done as soon as possible after receipt of the wound, has given excellent results. The decrease in cases of emphysematous gangrene has been favored by prompt and complete disinfection of the wound, and in many cases by a rapid transportation of the wounded to the rear. In the treatment of gangrene antisepsis has brilliantly affirmed its superiority over asepsis and, generally speaking it may be that in war surgery antisepsis plays a greater part than in times of peace.

“Epidemic cerebrospinal meningitis has occurred sporadically from time to time, but radical general hygiene measures have easily kept the disease under control. The value of the therapeutic use of serum cannot be estimated with certainty as yet, but in the French army the results have been most happy. Smallpox has been observed, but it is mild in degree and the number of cases is small, thanks to vaccination.

“Typhoid, dysentery, and cholera have appeared epidemically at certain points. The former has been met with in all the armies, even in the Swiss, and the same may be said of dysentery; the majority of cases do not result from ameba, but from infection from Shiga's bacillus. Cholera has appeared only in the oriental theatre of the war. Antityphoid vaccination has been resorted to in the English, French, and German armies and apparently the results have been good, and

although the morbidity has not been greatly diminished, it has certainly been otherwise with the mortality. Besides, it seems that this vaccination produces a much milder run of the disease and does away with serious secondary complications, but as yet we have no precise data as to the duration of the immunity conferred.

"As to cholera, prophylactic vaccination appears to give more positive results than in typhoid, and in the treatment employed on the German eastern front good results have been obtained by the simultaneous use of *bolus alba* and atropine. However, for these three diseases hygienic measures are the most important, both before and after.

"Typhus fever has caused great ravages at the eastern front, particularly in Serbia. The only means of efficaciously combating the affection is by destruction of *pediculus vestimenti* by careful cleansing of the body, and disinfection by steam of all objects that are not harmed by it, while for those which are perishable, dry sterilization is used. It is most important to have plenty of clean underwear and frequent facilities for bathing. In the Swiss army sulphur vapors have been found quite efficient in the treatment of scabies and pediculi. Venereal disease is best handled through an extremely severe police control.

"Mental affections have not been as prevalent as had been feared early in the war. Patients afflicted with psychoses should be placed in insane establishments as soon as possible, and so far, this has been accomplished satisfactorily. On the other hand, nervous affections, hysteria, neurasthenia, and other neuroses may well be cared for in sanitary establishments of the army. Their number is considerable."

RELATIONSHIP OF TUBERCULOSIS TO OTHER DISEASES.

The Medical Record in its issue of 1st January had the following: The points made are highly important and interesting; and, we think, should receive careful thought and attention at the hands of the medical profession.

"Apart from the fact of the inherent virulence of the tubercle bacillus, its almost universal distribution among the human races, and its tendency to cause an hereditary predisposition, although it is not itself thus transmitted, there are a number of disease entities which seem to prepare the system for the easier invasion. Or, it may be that the tubercle bacillus flourishes better in symbiotic relation with the bacterial agents causing the other morbid conditions. While the campaign of education in respect to the prophylactic measures necessary in the eradication of foci of infection has been of great value, the advances in epidemiological knowledge and control has perhaps been of even

greater value. And yet the morbidity tables from such diseases as measles, whooping cough, and influenza, diseases eminently predisposing to the development of tuberculosis, are still large despite the ever-increasing efficiency and vigilance of the health authorities. Indeed, so much of the tuberculosis incidence has its origin directly in one of these diseases that a large part of the campaign against tuberculosis can with profit be launched in this direction. The public is very gradually being weaned from the superstition that every child must contract measles, that the sooner over with the better, and that healthy children should be exposed to the disease on the first opportunity. Some physicians even, while not flat-footedly approving this notion, do not interpose very serious objection to it. They realize, indeed, the dangers to life from complicating bronchopneumonia though oblivious to the larger, though not so immediate, danger from tuberculosis.

“That the recent epidemic waves of influenza have played a very pertinent part in keeping the tuberculous population still rather high is universally conceded by the medical profession although the laity do not yet seem to understand even the inherent gravity of this disease. Many fulminant types of tuberculosis are, nevertheless, traceable to this disease. Until the public learns the true significance of the disease the quarantine regulations must be perhaps more strict than for other quarantinable diseases. Of the non-specific conditions figuring in the development of tuberculosis may be mentioned tonsillar disease. Because of the wide distribution of gland tuberculosis its benign nature has often received comment. It was even the belief at one time that gland tuberculosis immunized against further infection. Certainly, its wide distribution and its amenability to cure well illustrate Virchow's contention that there is no one who does not at one time or other have a tuberculous infection, but that most individuals easily overcome it. He found cured tuberculous nodules in the lungs of nearly all bodies coming to autopsy for other than this disease. Infection with tuberculosis alone seems to be self-limiting. But in conjunction with other bacterial agents the tubercle bacillus assumes an extreme virulence.

“Diabetic patients and those with cirrhosis of the liver seem to have an especial predisposition to infection with tubercle bacilli. In both instances the complicating tuberculosis appears late in life, and though ordinarily later-life tuberculosis is of slower course and more benign in nature, it is here particularly fulminant. This proneness to tuberculosis existing in cirrhosis of the liver illustrates the erroneous impression long existing that alcoholic indulgence of a high degree—which so often is the cause of the cirrhotic condition—will cure tuber-

culosis. On the contrary, alcohol is a direct as well as an indirect predisposing factor in this disease.

MOBILIZATION OF DOCTORS IN BRITAIN.

From the journals and newspapers of Great Britain, we learn much of the needs of the hour. Among other subjects calling for attention is the medical care of the sick and wounded soldier and sailor.

With the growing numbers of wounded from the front as Britain's army expands and the spheres of operations increase, this country is faced with a dearth of doctors, and the strain on the medical men left to look after the civilian population is becoming heavier every day.

Seeing that the needs of the army must be attended to first, this strain is bound to increase, and a movement is now on foot to get Lord Derby to assume the organization of the civilian medical service so as to free more doctors for the army by promoting greater efficiency and better organization at home.

The scheme, which is supported by a great many leading men in the medical world who see that much energy is wasted by its being directed into wrong channels, is to divide the entire medical strength of the country into groups somewhat on the lines of Lord Derby's system of recruiting. It is proposed to divide the doctors into the following three groups, according to age and physical fitness:

A—For service with the army and navy abroad.

B—For service with the army at home.

C—For civilian and public health, asylum and prison duties.

In group A it is proposed to place all those under 35 years of age, who are physically fit for service with the army in the field; in group B all those under 50 years of age, and in group C the remainder of the medical profession, including women doctors.

The strength of the medical profession in the British Isles is known. There are about 30,000 medical men on the register all told, and these 30,000 include the men who have retired from active practice. On them has fallen the responsibility of serving the sick and wounded from armies now to be raised to 4,000,000 men, and at the same time of providing for the needs of the civilian population on the British Isles of about 40,000,000 souls.

At least one-half of the entire body of the medical profession has now been called for service with the army and navy. The strain on the half left to look after the civilians has been carried to the limit,

and it is recognized that the only way in which further relief can be obtained for either service is by improved organization in the use of the men available.

Officers of the R. A. M. C.—all officers of the Royal Army Medical Corps are fully qualified medical practitioners—state that there is much waste in men and want of skill and consequent loss of life and limb. The following is a characteristic example: A young Harlem Street specialist, one of the leading men in London, volunteered for military service. He was sent to the front and found himself employed in ticking names off a list of wounded. Meanwhile operations demanding the highest expert knowledge and experience were being performed by men who were beginners at the work, and who knew very little about expert surgery.

The superintendent of one of the large London hospitals put the case as follows: "The mistake has been to rush off all the doctors to the base hospitals, distributing them on the old system of a unit to each regiment, and depleting the service at the place where it needed to be strongest, namely, at home. A specialist who joins the Royal Army Medical Corps is no longer regarded as a specialist; he is just a 'qualified man.' He may be an eminent pathologist, or an aural, expert, or an authority in any other branch of medical science, but to the War Office he is just an army doctor.

Here we can see defects that can and should be remedied. Every doctor or surgeon who goes to the front should be given duties to perform for which he is best fitted. By this arrangement, the soldiers would receive the best sort of attendance; and his chances of recovery would be enhanced.

THE IRREGULARS.

Under this heading we group all who practise, or wish to practise, medicine, without taking a proper course of study. The most experienced physicians and surgeons are ready to admit that, notwithstanding their long training at college, and then extensive opportunities afterwards, they are constantly meeting with cases that tax them to the utmost, both in diagnosis and treatment. That those who have only a few months' training, or none at all, must fail in most cases is quite apparent on the face of things. No amount of after experience can make up for a college course of three to six months.

The public was treated a few days ago to a most remarkable exhibition of sophistry when the Christian Scientists appeared before Mr. Justice Hodgins. They were represented by Mr. I. F. Hellmuth, a

lawyer of high standing. Mr. Hellmuth is reported as having said: "What Christian Science deals with is suffering and disease of a spiritual nature; it in no way deals with it in a physical or mental nature." Now, to the medical man this does seem monstrous nonsense. He further said of these people: "In reality we do not practise either medicine or surgery." In reply to questions by the commissioner it came out that these people claim divine power to heal and the divine understanding so that a person can put themselves in communion with the Almighty and that He will do for them what Christ did for the sick. But this leads at once to a *reductio ad absurdum*. The person needing treatment may be unconscious, or insane, or too young to understand. It would not be possible for such persons to put themselves in accord with the scientist who offers to treat him. Under these circumstances the Christian Scientist would be working direct miracles. But all disease with them is only "a delusion of mortal." They admitted that they charge for their prayers; and it does not require much of a college course to learn a few prayers. It came from the lips of a Christian present that before any one can practise Christian Science he must furnish affidavits showing that he has cured three cases. *Mirabile dictu!* Number one is a case of mild chicken-pox, number two is a trifling bruise of finger, and number three is headache from too heavy a dinner! These are *cured* and forthcome the affidavits, and the board of the church says well done, you are entitled to practise! They are seeking that this sort of thing may continue.

Then we turn from this humbug on science, and travesty on religion, to chiropraxy. Here we meet with a vile and spurious form of treatment that claims that all ailments can be righted by twisting, pulling, manipulating the spine. Any law that would permit this sort of thing to be let loose on the community, should be resisted by every known means. Here is a case of bronchitis, give the spine a twist; there is a case of pleurisy, give the spine a twist; yonder a case of tonsillitis, give the spine a twist; now a case of synovitis, give the spine a twist; and, once more, a case of appendicitis, just give the spine a twist. This sort of abomination, too, is seeking legal recognition. Eye diseases, ear disorders, mental distortions, broken bones, tumors everywhere and of any kind, all yield to the modern wonder who knows how to administer to the spine the proper sort of a twist!

Then the osteopath and the optometrist come along. These practitioners can work wonders, too. They, by marvellous genius, can learn in a few weeks how to diagnose and treat the most obscure conditions. They have no need for drugs. All the researches of chemistry go for naught! What use have they got for morphine, or quinine, or mer-

cury? Pain, and ague, and syphilis will disappear under the rubbing of the osteopath, as did scrofula long ago under the king's touch, even though he was a wicked king.

Members of the medical profession cannot afford to take any chances. They have to deal with persistent and subtle opponents. The medical practitioners of the Province of Ontario must be up and doing. He must stand for one portal of entry for all. Be he optometrist, osteopath, chiropractor, or Christian scientist, if he wishes to treat diseases or injuries, whether free or for a fee, he must first take such a course of medical study as would secure for him the license of the Province. The people are entitled to this protection against those who would seek to give them advice in the hour of sickness.

Every medical practitioner can do his bit. He can take the whole subject up with his member, and quietly and fully explain the whole case.

By this course much good can be done, error can be brushed away and the true conception of medical practice given its rightful place.

ONTARIO MEDICAL ASSOCIATION.

The programme for the Annual Meeting of the Ontario Medical Association, which takes place at Toronto, May 30th to June 2nd, is well in hand, and although some details have still to be completed, we are able to give a provisional outline of the discussions and papers which have been arranged.

