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# CANADA

# MEDICAL & SURGICAL JOURNAL

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Original Communications.

## THE GROWTH OF A PROFESSION.

AN ADDRESS DELIVERED AT THE EIGHTEENTH ANNUAL MEETING OF THE  
CANADIAN MEDICAL ASSOCIATION, HELD AT CHATHAM, ONT.,  
SEPT. 2 AND 3, 1885.

By WILLIAM OSLER, M.D.,

President of the Association; Professor of Clinical Medicine in the  
University of Pennsylvania, Philadelphia.

GENTLEMEN:—When I removed last year to another part of the great field in which, without distinction of race or country, we are all laborers, it seemed good to you, fellow-workers, in the kindness of your hearts, to nominate me President of the Association. If in the tumult of thoughts which come tumbling unbidden into a man's mind, the idea of such an honor ever came, truly it was as a speck in the horizon of my ambition towards which, as years rolled on, I might travel; but it has been ordered otherwise, and as exceptional circumstances have placed me in an exceptional position, I can but crave your indulgence in the exercise of an office for which I feel that I lack certain important qualifications.

Let me, in the first place, give expression to the general regret that the Association has not been able to carry out its programme and meet in Winnipeg as had been arranged, but with Mars in the ascendant, and Big Bear and Poundmaker on the warpath, our brethren of the prairie city thought it would be better—perhaps safer—to postpone the meeting in the North-West unto a more convenient season, when grim-visaged war shall have

smoothed his wrinkled front. But, again, let me express the satisfaction we feel at being able to meet here in Chatham among men we know so well, who have been so faithful to the Association, and in a section of the country in which the profession possesses so many able and industrious members.

In seeking for a theme upon which to address you, I felt that if we met in Winnipeg, some subject connected with growth and development would alone be in keeping with the remarkable progress which the North-West and its capital have made during the past decade. I thought that by tracing the lines along which the profession in a new country should advance, the meeting might perhaps help the movement and give a stimulus to thought and action, which is often one of the best effects of gatherings of this kind. When circumstances necessitated a change in the place of meeting, it seemed as if my subject, upon which I had spent some thought, should also be changed; but, on reflection, it was evident that the conditions in the older provinces were only an advanced stage of those existing in Winnipeg and Manitoba—progress should be our watchword here as there, growth and development the essential features of our professional life, and upon these topics I could as well address you in Ontario as in the North-West. I want, then, to tell you, in as few words as possible, just how far on we have got and what have been the methods of our progress. In some parts of the Dominion we may study the profession in its simplest form; in the North-West Territories, for example, it has not advanced beyond the amœba stage. The doctors there are so many unicellular creatures—masses of undifferentiated professional protoplasm, without organization or special functional activities. They cannot even exercise the rhizopodal mode of multiplication, but increase by the low inorganic method of accretion. In the older provinces, on the other hand, the professional units have combined for the general good into a sort of polypidom—the organized profession—a great advance on the amœba stage; there are also special organs of reproduction known as the medical schools, and there are signs of a nervous system—medical societies.

The three aspects, then, in the growth and development of

the profession to which I wish to direct your attention are (1) the organized profession ; (2) the medical school ; and (3) the medical society.

1. *The organized profession.*—In a well-arranged community a citizen should feel that he can at any time command the services of a man who has received a fair training in the science and art of medicine, into whose hands he may commit with safety the lives of those near and dear to him. For the State to regulate and determine the individuals to whom the citizen may apply, is not by most persons thought unreasonable. There are those, however, who would have no restrictions, but allow the utmost freedom and permit assumption and assurance to have full sway, and give to any man without education the right to practice medicine. This has never been the case in Canada. The men who came here in the early days to practise medicine were chiefly English and Scotch licentiates, who brought with them the traditions and customs of the profession in Great Britain. Very many of them were army surgeons, accustomed by long training to system and discipline. Without medical schools, the only recourse for a young man wishing to enter the profession was either to cross the ocean or to serve an apprenticeship with and receive instruction from a practitioner. Boards for the inspection of diplomas of men coming from outside the country and for the examination of the young men who had passed the necessary time with local preceptors were organized in the old Province of Quebec in 1788, and in Upper Canada in 1815—dates ever to be memorable in the history of medicine in this country.