The address in Medicine will be given by Dr. Elliott P. Joslin, of Boston, on the Treatment of Diabetes. A symposium on the Rôle of the Mouth, Throat, Nose and Accessory Sinuses in Disease has been arranged, in which Dr. Coldthwait, of Boston, Dr. Weston Price, Cleveland, Dr. Wishart, Toronto, and others will take part. Dr. Percy will give the address in Gynæcology.

Owing to the increasing problems presented by the war, in its medical aspects, a meeting of Military Medical Officers will be held.

Sectional meetings will be held in Medicine, Surgery, Obstetrics and Gynæcology, and Eye, Ear, Nose and Throat. A large number of papers have been arranged for the Medical Section, including "Treatment of Pneumonia," by Dr. Solomon Solis Cohen; "Neurosis in Returned Soldiers," Dr. G. Howland; "Effects of Gases on Soldiers," Drs. Elliott and Tovell; "Typhoid Inoculation," Dr. George Porter; "Tuberculosis," Dr. Parfitt; "Cerebro-Spinal Meningitis," Capts. Fitzgerald and McClennahan; "Canadian-made Drugs," Prof. Blackader, Montreal; "The Wassermann Reaction in Relation to Diagnosis and Treat-

ment of Syphilis," Prof. Connell, Kingston; "Duodenal Feeding with Tube," Dr. Cleaver, New York; "Treatment of Lues in Children," Dr. George Smith; "Treatment of Cancer," Dr. W. H. B. Aikins; "Pernicious Anæmia," Dr. Chas. Mackay-Seaforth. Papers have also been promised by Major J. W. S. McCullough, Dr. Alan Brown, Dr. Campbell, Napanee.

In Surgery there are papers on Appendicitis by Dr. M. O. Klotz, Ottawa; Gall Stones, by Dr. Olmsted, Hamilton; Pyloric Stenosis in Infants, by Dr. W. E. Gallie, Toronto; Fractures, by Dr. G. M. Rogers, Ingersoll; Intestinal Obstruction, by Dr. H. A. Bruce, Toronto; Renal Calculi, by Dr. W. W. Jones, Toronto; Transfusion, Dr. C. L. Starr, Toronto; Conservative Surgery in Injuries of the Hand, Dr. N. A. Powell; Intussusception, Dr. F. N. G. Starr; Perforated Ulcer of the Greater Curvature, Dr. J. K. McGregor, together with papers by Drs. G. A. Bingham, Toronto, W. T. Parke, Woodstock, and others.

The Eye, Ear and Nose Section has invited Dr. Justus Matthews, of the Mayo Clinic, and he is giving a paper on Tonsillectomy, with its General Results. There are also papers by Dr. E. Boyd, on Foreign Bodies in the Oesophagus; Treatment of the Blind after the War, by Dr. B. C. Bell; Orthodontia in its Relation to the Nose and Throat, by G. W. Grieve, D.D.S., and a paper by Dr. James McCallum.

The Section in Gynæcology and Obstetrics is not yet complete; but Dr. Percy, Dr. W. H. Weir, and Dr. J. H. Morgan have promised contributions.

As will be seen by this brief outline, there is a wealth of material to be discussed, and many papers by men of wide reputation. We trust later to announce the programme and arrangements more in detail.

WAR DEATH RATE DROPS.

Official statements recently made show a remarkable decrease in the death rate of wounded and sick soldiers in both the German and the French armies. For the German army the statistics show that while in the first months of the war three per cent. of the wounded and sick soldiers died, twelve per cent. were discharged, and 85 per cent. returned to active service, the death rate since then has fallen steadily until now the monthly average is 1.7 per cent., the discharges average 8.8 per cent., and 89.5 per cent. are still fit for service. For the French army the official statistics give the mortality among the sick and wounded soldiers in the war hospitals during the month of September, 1914, as 45 per 1,000, and during the past months as only 18 per 1,000.

ORIGINAL CONTRIBUTIONS

COUNTY ASSOCIATIONS.*

BY C. STEWART CAMERON, M.D., PETERBOROUGH.

THE subject assigned to me for discussion this evening is that of County Associations, but before dealing directly with this subject it is necessary that we should examine some general questions which naturally lead up to the necessity of County organization. We are speaking well within the facts, I think, when we say that no other body of men, in this Province at least, have so little organization as the medical profession. When any question of moment to the whole profession arises there is really no adequate machinery through which we may reach the individual members so as to get their opinion and also their support in giving expression to the desires of our men.

Certain conditions have arisen during the past couple of years which to our mind are compelling medical men to consider more seriously their relationship to the various agencies at work in the social, commercial and political development of the Province. The first of these was the Workmen's Compensation Act, an Act that was no doubt an important advance in the treatment of the working man when he was injured, but an Act that was absolutely unworkable unless it had the support and co-operation of the medical profession, and yet we find no provision whatsoever made for the safe-guarding of the interests of the medical man.

The second important question was that of the present Medical Commission authorized by the Provincial Government with a view of enquiring into many questions having a bearing upon the practice of Medicine in this Province. This to our mind will be an epoch marking event in the history of Medicine in Ontario, yet I am speaking well within the fact when I state that outside of the teaching bodies, the College of Physicians and Surgeons, and perhaps the Academy of Medicine, it is practically impossible to present the united views of the great body of the profession before this court.

A third condition which confronts us is the war. A great many of us may not to-day see that it has any particular bearing upon the medical profession, but undoubtedly before very long important questions will arise in the solving of which we must have a voice.

We think, therefore, in view of our unpreparedness in the past that it behooves us to put our house in order as early as possible so as to

* Read before the Academy of Medicine, Toronto, Jaanuary 4th, 1916.

deal with these questions as they may arise. We have in the Province of Ontario at the present time two organizations: One, the Ontario College of Physicians and Surgeons, and the other the Ontario Medical Association. The College of Physicians and Surgeons is, as you know, the legally constituted governing body of the profession, and has more particularly to deal with the educational standard of its members and the professional conduct of those enjoying its cause.

It has existed since 1867, and has done important work in helping to place the profession in the high position which it at present occupies in this Province. We do not think that any person would be desirous of interfering with the Council excepting to modify its regulations as necessity or changing conditions from time to time demand. The Ontario Medical Association is a voluntary organization that has existed in the Province for thirty-five years. It has had the support of the best men of our profession, and often times at considerable sacrifice to themselves for they did its work willingly and cheerfully so that the lamp might be kept burning. We believe, however, that these same men would agree with us that the time has come when the Association must take a deeper and more far-reaching interest in the rank and file of the profession and the questions that immediately effect them if it is going to survive as a real force in our medical life.

Let us examine for a moment and see wherein the Association to-day hardly measures up to its opportunities: First, less than twenty per cent. of the three thousand medical men in the Province are members of the Association. Secondly, the Association is only of value to those who attend its meetings and, to those, for the three or four days of the annual Session. Thirdly, there is no permanent means through which any question may be submitted to the individual members throughout the country. Fourth, we have no medical publication that speaks the mind of the members of the Association. These are some of the defects of our present organization. The question naturally arises how are these to be remedied? We believe that the organization of the county societies will go a very long way towards a glorified Provincial Association. At the present time we have some twenty-five local associations scattered throughout the Province mostly in the smaller cities and larger towns. In many instances these are live, active bodies who are doing their part in furthering the local interests of the profession. The suggestion of the Committee of the Ontario Association on County organization is that each county, as far as possible, should organize a society among its own members. Or if the county association is not feasible in certain districts perhaps areas contiguous to each other could be more easily united for society purposes. The boundaries of

the society should not be an arbitrary matter, but should be left entirely to the members in each locality, the important point being, however, that every medical man in the Province should be identified with some local society. It is true that these societies might not be able to meet frequently, and as bodies for scientific discussion they might be non-existent for the present, still through their president and secretary, who must be the liveliest men in the county, they would be able to keep in touch with every practitioner in the area covered by their Association. The fees for the up-keep would be purely a matter for the local society to deal with, but we think that a uniform set of by-laws would be advisable. The local unit would have many duties among which we could mention:

(1) Keeping of a correct register of all regular practitioners within their jurisdiction.

(2) Receiving recent graduates beginning practice and assisting them in becoming acquainted with their professional neighbors.

(3) In questions affecting the profession coming before legislative bodies of laying the facts before the local representatives.

These and many other duties would naturally fall to the local society apart altogether from the educative side.

Once having the county societies in operation we must then adopt some means by which the societies may be united under a central executive, and there is no reason why this central executive should not be that of the Ontario Medical Association changed to suit the new conditions. This would establish a direct relationship between the various county societies and the central association. Thus important matters affecting the profession, and all available information relating to them could be sent by the executive to the secretaries of the county societies, who in turn would place the information before their members. In this way every doctor in the Province would have full and uniform data before him, and would be in a position to intelligently express his views before his fellow practitioners or to those for the time being in political authority.

We believe the next step would be the employment of a paid secretary, with an office in Toronto, who would devote his whole time to the welfare of the profession, and whose duty it would be to communicate by means of literature and letters with the county associations all questions that would have a bearing on the position of the medical men. We think that the profession thus organized should be in control of its own journal, a journal devoted to the social and educational welfare of a universal profession with such emphasis on local conditions as may from time to time be necessary. Naturally it would be said that this all

requires money, and with this we agree, but we believe that the profession are willing to contribute any reasonable fee, provided they have results and with the three thousand reasonably prosperous practitioners in this Province, we see no reason why a program along the lines mentioned could not be successfully carried out.

It is true that we could not with wisdom gain all at once, but we think the time has surely arrived when we should boldly strike out and secure a more united profession throughout the Province, and we believe that when the Provincial Association can be of real service three hundred and sixty-five days in the year to the county associations and through them to their individual members, there will be no question about membership or fees—rather men will consider it a duty and a privilege to belong to an organization that is seeking to place its own members in possession of the very best conditions under which to practice their profession, while at the same time giving “without money and without price” every assistance to that research, the result of which, we pray, will be for the ultimate relief of the physical suffering of mankind.

THE LEGAL STATUS OF THE MEDICAL PROFESSION IN ONTARIO.*

BY H. S. OSLER, K.C.

THE legislation of the Province of Ontario regarding the medical profession is in the “melting pot” of a Royal Commission, and you are therefore not less interested in a consideration of the probability of new legislation than in a discussion of the status of your profession upon the basis of the administration of “The Ontario Medical Act” in its present form.

The subject cannot be viewed in a true prospective unless it is fully realized that questions of right and wrong are not involved, and that we are dealing merely with a branch of the complicated organization of a civilized community.

In the absence of legislation by the governing power of a State there is no restriction upon the natural right of one man to attempt to alleviate the affliction of another. That which may be said to be a common duty of humanity in a state of nature, inevitably tends, as communities become organized, to fall as a professional undertaking into the hands of those who have shown special aptitude for it.

Universal ignorance of the subject and the tendency of the afflicted

* Read before the Academy of Medicine, Toronto, Jaanuary 4th, 1916.

to grasp at promises and pretensions, as a drowning man at straws, have everywhere forced the State in the earlier stages of civilization to realize the duty of protecting its citizens by requiring a certain standard of competence from those who adopt the medical profession. This inevitably involves a monopoly of the practice of medicine in the hands of those who have submitted to the prescribed tests.

Eventually this is what has happened everywhere, but in each community national characteristics, the degree of civilization and education attained, and the varied calls of academic and vested interests and of political expediency, have combined to produce wide variations in the laws adopted.

In a comparatively new country like our own, we have been free from many of the complications which form the historical basis for many peculiarities of the system prevailing in England, and The Ontario Medical Act is in form a simple incorporation of the medical profession into a college consisting of all those who have acquired the right to practice.

Members of the college are identified by registration, and the duty of maintaining a standard of education and efficiency is imposed upon the governing Council.

This, then, essentially and in theory, is the legal status of the profession in the Province of Ontario. Entrance to the profession is made difficult and expensive, but on the other hand important privileges are conferred. To registered members of the college is granted the sole right to practice and to use the courts for the recovery of their fees. No others can hold the appointment of medical officer in any branch of the public service or in any charitable organization receiving public aid; they alone can sign any medical certificates required by law.

To the Council is also committed the power of domestic regulation of the ethics of the profession and of disciplining offenders, even to the extent of expulsion.

It is no small matter that all these rights and privileges are conferred upon a single corporate body in the common interest, and in theory the legal status of the profession may be said to be satisfactory.

Unfortunately, however, the legal profession has intervened, and the courts of the Province, by what, in my opinion, can only be termed a shortsighted and not well considered decision, have construed The Ontario Medical Act, as relating only to that branch of the Art of Healing in which drugs or medicines are used, thereby opening wide the doors to every sort of quack and humbug desirous of exploiting the misfortunes of his fellows.

The process was at first slow, individuals took legal advice as to

how to evade the provisions of the Act, and only by degrees have organizations grown up to claim freedom from all restrictions, using only the common cry, "We use no drugs," until before the Commission now sitting we find innumerable "practors" asking rights and immunities upon various grounds, resting at bottom upon the assertion of the freedom of the individual, the only answer to which is the incontestable right of the State to protect its citizens from imposition.

These so-called drugless healers have this in common, that they are not educated men, and whatever merit may attach to their so-called "systems" the medical profession stands upon firm ground in demanding that a modern State must recognize modern science and education, and cannot safely entrust to those who repudiate recognized standards, the privileges of recognition as medical practitioners.

We may, therefore, I hope, look forward to legislation which will confine to registered practitioners—those who have acquired a reasonable degree of education and experience according to the recognized academic standards—the right to practice the art of healing in this Province.

Only less important than the adoption of a proper standard of medical education is the question whether this standard is to be maintained, and the necessary tests applied, by academic bodies engaged in the education of medical students, or by a body consisting in the main of practicing members of the profession. The object of the test is to determine the fitness of the candidate to practice, and in my opinion it would be a fatal mistake to leave it in the hands of the teaching bodies.

Time will not permit me to state the arguments on both sides of this controversy, and I therefore only express the opinion which I have formed after such study as I have been able to give the question. Whatever may be the result of the deliberations of the Royal Commission, and whatever may be the differences of opinion regarding such legislation as may be subsequently passed by the Legislature, it is with great satisfaction that I am able to say that there does not appear to be any serious proposal looking to the passage of legislation which can prejudicially affect the status of the profession.

If mistakes are made they can, and doubtless will, be remedied. The essentially satisfactory feature of the situation is that all parties of influence appear to realize the importance of maintaining the standard of medical education in the Province, the only difference of opinion being as to the means to be adopted.

I am conscious of the inadequacy of these few observations to deal with a subject upon which a book could be written, but under the cir-

circumstances I have necessarily confined my remarks to generalities, touching only what appear to me to be the essential principles involved.

MEDICAL LEGISLATION IN ONTARIO.*

SUMMARY OF LEGISLATION TO REGULATE THE PRACTICE OF MEDICINE IN THE PROVINCE OF ONTARIO, FORMERLY UPPER CANADA; AND IMMEDIATELY AFTER THE CONQUEST, INCLUDED WITHIN THE PROVINCE OF QUEBEC.

BY H. B. ANDERSON, M.D.

IN the earliest settlements medical practice was carried out by the medical officers of the garrisons, stationed at strategic points, who had the right to practise by reason of their qualifications from the Imperial Government. The large influx of population following the close of the American Revolution in 1783 made it impossible for the military surgeons to attend to the needs of the people, especially at a distance from the garrisons. The dearth of properly qualified physicians was the occasion for the springing up of many irregulars and quacks, with little or no education.

The first step toward regulating practice was the passing of a law in 1788, known as the "Quebec Ordinance," of an "Act or Ordinance to Prevent Persons practising Physic and Surgery" (Laws of Lower Canada—1777 to 1792, p. 130) the preamble to which states the reason for legislation: "Whereas many inconveniences have arise to His Majesty's subjects in this Province from unskilful persons practising physic, etc." It was therefore provided under severe penalty, including fine and imprisonment, that no person should practise medicine without a license from the governor, the commander-in-chief of the Province, upon certificate of examination and qualification by an examining board, appointed for the purpose by the governor or commander-in-chief. University graduates in Medicine and commissioned or warranted army or navy surgeons were excluded from the necessity of examination.

After the establishment of Upper Canada as a separate province, the first legislation to regulate the practice of medicine was enacted by the Legislative Council and Assembly of the Province of Upper Canada at Newark in 1795, and was entitled "An Act to Regulate the Practice of Physic and Surgery" (Statutes of Upper Canada—No. 1, 32nd to 49th George III—1792 to 1809, p. 119). This Act provided for the appointment of a board of surgeons to examine and approve for license to practise in the Province, under the hands of, and seal of the medical

* Read before the Academy of Medicine, Toronto, Jaanuary 4th, 1916.

board and such members thereof as were present at the prescribed examinations. This board was to be appointed by the governor, lieutenant-governor or person authorized by him, and was to be composed of the surgeon to His Majesty's Hospital for the time being, with the surgeons of His Majesty's regiment doing duty in the Province, and all other authorized surgeons and practitioners, or any two of them, of whom the surgeon to His Majesty's hospital must be one. Penalties for practising without this license were provided; army and navy surgeons, university graduates, and others having the license to practise under previous enactments. Apprentices of the latter were excluded from the right to present themselves for examinations.

This Act was found to be unsatisfactory, and was repealed in 1806 (Statutes of Upper Canada—271). A Bill introduced into the House the following year to regulate the practice of medicine in the Province was dropped, and until 1815 the only legislative control was apparently under the "Quebec Ordinance," which again became operative. That more efficient control was considered necessary is evident from the following quotation from an editorial in the York Gazette, October 8th, 1808:

"The opinion we maintain of such a public want, arises from the conviction we feel, and the knowledge we possess, that the health, nay, frequently the existence of a fellow creature, is lost, being too often sacrificed to the pretensions or cannibal ignorance of Empirics, quacks and impostors. It is an incontestible fact that we are all created patients, but few of us are born physicians, and that education and studious practice, as well as a just judgment of diagnostics and the efficient operative qualities of prescriptions, form the necessary parts of fortunate and conspicuous practitioners."

Editorials and letters in the contemporary press, as well as an article by Bishop Strachan previously referred to, bear out this point. Consequently in 1815 the Legislative Council and Assembly of the Province of Upper Canada passed "An Act to License Practitioners in Physic and Surgery" (Statutes of Upper Canada—1810 to 1820, March, 1815). This Act is practically the same as the one repealed in 1806. It left the control of the profession in the hands of the military medical officers. It was provided that nothing in the Act should be construed to prevent "any female from practising midwifery in any part of the Province."

This Act was repealed in 1815, the preamble to the new Act stating: "The provisions . . . have been found to be impracticable." (Statutes of Upper Canada—1810 to 1820, p. 27—"An Act Constituting the Medical Board of Upper Canada").

The Act of 1818 provided for the creation of an examining board, afterwards known as the Medical Board of Upper Canada, to consist of five or more persons legally authorized to practise physic, surgery and midwifery; any three to be a quorum, on the certificate of two or more of the board, the governor general or administrator might license to practise. It was further enacted that the board should meet in the town of York twice yearly. Later, quarterly meetings were provided for.

The creation of the Upper Canada Board was the beginning of any effective control of medical practice in the Province. It may be noted that up until this time, not only the practice but the regulation and administration of medical affairs generally in the Province, was under the control and direction of the military surgeons.

In 1827 an Act was passed providing for the registration of previously qualified practitioners, as follows: "Upon the application of any person exhibiting a diploma or license as physician or surgeon, from any university in Her Majesty's dominions, or from the Royal College of Physicians or of Surgeons in London, or a commission or warrant as physician or surgeon in Her Majesty's naval or military services, and producing an affidavit made before any judge of any county court in Upper Canada, stating that he is the person named in such diploma, license, commission or warrant, the governor may grant to such applicant a license to practise Physic, Surgery and Midwifery in Upper Canada." (8th George IV—Cap. 3, S.Z.) (Statutes of Upper Canada—22nd Victoria, Cap. 40, p. 436.

The medical board began its duties January 4th, 1819, and continued to hold regular examinations and grant licenses until 1839, when an Act of the Provincial Parliament was passed, constituting "The College of Physicians and Surgeons of Upper Canada," with full powers to examine and grant license to practice and otherwise to control medical affairs in the Province. This Act (Statutes of Upper Canada—7th Wm. IV to 3rd Victoria, p. 73) was claimed to infringe the rights of the Royal College of Surgeons (London), and after a heated controversy, it was disallowed by the Imperial Parliament. The College of Physicians and Surgeons of Upper Canada held its last meeting in 1841.

When the College of Physicians and Surgeons of Upper Canada ceased to exist, by proclamation of the then Governor-General, Lord Sydenham, the control of the examination and licensing of practitioners reverted to the Medical Board of Upper Canada. He appointed Christopher Widmer, Wm. C. Gwynne, Robert Hornby, Walter Telfer, William Durie and Henry Sullivan as members of the board. The medical

affairs of the Province and licensing of practitioners were controlled by the Medical Board until October 7th, 1865, when the last meeting was held.

In 1859 was passed "An Act respecting the Medical Board and Medical Practitioners" (Consolidated Statutes of Upper Canada—22nd Victoria, Cap. 40). This Act is essentially a restatement of previous enactments.

In 1859 "An Act respecting Homeopathy" was passed, making provision for the appointment of a board of examiners to consist of five members (Statutes of Canada, Victoria 22nd, Cap. 47). This Act also outlined the course of study.

In 1861 was passed "An Act respecting the Eclectic System of Medicine," providing for an examining board and outlining course of study. (Statutes of Canada, Cap. 110, p. 331).

In 1865 the Parliament of Canada passed "An Act to Regulate the qualifications of Practitioners of Medicine and Surgery in Upper Canada." This was known as "The Medical Act for Upper Canada," and under its authority was created "The General Council of Medical Education and Registration of Upper Canada." The Act (Statutes of Canada—29th Vict.) passed Sept. 18, 1865, and the Council began its duties January 1st, 1866. The body created under this Act afterwards became known as "The College of Physicians and Surgeons of Ontario."

This was accomplished after Confederation under authority granted in 1869 by "The Ontario Medical Act (Statutes of Ontario—32nd Victoria, Cap. 44 and 45, p. 243). In order to obtain uniformity of examinations and control, provision was made for the admission not only of regular practitioners but of eclectic and homoeopathic practitioners who had been in practice before 1850. The latter were each to have a fixed representation of members in the Council. This was brought about by agreement between the Homoeopaths, Eclectics and regular practitioners to the repeal of the Acts of 1859, 1861 and 1866, under which, respectively, they had obtained legislation, empowering them to examine and grant license to practice in the Province. By this means the way was cleared for the passing of the Ontario Medical Act.

"The College of Physicians and Surgeons of Ontario" is the name adopted by the medical profession of the Province of Ontario in its corporate capacity. Every legally qualified medical practitioner in the Province is a member of this college. It is not an institution for the teaching of medicine.

This Act was passed by the Legislature of Ontario in 1869, and now the affairs of the profession in this Province are regulated by an Act passed in 1874—"An Act to amend and consolidate acts relating

to the profession of Medicine and Surgery in Ontario" (Statutes of Ontario—37 Victoria, 1874, Cap. 30, p. 223).

By this Act "The Council of the College of Physicians and Surgeons of Ontario" is empowered and directed to enact by-laws for the regulation of all matters connected with medical education; for the admission and enrolment of students of medicine; for determining from time to time the curriculum of the studies to be pursued by them, and to appoint a board of examiners, before whom all candidates must pass a satisfactory examination, before they can be enrolled as members of the college, and thus be legally qualified to practise their profession in the Province of Ontario.

The Council, moreover, has power and authority conferred upon it by this Act to fix the terms upon which practitioners of medicine, duly qualified in other countries, may be admitted as members of the College of Physicians and Surgeons of Ontario, this being the only mode in which they are become legally entitled to practise their profession in this Province."

The Eclectic representation in the Council and examinations ceased without special legislation about 1875.