It is a common experience that men do not always appreciate their blessings and advantages. Those who are the best off are the least sensible of it. I have often thought this of the profession in Canada in relation to the Medical Boards, when I have heard murmurs of discontent. As they constitute a special feature in the Canadian medical system, you will allow me to refer to their origin and functions at some length. Primarily, the Medical Board is simply a Bureau of Registration appointed by the State, as, in fact, the British Medical Council is to-day ; but here, at an early period, before the establishment of schools

and universities, it was an examining body as well, and granted permits to practise. As universities sprang up, the latter part of the duties of the Medical Board was in part abrogated, and the functions more or less limited to the registration of degrees. An exceedingly important change was effected when the Boards became elective bodies, truly representative of the profession. In Ontario, this was brought about by the Act of 1866, and in Quebec by the Act of 1847. In this province, the mode of selection of members is truly democratic, the profession in each electoral district selecting their candidate. In the Province of Quebec a more cumbrous and less distinctly popular mode is followed, whereby each constituent of a district votes not only for his own, but for the candidates in all other districts. As proxies are allowed, the entire election may be in the hands of any clique collecting the largest number; but this method is doomed, and the more popular one will shortly be introduced.

The struggle has all along been between the universities and the profession, as represented by the Medical Boards. The former have always maintained the right of their alumni to license without further examination—a privilege still granted in the Province of Quebec. But the universities chartered by the crown in past days did more: they opposed bitterly the incorporation of independent medical schools, as witness the hostility to the Montreal School of Medicine by the McGill University, and to the Toronto School of Medicine by the University of Toronto. Much of this opposition was based on the highest motives. The opponents were afraid that if numerous independent schools arose, each with licensing power, and the license recognized by the Provincial Boards, free trade in diplomas would result, the standard be lowered, and the profession, as a profession, ruined.

As at present constituted, the Medical Boards are entrusted by law with full power to regulate medical education in the provinces, to say what preliminary branches shall be required, of what the curriculum shall consist, and to make such changes as from time to time may seem advisable. When we consider the conditions under which we live, these enactments are in the

highest degree advantageous. There are in the Dominion eleven medical schools, many of which are corporations without any control, with faculties irresponsible as regards supervision by trustees, censors, or governors. Even of those which form actual parts of universities, the faculties are partly, or altogether, independent, and there have been instances in which, for greater freedom, the benefits of university connections have been sacrificed. The inevitable result of such a state of affairs is keen competition. The students are few, the schools are many; expenses are heavy, receipts are light; human nature is frail—what will follow you know—restrictions are relaxed, special inducements are offered, gradually the standard is lowered, the meshes are widened, examinations become a farce, and the schools degenerate into diploma mills, in which the highest interests of the profession and the safety of the public are prostituted to the cupidity of the owners. The depths to which unlicensed competition will sink the proprietors of some institutions pass the comprehension of a right-minded person. They will compass heaven and earth to gain students, resorting to measures of solicitation and inducement, various tricks and artifices, which would be deemed doubtful in a grave-yard insurance company. Finally, upon the proprietors of such schools comes a sort of moral paralysis, such a condition as divines call the hardened heart, when, incapable of seeing, much less doing, the right, they believe the system in which they work is a true and good one, and attempts at reformation become well nigh hopeless. The picture is not overdrawn. Unrestricted competition between numerous schools means free trade in diplomas, and free trade in this sense is synonymous with manslaughter.