The Ontario Medical Act underwent further revision in 1887 (R.S.O. 1887, Cap. 148), since which time no important changes have been made. Other Acts have been passed in 1891, 1893, 1895, 1902, 1914 and 1915 to make provision for matters of minor importance, but the general terms of the Act remain unaltered.

The purpose of the Canadian Medical Act (Statutes of Canada, 2nd Edward VII, Cap. 137) was chiefly to make provision for:

(1) The establishment of a qualification in medicine, such that the holders thereof shall be acceptable and empowered to practise in all the Provinces of Canada.

(2) The determination and fixing of the qualifications and conditions necessary for registration, including the courses of study to be pursued by students, the examinations to be undergone, and generally the requisites for registration.

(3) The establishment of such a status of the medical profession in Canada as shall ensure recognition thereof in the United Kingdom, and enable Canadian practitioners to acquire the right to registration under the Acts of the Imperial Parliament known as the Medical Acts.

MEDICAL FEES.*

BY DR. A. H. WRIGHT, TORONTO, ONT.

IT is generally considered, so far as I know, that the fees of such specialists as those of the eye, ear, etc., are reasonable and fair. After Lister revolutionized surgery—over forty years ago—one of the most important results was the brilliant work done in abdominal surgery. In connection therewith fees increased enormously. A considerable amount of commercialism developed chiefly in the United States, and to a certain extent in Canada. The operator sometimes investigated his patient's bank account to find out how much "he could stand."

We had supposed that extortionate charges were not known in Canada. We are now told, however, that, recently, certain physicians and surgeons of Toronto have made charges that were so unreasonable as to be disgraceful. I do not happen to know enough about any one of the cases reported to express a definite opinion, but I think that if Mr. A. thinks that Dr. Z. has charged him an exorbitant price for a surgical operation, the right thing to do is to refuse to pay, to let the courts decide the matter, and not spread street rumors that a surgeon has acted dishonestly without giving adequate reasons for his grave allegations.

Excessive fees should not be allowed; but how are we to prevent them. I have not time to discuss the methods of prevention, but I may point out the fact that most of the men against whom such charges are made are members of the Academy of Medicine, of the University Teaching Staff, and of the General Hospital Staff. The controlling authorities might take some action. They might not care to act as policemen or detectives, but they could at least create a sentiment against such wrong doing which would have a deterring effect.

The question of tariff naturally arises in this connection, but without attempting to discuss the question in detail it may be said that a tariff should be elastic. It happens, however, that no tariff will make a crooked man straight. It might be well to follow the customs of the past and make tariffs to a large extent local. A tariff framed for Toronto would not be suitable for Georgetown, Orillia or Whitby.

Now let me turn to the brighter side of the situation.

First an incident. About eighteen years ago a surgeon of Toronto saw a patient aged 40, whom he knew in her girlhood days, since which time she had lost her money. He took her to a private hospital, performed an ovariectomy, paid all expenses, and sent her home, well, in

* Read before the Academy of Medicine, Toronto, Jaanuary 4th, 1916.

three weeks; "just for the sake of old times," he told her, many others of his generous acts, was done quietly, without any street rumors following.

The Mail & Empire told us, December 28th, 1915: "For over twenty-five years Dr. Rowan, of Toronto, practised medicine in the east end, and those who knew him best feel that he died a martyr to his love of the poor, for one of his characteristics was to give at least three quarters of his time to the poor, free of charge, and also to furnish medicine free of charge." The Globe spoke as follows about Dr. G. S. Cleland, after his death six years ago,—“He was loved and respected by all his patients, and the whole community of Riverdale, and indeed was looked upon throughout the district as another Dr. McClure.”

Dr. Z. was attending Mrs. X. The X family, once well to do, were now—through no fault of their own—poor—and proud. Dr. Z. understanding the situation decided to charge the least possible fee, one dollar, a visit; paid twenty-five visits, but neglected to chalk down ten. In making up his books he found fifteen visits charged, and sent an account for \$15.00. X. if he can will pay the \$15.00, and although he may feel that the charge is small he will consider that he is paying his way.

Hundreds of doctors in Toronto may be performing generous acts from year to year, and we hear little or nothing about them, but if two or three send unduly large bills the reports thereof spread through the city like a red hot prairie fire.

A few words as to Doctors' Incomes. It may be stated that in Ontario a large proportion of them are small, so small that there is no possibility of saving anything as years roll on. Very few doctors become wealthy. The majority are poor or making a bare living, and leave practically nothing for their families when they die. Excessive charges are very rare, and the average fees for the whole Province are low, too low I think.

I have referred to certain lines of action which cause in us some shame, and of other things which cause some pride, but let us avoid the pride that begets vanity and self-esteem, let us rather cultivate humility, and let us ever strive to maintain honesty, honor and dignity in our profession.

CURRENT MEDICAL LITERATURE

ANALGESIA AND ANESTHESIA IN LABOR.

The undue prominence given to the Freiburg method by an enterprising though questionable publicity has tended to divert attention from the traditional and probably little less effective methods of subduing the pangs of childbirth. Edwin P. Davis (*American Journal of the Medical Sciences*, January, 1915) finds that the experience of various American observers in the use of scopolamine-morphine seminarcoosis is not as yet sufficient to warrant a decision as to the efficacy of this procedure. In his own hands the use of these drugs has produced severe headache and vomiting in the mother.

In the management of labor Davis has adopted a procedure, the results of which are apparently safer and none the less certain than those of "dammerschlaf." During the first stage of labor the suffering is allayed by thoroughly emptying the bowel by means of a hot, high enema, by frequent emptying of the urinary bladder, by the use of bromides by the mouth, by enforcing quiet, and by securing the comfort of the patient. If these measures fail and if the patient is threatened with exhaustion from irritation, morphine and atropine should be given hypodermically.

During the second stage of labor, if there is considerable suffering and if the uterine contractions are irregular, there are administered hypodermically strychnine 1-60 to 1-30 grain, digitalin 1-100 to 1-50 grain, and codeine $\frac{1}{4}$ to $\frac{1}{2}$ grain. These may be repeated in an hour if necessary. When expulsion is imminent the patient is made to inhale a small amount of ether at the height of a pain, and this anesthetic is given freely and quickly at the moment of expulsion. The results of this method of treatment are that the patient does not know when the child was born, nor does she recall any sensation of suffering. Shock, headache, and nausea are absent, and there is no bad effect upon the child.

One important advantage of this method of treatment is that it is adapted for routine private practice and requires no especial degree of skill or vigilance. The author condemns the use of chloroform on the grounds that this tends to produce uterine relaxation and is more apt to be followed by hemorrhage than ether is. Although the fetus is affected by large doses of morphine and prolonged anesthesia, no serious result is to be feared from the ordinary and careful use of morphine and ether.—*Medical Record*.

TWILIGHT SLEEP.

Dr. W. H. Knipe said that the wonderful results obtained by Kronig and Gauss in Freiburg had led many men to attempt the use of scopolamine and morphine during labor. The fact that these attempts were frequently unsuccessful might be attributed to a poor preparation of scopolamine, to the use of too much morphine, to the attempt to achieve absolute painlessness in childbirth, or to a technic which was entirely different from that recommended by Gauss. The method of administering these drugs which was attempted some years ago in this country was wrong, the preparations were not stable, morphine was used too freely, and scopolamine was given in too large doses. It was essential for those who were using the Gauss method to follow it in every detail. From Freiburg and elsewhere in Germany 8,000 cases had been reported knowledge of obstetrics so as to know when interference was indicated; that he must give all his time to the patient after the first injection; that a preparation of scopolamine must be used which was stable; that morphine must be used with extreme caution; that the environment be such that reasonable quiet and the absence of bright light were obtainable. The ideal place was a hospital. Patients reacted very differently to scopolamine and after the first injection of morphine and scopolamine had been given the reaction to the pupillary, motor coordination, memory, and Babinski tests must be noted. The idea was to keep the patient neither in a zone in which impressions were perceived and stored in the memory and in which the patient was awake, nor in a state of narcosis. In the proper zone the patient gave evidence of painful sensations, but after the ordeal was over, she had no memory of these pains nor of the birth of the child. Absolute painlessness was an indication of overdosing. The first dose consisted of morphine hydrochloride 0.01 grain injected subcutaneously, and at the same time while the needle was in place 0.0003 to 0.00045 scopolamine hydrobromide solution was injected. The first dose of morphine was never to be repeated. In from one-half to three-quarters of an hour the memory test was applied, an object was shown after twenty to forty minutes. If the patient remembered, a second injection of 0.00015—0.0003—0.00045 gram scopolamine was given according to the reaction of the patient. The third and succeeding injections followed, according to the memory tests, using 0.00015 or more of scopolamine as necessary. The essential point was the gradual scopolamine technic. It required from one and one-half to two hours for the twilight zone to be reached, and if one had not that much time at his disposal, it was better not to attempt to achieve amnesia. Instead of morphine one might use morphine meconate, although Gauss still used morphine hydrochloride, and his experience led him to do

likewise. The Freiburg routine gave fair results as far as the mother was concerned, but there was a large percentage of children born with oligopnea and apnea, and, while in the hospital with proper attention, these babies were made to breathe, in many cases it required considerable effort and the method could not be recommended as a routine for general use. One must also realize that any drug as powerful as scopolamine could not be used as a routine measure when dealing with subjects of varying susceptibility. There were certain disadvantages in the conduction of the twilight sleep. It required the constant attendance of a physician, was not easy to carry out, required experience in the method, and considerable obstetrical knowledge, because the patient's outcries did not force interference where it might be indicated. The physician might find it difficult to secure a stable solution of scopolamine, and if an unstable one was used the results might be bad. Again, attention must be paid to the details of quiet and darkness. If the drugs had been improperly used, there was considerable danger to the child, the period of labor might be prolonged so as to endanger the life of the child, and slight overdosing might produce oligopnea. These conditions might not be serious in the hands of an expert, but might prove fatal unless proper measures were instituted. That there were also wonderful advantages in a properly conducted twilight sleep must also be admitted.

Dr. Ross McPherson said that Dr. James A. Harrar and he had tried this form of amnesia in 115 cases, all of primiparae, in the wards of the New York Lying-In Hospital. Of these 115 cases amnesia was secured in seventy-five, partial amnesia in eleven, and in twenty-five there was no result. The four remaining were too far advanced in labor to derive any benefit from the drug. In nearly all the cases in which amnesia was secured, the treatment was started from three to seven hours before the termination of labor. There were no bad results that could be attributed to the use of the drug as far as mortality was concerned. One mother showed a rapid weak pulse (140 to 160) for two hours after delivery with slight delirium, but soon became normal and showed no ill effects the following day. There was no asphyxia attributable to the unresolved pneumonia, one may hope for a complete closure of the wound in two weeks. At no time should irrigation be practised. In the com- If one is dealing with a simple pneumococcus case uncomplicated by treatment and no hemorrhage post partum of moment. The average duration of labor was somewhat shorter in the cases receiving the sleep than in the average cases. They had noted in general a more rapid dilatation of the cervix than usual, with a somewhat slower second stage than was expected. This, however, had given rise to fewer lacerations of the perineum and might be hastened, when the delay seemed too long,

by the use of pituitrin. The involution of the uterus and the puerperium were in all cases uneventful. It seemed that in sixty or seventy per cent. of cases they had a valuable method of abolishing a woman's recollection of pain in labor, provided that the described technic was carefully carried out, the cases carefully chosen, and the drugs reliable and stable, the last being of great importance. The employment of these drugs in no way lessened the necessity for obstetrical skill, but rather increased it. In short, they had another valuable therapeutic aid in selected cases, but not a panacea for the pains of labor.

Dr. Abraham Rongy said that one could not take every obstetrical case and tell the patient that she would go through a painless labor, for it was *not* a painless labor, but an attempt to get the patient into a state of amnesia. The patient did not remember the pain and hence was as well satisfied as though she had never gone through it. In their series oligopnea. The first stage of labor was shortened, the second lengthened. There seemed to be no effect so far as hemorrhage was concerned. Amnesia was obtained in about eighty per cent. of the cases. In the event of delay of the head on the brim of the pelvis, pituitrin was used guardedly.

Dr. Samuel Bandler thought that before going so far afield in discussing this subject it was well to ask, What did they gain by this treatment? It seemed that labor lasted longer than under normal conditions, even though the patient forgot that she had had pain. His experience with pituitrin had been large and he had never seen a case of asphyxia. He believed that morphine, hyoscine, and scopolamine inhibited the action of pituitrin, and if one used these drugs the addition of pituitrin did not shorten the second stage of labor. With the use of pituitrin he now had one forceps case where formerly he had four or five. He felt assured that the oligopnea reported was due to morphine and hyoscine.

Dr. James A. Harrar said that in his experience the general effect had been a rather more rapid dilatation of the cervix than usual, with a shortening of the first stage, followed in a certain number of cases by delay on the perineum. This resulted in a diminution of the number of perineal lacerations. Examination of the mother's urine before and after labor had not shown any bad effect on the kidneys. The involution of the uterus was not hastened in any way. In about 125 cases it was his impression that any deleterious effect on the baby was due to bad obstetrics rather than to the scopolamine. In their enthusiasm over the high percentage of successful amnesias, they must not forget that attention must be paid to delay on the perineum; the fetal heart must be watched. Another point was the tendency to delirium as the head distended the vulva; this was probably due to the commotion resulting from moving

the patient to the delivery table. The patient should be allowed to remain in bed. Primary inertia was a positive contraindication to this treatment and it was also to be avoided in cases in which operative manoeuvres were anticipated, in ante partum bleeding, and in bad lung and kidney cases.

Dr. Robert L. Dickinson, of Brooklyn, said it seemed to him that in the twilight sleep, the patient was under the influence of belladonna poisoning; she was belladonna crazy and excessively thirsty just when one wanted her most quiet. One could not sew up a perineum with the patient in such a restless condition. The time was coming when this method would be applied to every primipara, but at present it belonged entirely to the skilled obstetrician and not to the public.

Dr. George P. Shears stated that some twelve or fifteen cases in which this treatment was used had come under his observation at the City Hospital, and the effect on the mother was wonderful; there was no subsequent hemorrhage, no relaxation, and the mothers recovered quickly, but the subject had its dark side, and that was the danger to the baby. The effect of the morphine, scopolamine, chloroform, and either, in case it became necessary to apply forceps, was such that to tell anyone the baby was better under such conditions was too much of a strain on the imagination. When the second stage of labor was prolonged, there was increased danger. He did not believe that the dangers to the fetus could be entirely eliminated.

Dr. Samuel Druskin recalled that Doctor Crile had pointed out the effects of insomnia, anxiety, and violence on the human economy, and they should not underrate the fact that by the use of this treatment the mother was spared the effect of a disagreeable experience. The pituitrin was somewhat weakened in its effect by the morphine, nevertheless it gave sufficient contraction to cause the expulsion of the child. They had used the treatment with safety in cardiac and kidney cases.

Dr. Ross McPherson said that in their series the average duration of labor had been shortened. He disagreed with what was said about early rising after childbirth, and felt convinced that early rising tended to subinvolution. He could not say that twilight sleep shortened the period of involution, but it certainly did not lengthen it.

Dr. Samuel J. Scadron had had under observation about 250 cases in which the twilight sleep was used, and had seen no untoward effects on mother or child from the use of scopolamine. In most of the cases only one dose was given of morphine hydrochloride (grain 1-6). Scopolamine had no cumulative effect. It appeared in the urine, fifteen to twenty minutes after the first injection. By the time the third dose was administered, the first had lost its effect. Doctor Scadron emphasized the danger of pituitrin in combination with morphine and scopolamine.

In one series of cases, 15.2 per cent. of the infants were born with oligopnea, and he believed this was due to the pituitrin. Some of the patients receiving this treatment were permitted out of bed forty-eight hours after delivery, and many at the end of five days showed as great a degree of involution as did other patients after ten days in bed. This was attributable to the fact that patients did not experience the great exhaustion after labor that others did, and also to the daily exercises described by Docor Knipe.

Dr. Ephriam K. Browd's experience with pituitrin had convinced him that if the cervix was imperfectly dilated, its use was contraindicated and its effect on the child was dangerous. The employment of pituitrin was limited to the second stage of labor and to dystocia. Scopolamine would prove useful in cases of cardiac, renal disease, extreme anemia, or neurasthenia, or in cases in which anesthetics could be used. They had not been told how far this method was applicable in cases of malpresentation or malposition.

Dr. Alfred Hellman's visit to Freiburg had rapidly convinced him of the value of this treatment. There were several points that had impressed him and one of these was the rapidity of recuperation after labor. The mothers did not suffer from great exhaustion, and the uterus returned to normal much earlier. They had always been able to revive the babies, and Gronig believed that the delay was often valuable as it prevented breathing before the child was born.—*New York Academy of Medicine, New York Medical Journal.*

GASTRIC CANCER.

An analysis of 712 consecutive cases of gastric cancer from his records at the Mayo Clinic and in the Augustina Hospital at Chicago is given by F. Smithies, Chicago (*Journal A.M.A.*, Feb. 20, 1915). All of the cases were operatively and pathologically proved to be gastric cancer. There were 483 males and 229 females, mostly ranging in age between the fifth and eighth decades of life, though there were some cases as young as twenty years. A family or blood relationship history was proved in 9.4 per cent. of cases. Trauma was demonstrated in 3.1 per cent. and in 2.2 per cent. it appeared to precipitate symptoms; 1.9 per cent. of cases gave absolutely no clinical symptoms pointing to gastric cancer, which was only determined by exploratory or post-mortem examination. He also says that we have no clinical procedure other than history taking for early diagnosis. Early diagnoses are usually lucky guesses, or occur after gastric exploration. The only dependable early diagnosis is after laparotomy and examination by a capable surgical

pathologist; the Roentgen ray, the Wolf-Junghan's test, or edestin digestion may be useful in sometimes excluding cancer in its early stages, but are of relatively small value in determining its presence. His studies indicate that there are at least three types of happenings leading up to a diagnosis of cancer. 1. A symptom complex of two definite and different stages (*a*) gastric disturbance, non-malignant and generally chronic; (*b*) gastric malfunction of malignant type. 2. A symptom complex of distinctly apparent pernicious nature. 5. A group of cases in which there is usually evidence of irregular gastric disturbance, on which is superimposed an easily recognized malignant type. Sixty-one per cent. of the proved cancer cases were of the first type, the average of the first stage being over 11.7 years, and of the second stage nearly six months. The symptomatology of the first period was practically that recognized as gastric ulcer, with indigestion, hunger pains relieved by eating of alkalis, some pain in back, in 54 per cent. gradual loss of weight during the attacks, partly compensated for in the intervals, vomiting in the majority, and bleeding in 17 per cent. In this class of cases there may be complete cure with stoppage of symptoms or it may result in typical chronic benign ulcer or in gastric cancer. The prognosis of the occurrence of any one of these is impossible. In the second stage vomiting is more constant, and the gastric disorder becomes more continuous. The loss of weight is more steadily maintained, the vomiting becomes darker in color, sometimes of the "coffee ground" type in advanced cases. Macroscopic changes are not usually visible in the stools unless other organs are involved, but on a milk diet chemical tests for blood were positive in 83.4 per cent. Two hundred and twenty-five of the 712 cases, or 31.6 per cent., were of the second type and careful history taking failed to elicit any gastric disturbances previous to an average time of 7.4 months before coming under observation. This does not prove that there were no gastric disturbances. The longest history of gastric disturbances in this group extended over $3\frac{1}{4}$ years, the shortest barely three weeks. It is often extremely difficult to tell in this primarily cancer group just when the cancer began. The symptom complex is largely like the others to which the manifestations of malignant systemic poisoning are added. The whole course of the ailment is a condensed form of the other, or in chronic form or as Smithies says of the "tabloid" type. Fully two-thirds of the patients have more or less vague recollections of how they were gastrically affected before loss of appetite, weakness, mental inertia, abdominal distress, weight loss, or physical signs indicating more than chronic indigestion gave them warning. Capricious appetite was common, and disagreeable eructations frequently appeared early. Vomiting was observed in 79 per cent. and in 64 per cent. it was a daily occurrence. There were thirteen instances

cation was marked from the first. The very rapid progress of these which Smithies calls "fulminant" cancer, where profound cancer intoxication was not explained by the character of the growth and it is difficult third group of gastric malignancies showing long histories of atypical dyspepsia, was seen in only nine cases, and the clinical symptomatology usually pointed to disease of the gall-bladder, appendix, large bowel, or pancreas. The beginning of the malignant period was similar to that in the other groups. Smithies concludes his paper with the following: "There is at present no known medical cure for gastric cancer. We have as yet no dependable means at our command for the recognition of the disease at a stage when we can positively state that the affection is surgically curable. The cases of gastric cancer early diagnosed are those in which the clinical symptomatology is that which we associate with chronic gastric ulcer and in which laparotomy has been urged on the suspicion that cancer might be present. Where microscopists disagree regarding the diagnosis of sections of extirpated tissue clinicians can scarcely be expected to make early diagnosis of gastric cancer before laparotomy. The question for clinicians and pathologists to settle is not how many cancers had previous ulcer pointings, nor how frequently gastric ulcer changes from simple to malignant form, but just how one is to tell clinically in case of a given chronic gastric ulcer what future course it is destined to pursue. This is the crux of the situation. At present we have no means of prognosing the future course of any gastric ulcer, acute or chronic. The life history of the affection seems to depend on certain unknown factors that are apparently highly individual."

INTERCOSTAL THORACOTOMY IN EMPYEMA.

Howard Lilienthan (*New York Medical Journal*) describes an original method of treating empyema as follows: With the patient under nitrous oxide and oxygen anesthesia a long intercostal incision is made, beginning at a point just outside the costal angle and continuing for the length of the bony rib. A part of the latissimus dorsi and serratus magnus must be divided. This incision throughout its entire length should enter the pleural cavity. With blunt retractors the ribs are now separated until the blades of a rib spreader can be interted. In working upon the left side the forced retraction must be carried out cautiously, while the operator observes by sight and touch the region of the pericardium. It is conceivable that this membrane, covered by thick plastic exudate, may be ruptured by too violent stretching. When wide retraction has been accomplished and the chest emptied of fluid, sys-

tematic inspection of the lung should be made with a view to determine, if possible, the site and character of the focus of infection. A minute point of gangrene, a small bronchiectatic abscess, a sign of traumatism perhaps inflicted by the aspirating needle, or the presence of a broken-down tumor should be dealt with as occasion seems to demand. The entire hand being introduced into the adult thoracic cavity, adhesions may be broken down and lymph coagula removed. With the retraction in the adult of, say, from four to seven inches, perfect visual exploration is now possible. In children the opening, though smaller, will be found ample for exact manipulation. When satisfactory expansion has been secured and the intrathoracic work has been finished, the rib spreader may be removed and the chest permitted to assume its normal shape. It will be found that the ribs come together nicely, but that on account of the division of such a large part of the intercostal muscles the bones are not as firmly drawn together as when the incision is shorter. Two or three short drainage tubes, carefully secured so that they cannot slip within the chest, are now put in, and it will be found that they are not obstructed by rib pressure. A few interrupted sutures through the skin will close the long wound sufficiently, one or two additional sutures helping to approximate the divided latissimus dorsi. A thick dry dressing is now applied and the patient sent back to bed. Breathing exercises and especially blowing exercises are to be commenced almost immediately. Complicated cases and especially in the metastatic empyemas, revision may be required. If so, it is merely necessary to reopen the wound and again separate the ribs with the spreader far enough to permit exploration of the suppurating cavity.—*Medical Record*.

BERIBERI.