From this disastrous condition the medical boards have saved Canadian schools. Bitterly did the colleges fight against increasing the powers of the boards, jealous in the extreme of their chartered rights, and too often eager in obstructing, instead of furthering, useful legislation, they have found, though they did not know it, victory in defeat. The principle is sound and well founded; the united profession of a country or a province should be the guardian of its own honor; greater than

the schools, which are but a part of it. The control of all matters relating to medical education and practice may safely be entrusted to its care.

The incorporated body of the profession in each of the provinces of Canada is variously known as the "College of Physicians and Surgeons," the "Medical Council," or the "Medical Board," and, as you are all well aware, by the Act of Confederation, each province is left to regulate its own educational affairs. Within the past ten or twelve years, so many important changes have been affected, particularly in the older provinces of Ontario and Quebec, that the boards are gradually approaching a state of efficiency.

As regards education, the ideal board should perform the following duties: 1st. Test the fitness of young men to enter upon the study of medicine; 2nd. Order the curriculum in a manner best suited to the country and the requirements of modern medicine; and 3rd. Control absolutely the examinations for the license to practice. Upon each of these points I propose to make a few remarks, referring particularly to existing conditions:

1. *Preliminary Education and Matriculation.*—In most of the provinces a thoroughly satisfactory system prevails, and a young man, before entering upon the study of medicine, must give evidence that his general education is of such a nature as will enable him to prosecute intelligently the study of a learned profession. If the examination is satisfactory, he is permitted to register, and his studies date from this period. A Board should control its own matriculation examination, and should accept no other. It is directly responsible to the profession that no incompetent person shall be admitted to study. The check comes lighter to a young man, and is more easily borne at this time than later in his career. The examiners should be independent persons, engaged in general teaching, and there should be at least three or four. No one man can conduct a preliminary examination with entire satisfaction. The organization of the board of the matriculation examiners in Quebec should serve as a model for all the other provinces. It was a

decidedly retrograde step when the medical council of this province relegated the entrance examination to other hands, and the acceptance of the intermediate High School certificate is not without disadvantages. We want increasing watchfulness in this matter, and in the interests of higher education the boards should receive the cordial support of the medical schools in their endeavors to arrive at an honest and satisfactory standard. That there has been laxity in the past, every one knows only too well who has had to read many examination papers. Throughout Canada the subjects for matriculation have closely followed those recommended by the British Medical Council, and embrace the elements of a good general education, with a fair amount of Latin. To these special subjects have lately been added Natural Philosophy, Chemistry, and Botany (optional). The student has had in the past to contend with several difficulties which should be removed. He has had to pass in some cases two examinations: one before the Board of his province, and the other before the university at which he wishes to take his degree. Now the matriculation examination of the Boards should be placed on such a level, and conducted in such a way, that any university could consistently accept it in lieu of its own; and if it was universally recognized by the profession, by teachers of high schools, and by the candidates, that there was but one portal of admission to the study of medicine, and that through the medical board by means of its authorized examiners, a great deal of trouble and annoyance would be prevented. Again, in the interests of the student, the greatest care should be exercised in the selection by the examiners of subjects which the candidates will find taught in the advanced classes of the high schools. Similar books to those read for the other matriculations should as far as possible be chosen. Lack of attention to these apparently petty details has caused no little irritation on the part of students and teachers.

Let me, then, urge upon you the importance of doing all in your power to put the preliminary education of the students on a good basis; it is in your own hands—insist on competent, independent boards, responsible to your chosen representatives;



and, what is equally important, impress upon your students and the young men who seek your advice, the need of careful preparation. As a result of some years of observation, I should say that the general practitioners throughout the country are not quite alive to their duty in this matter. Too often young men go up for examination imperfectly prepared, and just slip through, to flounder on, hampered at every turn by defective preliminary training.