Periberi is said by A. M. Walcott, Porto Velho, Brazil (*Journal A. M. A.*, Dec. 18, 1915) to be a very common disease in the Brazilian portion of the Amazon basin, and his experiences with it there and elsewhere have convinced him that in all places it is the same disease. He refers to a former article by Dr. Carl Lovelace (*Journal A. M. A.*, Dec. 14, 1912, p. 2134), who opposed the dietic etiology, thus agreeing with the common opinion among the Brazilian physicians. He was surprised to find that many American physicians also opposed the dietetic theory and hold to a microbic or locality etiology. As physician in charge of the sanitary conditions of the force building the Madeira-Mamore Railway, he ordered certain changes in the diet, eliminating polished rice, macaroni, tinned vegetables and fruits, tinned soups, fish and meats, and substituting fresh fruit, cereal porridge, fresh eggs with ham or

bacon, coffee or cocoa and toast at breakfast. At lunch or dinner different fresh vegetables, including Irish or sweet potatoes and local supplies of this kind, dried peas and beans, etc. Very occasionally tinned fruits appeared. For the native laborers and second-class employees a similar course was followed as far as possible. By the changes in the diet, effective since 1912, beriberi has been eradicated from the medical department of the Madeira-Mamore Railway and other employers of labor are beginning to follow the same course. Since 1912 the medical department has tried to substitute for polished rice the unpolished, and wheat flour with the bran not removed and a plentiful supply of rye flour, instead of the white flour that had been in use. The prospects, he thinks, are good for complete eradication of the disease and the economic advantages are great, many thousands of dollars being saved every year. Walcott believes that beriberi is more common in the United States than has been suspected heretofore.

AMOEBAE IN PYORRHOEA ALVEOLARIS.

Dentists have hitherto looked on pyorrhoea alveolaris either as a general disease with local manifestations or as a local disease of bacterial origin. Lately, however, it has been suggested that it is a local disease of amoeboid origin. In particular Bass and Johns are exponents of this view, and in a short memoir, which gives evidence of much thought and careful study, they maintain that both the cause and the cure of what they prefer to call alveolo-dental pyorrhoea have been established beyond dispute. The cause is the *Entamoeba buccalis*, and the cure emetine, which causes rapid disappearance of the amoeba. They have found the parasite in more than 300 cases in which the disease had developed to an extent which permitted it to be diagnosed, but have always failed to find it in microscopic preparations that contained no pus. The special "habitat of the organism is the dying tissue at the bottom of the lesion the pocket) where bacteria and other agencies are few or absent . . ." Other evidence that the entamoeba is the specific cause of alveolodental pyorrhoea is "the very certain and rapid results that follow treatment with a specific amoebicide, whether applied locally or given hypodermically." They believe that the *Entamoeba buccalis* finds a suitable habitat in tissues injured by trauma, such as misuse of the toothpick or dental silk, and that by its motile activities it implants into these tissues the bacteria which adhere to it. It thus censures a constantly deepening infection. Once the amoebae are destroyed the tissues are given a fair chance are destroyed the tissues

are given a fair chance of healing, but pockets must be mechanically destroyed, since reaccumulation will keep up the irritation and prevent healing. Whatever may be the part played by the entamoeba, there is no doubt of its presence, though the fact that it is found most abundantly in the depths of the pockets, that is, in the well-developed lesion, may suggest to some that it is rather a secondary than a primary factor. It has, indeed, been regarded as a scavenger. Further, the trauma which is postulated as necessary for its implantation (by providing injured tissue) is by no means a necessary factor to the development of the disease, which habitually attacks the most secluded spots. The results of using emetine are said to be very good, but we are not told of any cases treated by this drug alone. A statement as to the local treatment accompanying its use ought to have been given, since by thorough local treatment the disease may always be cured—so far as cure may be spoken of in a recurrent condition—and the use of a rather uncomfortable drug avoided. But the opinion expressed is worthy of consideration, and it is to be noted that they have been able to fix the entamoeba by heat. The essay contains many good illustrations.—*British medical Journal*.

VACCINES IN GONORRHEA.

C. C. Warden, Ann Arbor, Mich. (*Journal A. M. A.*, Dec. 18, 1915), restates the facts formerly shown in an earlier paper in regard to the autolysis of the gonococcus in water, and its toxicity, inversely proportional to the length of time the cocci have been in suspension, argues against the views on which the vaccine treatment has been largely based, and says that there are objections to all vaccines for this disease. The beneficial results following vaccines treatment in gonorrhoeal rheumatism, which seem contradictory to this view, are held by the author to suggest that conditions about the joints may be more favorable to lysis of the cocci than the tissues of the urethra, and that the products of lysis may contribute to the symptoms. He holds that the organic nitrogen of the gonococcus is not altogether available as antigen, but that the fats of the gonococcus, if preserved in the vaccine, would improve its efficiency. He gives a preliminary report of a forthcoming paper by L. E. Schmidt and himself on complement fixation tests in which the best of the commercial antigens and the vaccines produced by himself with the unautolyzed cocci were compared. Up to the present, 279 tests have been made and the results show the importance of the fats of the cocco in the reaction. The serums of fifty normal individuals gave no fixation, neither did those of forty-two persons with other diseases than gonor

rhea. In acute cases under one month, the commercial antigen gave positive tests in 20 per cent., lipid antigen in 50 per cent. In subacute cases up to six months, commercial antigen was positive in 20 per cent., lipid in 75 per cent. In cases of long standing with repeated or recurring attacks, commercial antigen tests were positive in 33 per cent., lipid in 65 per cent. In past cases—over six months to thirty years—of doubtful character, commercial in 16 per cent., lipid in 50 per cent. In children, all stages included, commercial in 10 per cent., lipid in 66 per cent. "With my lipid antigen, complement fixation appears at an earlier period, occurs with greater regularity during the disease, and endures longer than with commercial antigen. All watery antigens are likely to show periods of alternating positive and negative reactions during an attack of gonorrhoea, in which the administration of vaccine takes no part. The lipid antigen shows less fluctuation of this character." These facts appear to put these fatty substances in an important light from an immunologic view, and in the treatment of gonorrhoea with gonococcus fats. The cases thus far include acute chronic, simple and complicated conditions in female and infant girls. In some, the subcutaneous inoculation of the fat has been followed by marked improvement and in some undoubted cure. The chronic cases showing posterior involvement with slight discharge, the cocci have disappeared after one to three inoculations, and the acute cases taken in the first two days showed complete disappearance of gonococci in smears and cultures and absence of discharge within a week after one inoculation. Between these extremes the acute cases with copious discharge and considerable edema have required more inoculations with increasing doses. In some instances there has been slight constitutional reaction, characterized by chilly sensations a few hours after the injection, but followed by marked clinical improvement. These reactions, local and constitutional, he is inclined to credit to the sudden tysis of the cocci in the body of the patient.

TREATMENT OF PHTHIRIASIS.

Sergent and Foley, in the *American Journal of Tropical Diseases and Preventive Medicine*, August, 1915, are credited with the statement that, since the agent transmitting both typhus fever and relapsing fever has been proved to be the body louse, a campaign against this type of vermin is the basis of prophylaxis against these diseases. A satisfactory procedure is to change and disinfect the clothing and have the patient bathe. Where this is not feasible, the authors have found that an equally good result may be obtained by using oil of eucalyptus to

destroy the vermin *in loco*, on the clothing itself, and while the body is still clothed. The louse inhabits the underclothing, except in the periods when it is sucking blood, a process lasting but about twenty-five minutes and not repeated every day. Pieces of cloth moistened with oil of eucalyptus and then dried in the open air were found to kill lice, when these were placed in contact with it, in a few second. The odor of the oil was also found to kill lice through thick cloth. The clothing of eight men infested with lice was lightly sprinkled with the oil. In twenty-four hours all the lice had in each instance disappeared.—*N.Y. Med. Jour.*

PERSONAL AND NEWS ITEMS

One of the valuable signs of the times is that the public is at last awakening to the enormous wastage of child life that is going on constantly, and that with attention might be greatly reduced.

A proposition is on foot in London to form a College of Nursing with the object of regulating the course of studies, both practical and theoretical for nurses, the examinations they should undergo; and in general to secure a uniform standard of efficiency.

Dr. Crawford William Long was born 4th November, 1815. He employed ether for an operation on 30th March, 1842, and again on 6th June, 1842, and advocated its use among his doctor acquaintances. He thus antedates the claim of W. T. G. Morton.

George Oliver, M.D., F.R.C.P., died recently. He was known as the one who introduced the "Oliver test papers." He also won fame by his researches, along with Sir Edward Schafer, on the suprarenal glands. He was in his seventy-fourth year.

Dr. Sir George Scott Robertson, M.P., died in London in his sixty-third year. He saw much active service in India, Afghan and Africa. He won great fame by his defence of chitral in 1895.

The China Medical Board, which left for China last August, was composed of Professors Welsh and Simon Flexner, and Dr. W. Buttrick. These eminent scientists have returned and report favorably of the reception accorded them. They contend that the medical college in China should be on a high plane.

Dr. James Clarke White, the noted dermatologist, died recently in Boston at the age of 83. He was one of the first to introduce the study of dermatology into America.

In London, Eng., where the playgrounds attached to the school-

houses have been in use of as a means to furnish a system of open air education for the children. The plan has given much satisfaction, and the children have been much benefitted in health.

Up to the 10th November, 1915, there had been 579 cases of typhoid fever. Among those who had been vaccinated with 39 deaths. On the other hand there had been 571 cases among the unvaccinated with 115 deaths.

Sir Frederick W. Hewitt, M.D., M.A., M.V.O., died on 6th January. He was born in 1857. He was a leading authority on the subject of Anæsthetics, and published many articles and several books on this subject.

Professor Guido Baccelli, Professor of Medicine in the University of Rome, died of heart failure eighty-fourth year. He held the rank of Senator of Italy.

Dr. Emil Goetsch contributes a lengthy article to *The Johns Hopkins Hospital Bulletin* in which he sets forth the results of his experimental researches on the influence of feeding pituitary gland extract on the growth of the body and the development of the sexual organs. He concludes the anterior portion of the gland does cause both body growth and sexual development.

Sir William Turner, K.C.B., Principal and Vice-Chancellor of the University of Edinburgh, has completed his 84th year. He held the chair of Anatomy in the University of Edinburgh for many years. Latterly he has also been Chairman of the General Medical Council.

The United States Supreme Court has unanimously upheld the Food and Drug Act. The decision was that it is a fraud to make an unjustifiable claim of curative merit for any preparation, as well as to misrepresent its composition.

The Western Medical News returns with vigor to the subject of the Prevention of Bovine Tuberculosis, and argues that the Bureau of Health has not fully discharged its duty.

The Department of Medical Research for South Africa is going on with its investigations on pneumonia. Dr. F. S. Lister informs us, in the *Medical Journal for South Africa*, that 100 to 400 millions of killed pneumococci repeated thrice subcutaneously gives rise to no appreciable agglutinin or opsonins in the sera of rabbits; whereas, four days after the intravenous injection of 100 millions of similar vaccine, agglutinins and opsonins are easily demonstrated. He contends that the intravenous is the proper method. It is claimed that when the killed pneumococci are those employed they are useful.

When the war broke a medical student in France at once enlisted. He won the Military Medal and Cross for bravery. He was wounded

in the legs by a shell. In the hospital propped up he wrote his graduation thesis on shell wounds, his own case being No. 57 in his essay. President Landouzy in conferring the degree said that his own grandfather had won his degree under somewhat similar circumstances.

In 1876 the Boston Medical Library contained 4,488 volumes. In 1915 it contained 85,963 volumes. It is the fourth in size in the United States.

David William Cheever, A.B., M.D., LL.D., was born in Portsmouth, N.H., in 1831, and died in Boston, December, 1915, at the age of 84. He held a number of official positions in connection with Harvard University.

The National Committee for the Prevention of Blindness in the United States is carrying on an excellent campaign. It states that one-half of the blindness in the country is preventable.

Dr. Harry B. Yates, who was with the McGill University Hospital, died in France on active service.

Dr. Scott Huntingdon, of Havana, an American citizen, gave up his practice and offered his services as a member of the Canadian A.M.C. He has been given a commission.

The four western universities have offered to raise a battalion from these institutions, and a committee appointed to take the matter in charge.

Drs. Murray MacLaren, Geo. E. Nasmith and Arthur E. Ross, of the Canadian A.M.C., have received the honor of Companion of St. Michael and St. George.