2. *The Regulation of the Curriculum.*—The general profession, through its delegates, has an incontrovertible right to regulate and frame the curriculum of study which men shall follow who aspire to join its ranks. The governments allow this right, and have empowered the Boards to frame such measures as they see fit. In the exercise of this function there has been a little friction in the past, and in no one of their duties will the boards of the various provinces require to proceed with greater circumspection in the future. That there has been a good deal of tinkering, and not always of a satisfactory kind, is a complaint frequently made by schoolmen. That there has been very little, and that the results, on the whole, have not been bad, would, I think, be the verdict of any one who looked into the matter fully. The curriculum is at present in a transition stage, and we must expect in the next few years to see important changes, but into these I do not propose to go in detail. One thing is clear, the Boards and the teaching bodies must act in concert—in the interest of the student and of the profession harmonious action must be arranged. In this country the students of all classes seek the degree as well as the license and are not, as the majority are in Great Britain, satisfied with the latter. Hence the imperative needs of a certain uniformity in the requirements of the boards and of the universities. The teachers cannot possibly arrange the instruction on diverse plans. The duty of the Board is to lay down a minimum curriculum to which every student shall conform, and which the schools can easily carry out. The university requirements, while as much higher as the authorities chose to exact, should be laid down in the same lines, so that a student could easily

proceed in his studies for the one or the other without inconvenience, and the teachers prepare a man for either examination without needless repetitions.

Fortunately the universities and teaching bodies are well represented—too well in Ontario in proportion to the territorial representatives—on the boards, and the introduction and regulation of the necessary changes in the curriculum will fall chiefly into the hands of their delegates, but there are many details which require careful attention on the part of all. The members of the educational committees have their work laid out for the next few years. Among important questions which await settlement in some of the provinces are the strict enforcement of the four years of study and the advisability of prolonging the session to nine months, or, what amounts to the same thing, making the summer session compulsory. The plan of allowing a student to pass one of his four years of study with a physician should be done away with at as early a date as possible. For two reasons: in the first place it is, in a majority of instances, a farce, and we find on inquiry that the student has been pursuing his usual avocation, and perhaps going to a doctor's office in the evening; it is certainly not the equivalent of a session at college. If allowed at all, it should not be the first year, but the third, as permitted in the Province of Quebec, for then a student is in a position to obtain really valuable instruction in practical medicine and surgery from his preceptor. I was surprised a few years ago, on obtaining the statistics from the registrar of one of the boards, to find how many men there were who passed on the three sessions. In this matter, the boards should not be behind the leading universities, which no longer recognize the year with a physician as the equivalent of a session. And, in the second place, the change should be made in the interests of the schools themselves. On no possible scheme can a three-sessions course be satisfactorily arranged. Either a man pays too much attention to his primary subjects in the first two sessions and leaves the important final branches for one short session, or he tries in his second session to work hard at both and ends in a muddle-pated condition

which unfits him for either. The prolongation of the session to nine months, as now exists in some of the schools of the Province of Quebec, must ultimately come in all the colleges. How the foolish habit arose of giving six months vacation we need not stop to inquire—the folly of it is too evident to need remark; and we can safely predict that within ten years the nine months course will be universal; either as a continuous session, as at Laval University, or by making the now optional summer session compulsory.

3. *The control of the licensing power.*—This is the most important function of the medical boards. Acting on behalf of the State, it is their duty to see that all candidates for the license are properly qualified. They stand as the guardians of the public and of the profession, and here their responsibilities are indeed great. In the ideal condition, there should be but one portal in each country through which a man can enter the profession and legally exercise its rights—a uniform standard of qualification to which each one must conform. This is secured in some countries by the direct action of the State, which appoints examiners for the purpose. But a better system is that which we have here reached, in which the State entrusts the incorporated profession with the duty. On this question the hottest battles of the profession have been and are being fought. The universities and chartered colleges have contested, inch by inch, the rights of the profession in this matter, and the struggle has not everywhere concluded. The possession of a degree in medicine from a university, no matter how reputable, cannot on any reasonable ground carry with it the right to registration and practice. The schools are independent bodies, outside, in a large measure, of State, and altogether of professional, control; they are numerous, and the competition between them is close; the requirements for graduation are variable, and the standard of examination unequal. They are close corporations, and neither the public nor the profession ever know what transpires in their councils. In the majority the teachers are also the examiners. Such a state of things can only lead to relaxation, and is fraught with danger to the best interests of all concerned.