Throughout the United States there is much activity shown on the subject of Care of Children. Many places have a "Baby week."

The death is announced of the famous surgeon Ivan Pavloff Petrovitch, aged 67 years. He was professor of physiology at the Institute of Experimental Medicine in Petrograd, the physiology of the heart being the special subject of his research. He was awarded the Nobel Prize for medicine in 1904.

A school for the training of medical officers has been opened in Toronto. Hart Hall at the University of Toronto will be used for drill purposes.

Professor V. G. Henderson, for some time holding the rank of captain, has been appointed Junior Major by Lt.-Col. J. A. Cooper of the 198th Battalion.

Dr. Jacob Cargis, an American Methodist medical missionary, who has arrived in Petrograd after a thrilling experience, having had several

narrow escapes from death in Urumiah. Northern Persia, declares that an American doctor named Simons or Shimmum was burned to death by the Turks and Kurds in that region.

Britain has the biggest hospital ship in the world. She is the new 48,000-ton liner *Britannic*, which was built at Belfast for the White Star Line. As soon as completed, she was taken over by the Admiralty, towed to Liverpool, and converted into a hospital ship. The *Mauretania* and *Acquytania* are also being used for hospital service.

Dr. Archie Gilchrist, of Toronto, who was studying in London when the war broke out at once offered his services. He was attached to the Worcestershire regiment. He was recently wounded but was reported as doing well. He was mentioned by Sir John French, and was promoted to the rank of captain. He was again mentioned, and awarded the military cross for distinguished services.

Dr. Duncan Alex. Campbell, of North Bay, enlisted for service and appointed to new Orpington Hospital, Kent, Eng.; graduated in Toronto about five years ago.

The Russians themselves, calculate their casualties thus far at 3,000,000 and state that 1,000,000 German and Austrian prisoners of war have been sent to the interior of Russia or to Siberia. It is said Russia no longer needs foreign assistance in hospital work, although many physicians from other countries are still in service at the front. Life in Petrograd is described as virtually normal.

Dr. Alex McKay, Chief Medical Inspector of the Public Schools of Toronto, has joined the Ontario Military Hospital at Orpington, England.

Dr. Perry G. Godsmith, of Toronto, who has been serving in a hospital in France since the war broke out, is home on furlough.

Hon. Phillippe Roy, Chief Commissioner for Canada in Paris, has forwarded to Sir Robt. Borden a report by the chief surgeon of the Canadian hospital at Dinard of the work carried out by that institution since the beginning of the war. Mr. Roy also states that the Canadian hospital at Saint Cloud will soon be in a position to receive wounded.

Col. Gorrell and his staff at Cliveden and all the Canadians have their hands full. To revisit the hospital there is to find that an institution which twelve months ago was pretty well confined to a covered tennis court, has now spread itself over the adjacent golf links. The long wards of asbestos construction are always full, and are called after the different Provinces of Canada. Recently 158 patients arrived, and were all transferred from the railway some miles distant, examined, and put comfortably into bed inside of an hour and ten minutes. Canada has reason to be proud of its hospital at Cliveden.

Two wealthy Americans have made the gift to France of a hospital train of thirteen cars. The gift has been accepted. The train has the most modern equipment, and can accommodate 225 wounded soldiers.

The late Miss Elizabeth White, Toronto, bequeathed \$12,000 to hospitals and charities.

The following appointment have been announced for the Ontario Hospital at Orpington: Lt.-Col. A. G. Ross, M.P.P., Officer Commanding; Lt.-Col. I. H. Cameron, Chief of Surgical Staff; Sir Wm. Osler, Consulting Physician; Lt.-Col. Graham Chambers, Chief of Medical Staff; Lt.-Col. Donald Armour, Consulting Surgeon.

OBITUARY

WILLIAM BROCK.

Dr. Brock, who had practised in West Lorne, Ontario, for many years, died suddenly. He was one of the best known medical men in the county of Elgin. He became a member of the College of Physicians and Surgeons in 1874. He held the office of coroner for a number of years.

JAMES R. JONES.

Dr. Jones died in Winnipeg on 11th January. He studied in the Toronto School of Medicine and graduated from the University of Toronto in 1878, receiving the Ontario license in the same year. He went to Britain after graduating and acted for a time as house physician in London hospital to the late Sir Andrew Clark. He was also house surgeon in Soho Hospital for Women. He settled in Winnipeg and occupied the positions of Professor of Medicine in Manitoba University, physician to the Winnipeg Hospital, and President of the Physicians and Surgeons of Manitoba.

ARCHIE V. BECHER.

Dr. Becher, of London, Ontario, died of pneumonia at Quebec in the end of December last. He had gone as medical officer with the 33rd battalion and held the rank of Major. He was in active service during the South African War. After that war he took up the study of

medicine. He was in his thirty-six year. He was a graduate of the Western University of 1900. His brother, Lt.-Col. H. C. Becher, was killed in France in action last June, at Girenchy. He leaves a widow and young son.

H. S. MONKMAN.

Dr. H. S. Monkman, of Vegreville, Alberta, was killed in action in France on 2nd December. At the time of his death he held the rank of Captain in the Third Canadian Mounted Rifles. He was a graduate of the Ontario College of Pharmacy in 1907, and also M.D. of the University of Toronto in 1906. He practised at Vegreville, Alta.

J. LEROY MAVETY.

Dr. (Captain) Mavety died in France of accidental poisoning. He was son of Reverend J. E. Mavety, of Ottawa. He joined the R.A.M.C. and was with the North Midlands Field Ambulance. He was mentioned for signal bravery. He graduated from McGill in 1911.

P. JAMES PIDGEON.

Dr. Pidgeon, of percé, Gaspé, died last November, at the age of forty-seven. He was a son of Dr. J. A. Pidgeon, of Gaspé.

G. CHEVALIER.

Dr. Chevalier died in Montreal a short time ago. He had practised at one time in Quebec. He was born at St. Eustace in 1822.

EUGENE G. QUESNEL.

Dr. Quesnel, of Ottawa, died at Alfed, Ontario, last November. He was born in 1868 and graduated from Laval University in 1895. He practised for a time at Rockland, and then became medical superintendent of the hospital at Sudbury. Latterly he practised in Ottawa.

R. G. C., KELLY.

Dr. Kelly, of Watford, Ontario, died suddenly last December. He was in his 45th year. He had taken an active interest in military affairs

and was Lt.-Col of the 27th Lambton Regiment. At the time of his death he was engaged in the formation of the 145th Lambton County Overseas Battalion. His death was caused by apoplexy. He left a widow and four children.

GEORGE ELIOT.

Dr. Eliot, of Grenfell, Sask., died last November. He was born in India in 1854. He held the diploma of the Royal College of Surgeons, London, 1877. He came to Canada in 1881.

ALEXANDER D. STRUTHERS.

Dr. Struthers, of Bedford, Quebec, died on 2nd December, in his 66th year. He was born in St. Thomas, Quebec. He graduated from McGill in 1882. He is survived by his widow and daughter.

AUGUSTUS F. SCHMIDT.

Dr. Schmidt, of Montreal, died there last December. He was born in 1861, and graduated from McGill University in 1886.

BOOK REVIEWS

CRAGIN'S OBSTETRICS.

A Practical Text-book for Students and Practitioners. By Edwin Bradford Cragin, A.B., A.M., (Hon.) M.D., F.R.C.S.; Professor of Obstetrics and Gynaecology, College of Physicians and Surgeons, Columbia University, New York; Attending Obstetrician and Gynaecologist to the Sloane Hospital for Women; Consulting Obstetrician to the City Maternity Hospital. Assisted by George H. Ryder, A.B., M.D., Instructor in Gynaecology, College of Physicians and Surgeons, Columbia University, New York; Assistant Attending Obstetrician, Sloane Hospital for Women; Associate Surgeon, Woman's Hospital, New York. Octavo, 858 pages, with 499 engravings and 13 plates. Cloth, \$6.00 net.

The author's eminence as a specialist in the fields of Obstetrics and Gynecology, his remarkable success as a practitioner and an instructor, and his exceptional advantages and experience as Attending Obstetrician and Gynecologist to the Sloane Hospital for Women, combine to make the appearance of this new work an event of great interest and importance to the medical world.

During a protracted service as medical head of the Sloane Hospital for Women, where over 1,800 deliveries annually occur, the author has enjoyed exceptional opportunities for observation and experience in obstetrics; and for several years he has felt a growing sense of the duty of placing before the profession and students of medicine the methods of this institution and the results obtained. The present text-book of Obstetrics has seemed to him the most rational and perhaps the most useful way in which to meet this obligation. The work, in the methods advocated, is based upon the statistical results of the Sloane Hospital and upon the experience gained by the author in the hospital and in private practice. Another object of the work has been to present American statistics in obstetrics which, it is believed, represent the most extensive and careful records available in this country.

The fact that many text-books now before the profession, although very valuable for reference, are too large for the undergraduate student, has been appreciated by the author, and he has covered the subject concisely, eliminating all unnecessary discussion.

Professor Cragin has written a book which will be found not wanting in any essential feature either as a student's text-book or a practitioner's reference work.

In reviewing this work we feel that it has so many outstanding and meritorious features that the medical profession will welcome its appearance; and the day is not far distant when it will have found its way into the colleges as a favorite text-book.

SURGICAL OPERATIONS WITH LOCAL ANESTHESIA.

By Arthur E. Hertzler, A.M., M.D., Ph.D., F.A.C.S., Surgeon to the Halsted Hospital, Kansas; Swedish Hospital, Kansas City, Mo.; General Hospital, Kansas City, Mo. 327 pages, 173 illustrations, cloth bound. Price, \$3.00. Second edition. New York: Surgery Publishing Company.

The rapid sale of the first edition covering minor surgery and the demand for a more complete work upon the subject covering both major and minor surgical work, has induced Dr. Hertzler to present this second volume, which for completeness as to detail and price we believe places it in a class by itself among those text-books upon this most interesting and growing subject.

Dr. Hertzler's vast surgical experience and his work with Local Anesthesia particularly fits him as an authority upon this subject, and thus the second edition of his book places within the hands of the doctor a manual which for completeness and comprehensiveness, particularly recommends it.

From a review of this book Dr. Hertzler seems to have overlooked no point of major or minor importance. The large number of illustrations clearly places up to the eye of the reader the text of the book, and both the general practitioner and surgeon will appreciate this work as a reliable guide in their operation work under Local Anesthesia.

PAINLESS CHILDBIRTH.

By Carl Henry Davis, M.D., Associate in Obstetrics and Gynaecology, Rush Medical College, Chicago; Associate Attending Obstetrician and Gynaecologist to the Presbyterian Hospital, Chicago. Forbes and Company, 443 South Dearborn Ave., Chicago, Ill., U.S.A. Price, \$1.00.

The first part of the book traces the development of the attempts to relieve the suffering of labor. The chemistry, pharmacology and toxicology of the various analgesics are compared and their advantages and disadvantages considered with unbiased fairness.

In the second part of this volume eutocia is given as the goal for which the physician is striving. The author believes that in the cry for painless childbirth that the desire of mothers is for eutocia,—not amnesia. Granting that painless obstetrics is desirable the author pleads for safer and better obstetrics. He claims that with all the modern progress in preventive medicine that there has not been a corresponding increase in the safety of maternity.

Recognizing the need for relieving pain in many cases of childbirth, Dr. Davis offers in the highly important third section of his book a method which should receive the consideration of every physician whether he practices obstetrics or not. This is the nitrous oxid-oxygen analgesia.

While the advocates of "Twilight Sleep" agree that it should be used only in an especially equipped hospital and by a specialist, Dr. Davis believes that the nitrous oxid-oxygen analgesia may be used safely and efficiently by every physician who is trained in the science of obstetrics. He believes that nitrous oxid-oxygen analgesia is a logical method of relieving the suffering during childbirth and a great aid in securing eutocia.

INSTINCT AND INTELLIGENCE.

By N. C. Macnamara, F.R.C.S. London: Oxford Medical Publications. Toronto: McAinsh & Company, Ltd. Price, \$2.00. London: Henry Frowde and Hodder and Stoughton, 1915.

This is an exceedingly interesting and scholarly book. The author develops his argument by tracing the evolution of the nervous system

from the lowest to the highest types of animal life. He holds firmly to the view that there are certain instinctive qualities which to a large extent determine the individual's behaviour throughout life. These qualities are not eradicated by education and training. The author states that it is highly important to properly develop the nervous system, apart from the training of the mind. We congratulate the author on his able presentation of the case.

ALTITUDES IN THE DOMINION OF CANADA.

From the Commission of Conservation, by James White, F.R.C.S., F.R.G.S.; assisted by George H. Ferguson, A.M. Ottawa: The Mortimer Co., Printers, 1915.

This volume from the conservation of energy is valuable in the vast amount of tabular information it furnishes about the attitudes of Canada. The volume will prove of much usefulness as one of reference. It furnishes a number of maps.

AUTOPLASTIC BONE SURGERY.

By Charles Davison, M.D., Professor of Surgery and Clinical Surgery, University of Illinois, College of Medicine; Fellow of the American College of Surgeons; Surgeon to Cook County and University Hospital, Chicago, and Franklyn D. Smith, M.D., Clinical Pathologist to University Hospital, Chicago. Octavo, 369 pages, with 174 illustrations. Cloth, \$3.50 net.

The authors have succeeded in presenting, in clear and concise form, a vast array of facts and theories covering this important subject. The work brings to the reader not only the proved results of the author's own practice and experimentation, but it also includes a painstaking resume of the literature which has appeared during the last few years.

Wherever the literature is at variance with their experimental and clinical deductions, the authors have presented the literature as it exists in addition to their own findings, thereby permitting the reader to draw his own unbiased conclusions. The authors' own opinions are based upon histopathological study and analysis of tissues removed from experimental animals at varying periods of time after an operation had been performed. This experimentation includes not only problems with the regeneration of osseous tissue, but problems in technic, mechanics and minor problems in this difficult field of surgical science.

Perhaps the most important section of the work is that which treats of the repair of intractable, recent, simple fractures by the autoplasmic transplantation of bone. It is to be hoped that the methods

therein described will largely replace the user of metallic foreign bodies for fixation in fractures of this character which require open operation.

The book is amply and admirably illustrated with original photographs and röntgenograms showing the methods employed and the results attained by the authors in their extensive experience.

THE PRINCIPLES AND PRACTICE OF SURGERY.

By Richard Warren, M.D., M.Ch., Oxon., F.R.C.S., Assistant Surgeon and Teacher of Clinical Surgery at the London Hospital; Senior Surgeon to the East London Hospital for Children Examiner in Surgery at the University of Oxford. Two octavo volumes of about 700 pages each, with 505 original illustrations. Cloth, \$7.50 net.

The aim of Warren's Surgery is to place before the reader the more practical issues of the science, from the standpoint of the general surgeon. Theoretical considerations are detailed only when of importance in diagnosis or treatment.

Alternative methods of treatment are discussed only where the course of the disease or the condition of the patient renders such alternative methods desirable. Special attention has been paid to those sections where, in the last few years, surgery has made such enormous strides, viz., with regard to blood vessels, bones (including fractures), joints, the air passages, the abdomen, and the urinary system. A clear account is given of the best methods of treatment now in use, and the author very helpfully directs attention to those which in his own experience have proved sound and satisfactory.

The work has been produced in admirable style, and in its text and illustrations it will be found entirely adequate. It will undoubtedly take a leading place in the world of surgery.

MISCELLANEOUS

THE SOLDIERS' HOSPITAL AT RICHMOND HILL.

An eloquent appeal has been sent out over the British Empire for help towards the arranging of the well-known hostelry of the "Star and Garter" into a hospital for such of the soldiers and sailors as are permanently disabled. Her Majesty the Queen, whose conduct of the manifold interests and occupations during the war has been beyond praise, has given this great building to be a "Women's National Mem-

orial," and an appeal is being sent to touch every English woman. One wing is to be named "The Edith Cavell Wing," also a wing to be called "The Brave Twenty," in memory of the martyred nurses who were drowned in the transport sunk by the enemy in the Mediterranean, and went with the undying words, "Fighting Men First," when called to enter the boats. The situation of the hospital will be known to thousands as being one of the most beautiful in England, overlooking Richmond Hill, near London, and rich in historic memories and surroundings.

PROVIDING MEDICAL ATTENDANCE.

Arrangements have been made by Lieut.-Col. Marlow, Director of Medical Services, for a new plan of providing medical attendance for troops recruited and billeted in villages and towns where the medical officer of the battalion is unable to superintend the entire work of his unit. Civilian practitioners will be instructed to act as medical officers for these small squads of recruits and will be paid according to the numbers to be attended. It is estimated that about seven doctors will be required for each county battalion, and as there are over 25 such battalions being organized, about 200 doctors will get appointments. The list is now being made up by the Director of Medical Services.

Where 50 men or less are stationed the doctor will receive one dollar per month. Where over 50 and under 100, a salary of \$2 per day will be paid; where less than 150 and over 100 the pay will be \$3 per day, and for over 150 a daily salary of \$4 will be received by the doctor. He will have to perform all the usual duties of the medical officer, and the paymaster of the unit will issue pay cheques in the usual way. This order started on February 1st.

TORONTO'S VITAL STATISTICS.

	Jan. '16	Jan. '15	Dec. '15
Births	1,041	1,019	1,035
Marriages	493	398	592
Deaths	724	504	606
Deaths from contagious diseases number 94 compared with 36 in January, 1915, and 94 in December, 1915.			

Measles accounted for 52 deaths, tuberculosis 23, while spinal meningitis claimed three victims. Following is the comparative table:

	Jan. '16	Jan. '15	Dec. '15
Scarlet Fever	3	..	3
Diphtheria	9	10	12

Measles	52	..	32
Whooping Cough	4	2	1
Typhoid Fever
Tuberculosis	23	24	35
Spinal Meningitis	3

ONTARIO'S VITAL STATISTICS.

The detailed returns show:

Diseases	Cases	Deaths	Cases	Deaths
Smallpox	21	0	20	1
Scarlet Fever	152	3	140	5
Diphtheria	297	42	355	22
Measles	3,018	59	3,432	34
Whooping Cough	136	10	111	5
Typhoid Fever	35	8	62	2
Tuberculosis	140	68	98	66
Infantile Paralysis	1	1	2	0
Cerebro-spinal Meningitis	21	17	8	7
	<hr/>	<hr/>	<hr/>	<hr/>
	3,821	208	4,228	142

ONTARIO HOSPITAL STAFF.

List of doctors for Ontario Hospital at Orpington:—Dr. G. W. Aitken, London; Dr. D. A. Campbell, North Bay; Dr. M. M. Crawford, Toronto; Dr. Douglas Curry, St. Catharines; Dr. J. W. Clarke, Toronto; Dr. T. A. Carson, Orangeville; Dr. G. Fripp, Sault Ste. Marie; Dr. L. C. Fallis, Toronto; Dr. P. V. Graham, Toronto; Dr. A. B. Greenwood, Sutton West; Dr. Arthur Gunn, Durham; Dr. D. A. Hilker, Hamilton; Dr. G. L. Jepson, London; Dr. Ross Alexander Jamieson, Toronto; Dr. J. E. Kane, Kingston; Dr. D. L. Kennedy, Kingston; Dr. Smilie Lawson, Toronto; Dr. McCartney, Fort William; Dr. H. McIntyre, Harriston; Dr. H. W. Martin, Hamilton; Dr. McArthur Thorpe, Norwich, England; Dr. Alex. McKay, Toronto; Dr. A. W. Nixon, Georgetown; Dr. E. F. Richardson, Port Hope (now of Aurora); Dr. Berkeley Stark, Toronto; Dr. Harley Smith, Toronto; Dr. R. A. Thomas, Toronto; Dr. R. J. Wilson, Toronto.

Doctors for the psychopathic section of the Ontario Hospital at Orpington: Dr. Fisher, at front; Dr. Graham, at front; Dr. Williams, at front; Dr. Edward Ryan, Kingston, Ont.

RESOLUTION OF TORONTO ACADEMY OF MEDICINE.

That the Council of the Academy of Medicine, Toronto, regrets that at the hearing before the Medical Commission on November 3rd,

Dr. Goldwin Howland, who had been asked to speak for the Academy, took the opportunity of expressing his personal views.

That this Council wishes to place itself on record as not being in accord with the views then expressed as his personal opinions by Dr. Goldwin Howland before the Medical Commission, and as published in the Canadian Journal of Medicine and Surgery, January, 1916, pages 18 and 19: "In regard to the question of the education and organization of the second class irregular practitioners, I desire to state my views apart from my position as a representative of the Academy of Medicine, and I do so because from my work as a nerve specialist I am constantly in touch with the work of these irregular practitioners, etc."

That this resolution be published in all the Canadian medical journals.

LETTER FROM DR. A. PRIMROSE.

"We are having a taste of most inclement weather to-day, but we cannot complain, as hitherto we have had bright sunshine for about six weeks. Last night it began to blow, and then rain, through the night it got colder, and we have had a driving sleet all day. I had some operating to do, and we managed to get the operating tent very comfortable, with a temperature of seventy degrees. This was accomplished by a number of coal oil stoves. Our operating tent is quite good now. It is a large marquee, which we have floored, and have laid down linoleum. It is about thirty feet long. We have two operating tables, a series of sterilizers, instrument cupboards, etc. It is really quite imposing and remarkably well equipped, so that when our medical visitors go around for inspection of our hospital they are greatly surprised by the completeness of the equipment in the operating room.

"Another show place is our laboratory, which is remarkably well equipped and the envy of some of our neighbors in the British hospitals. The fact is the fund we had raised for our equipment was a perfect godsend. We were able to get all necessary apparatus, and it is being used to tremendous advantage, in fact in the laboratory a considerable amount of work is being done to solve problems outside of our own hospital, because it is the only laboratory sufficiently well equipped to do the work. Prof. J. J. Mackenzie, Dr. Duncan Graham and Dr. C. G. Imrie compose our laboratory staff, and they are very busy men.

"Another department equally efficient is the dental department.

Dr. George Gow and Dr. Mallory are doing a tremendous amount of work in their special tent. They have had to do a lot of work for men outside our unit, as there are no other skilled dentists hereabouts. They work all day and every day, and are both unexcelled in their professional work, and we are very lucky to have them. So many Tommies lose their teeth at the front. This is due to the life they lead and the eating of "hard tack." Some poor chaps come in in a miserable condition, having lost their teeth and being unable to masticate their food properly, they are miserable indeed. There is no choice of diet at the front. They must eat what is given out to them and what is available, so it comes about that our dentists are doing noble work."

MEDICAL PREPARATIONS

AN IMPORTANT SILVER GERMICIDE.

There are numerous silver salts on the market. One of the most efficacious of these is believed to be the proteid-silver compound manufactured by Parke, Davis & Co. under the name of Silvol. This product occurs in scale form, has a dark lustrous appearance, and contains about 20 per cent. of metallic silver. Silvol is slightly hygroscopic, consequently is readily soluble in water. Aqueous solutions of any strength desired may be prepared from Silvol—solutions having this important advantage: they are not precipitated by proteids or alkalies or any of the reagents that commonly affect other silver compounds in solution. Moreover, Silvol solution do not coagulate albumin or precipitate the chlorides when applied to living tissue.

The user of Silvol is indicated in inflammatory affections of mucous membranes generally. It may be used locally in solutions as strong as 40 per cent. without producing pain or irritation. In acute gonorrhoea, as an abortive measure, a 20 per cent. solution may be injected every three hours, while in the routine treatment the injection of a 5 per cent. solution three times a day is recommended.

Silvol penetrates tissue and destroys pathogenic bacteria. It is non-toxic. The product is available in two forms: powder (ounce bottles) and capsules (6-grain), bottles of 50. The contents of two capsules make one-fourth ounce of a 10 per cent. solution. For application to regions where the use of an aqueous antiseptic solution is impracticable, Silvol Ointment (5 per cent.) has been devised. This ointment is marketed in collapsible tubes (two sizes) with elongated nozzle.