A uniform system has not yet been adopted in all the provinces. In too many the possession of a degree, obtained after a proper course of study, still entitles the holder to the license, all others having to submit to examination. In the Province of Ontario the most advanced position has been reached, and the one road to registration is through the examination conducted by a board appointed by the medical council. To this the other provinces must ultimately come. It is what the profession in Great Britain has been striving after for years, and so far striving in vain against the power of corporations and vested interests. In the Province of Quebec the medical board accepts degrees from the local universities to which it sends assessors—after the manner of the British Medical Council—who report on the nature of the examinations. Others than the holders of such degrees must submit to examination. Although this method has not worked badly, it is but a make-shift, and must finally be replaced by a central board of examiners, who shall test the qualifications of all candidates. Unfortunately the prevalent conditions of that province are such that a dual board will be needed, one for the French and one for the English.

In carrying out the details of a central examining board, there are inevitable difficulties which at first cause worry and discontent, but, with patience and mutual forbearance, gradually vanish. The choice of suitable examiners is a delicate matter, and one on which the schoolmen are apt to air grievances more or less just. They certainly should not be selected at random from the members of the council. A few years ago a friend of mine was nominated examiner in chemistry at the Quebec Board. He was a remarkably able practitioner, with a very indistinct and hazy knowledge of chemistry, and it was hard to say who was most uneasy at the examination, Dr. ——— or the students. Teachers in the schools have good grounds for complaint when the Boards select as examiners on special subjects—such as anatomy, chemistry, physiology and pathology—men who have been for years in active practice without any possibility of keeping their own knowledge on these subjects fresh and practical, and who to “brush up” require to work as hard, may be, as the poor candidates. With the more practical

branches these difficulties do not exist, and the Councils have a wide field for selection. Where special technical knowledge is needed, it would be preferable even to override the law which forbids the selection by the Boards of any teacher as an examiner on his own subject. For the "Staats-Examen" in Germany, the professors in different departments are usually chosen by the government to conduct the examination in their special branches. The point is one to which the Boards should attend carefully in the future. They lose the respect of the profession and of the students in nominating as examiners men without special qualifications in certain fields.

The examinations for the license should be made in all respects as practical as possible, but to do this a Provincial Board must possess its own building and appliances, and make arrangements with hospital authorities to have free access to a sufficient number of patients. As the work is done primarily in the interests of the public, it is clearly the duty of the legislatures to assist in making suitable provision, and it seems probable that Ontario, the first to set the example of a one-portal licensing system, will also be the first to have a local habitation worthy of her incorporated profession. Such a building should contain the paraphernalia necessary for examination purposes. The division into a primary and final examination, as at present made in most of our universities, and at the Ontario Medical Council, seems the best arrangement. The former embracing anatomy, physiology, general and medical chemistry, and materia medica; the latter, the practical branches of medicine, surgery and midwifery. In practical details, the "Staats-Examen" of Germany might in many particulars be followed.

A serious difficulty has been felt in conducting the examinations satisfactorily as regards time, place and rapidity. They should come off after the university examinations have been completed, and not, as now, immediately at the close of the session. More time could then be given, which will be necessary if the tests are to be made more practical. As the number of candidates increases, the examiners on each branch should be doubled. One centre in each province should be chosen for the sittings of

the Board, and in almost each instance this will be the chief town. To go to Quebec for one meeting and Montreal the next, as is the practice in the Province of Quebec, and to hold an examination in Kingston as well as in Toronto, are touching and tender tributes to age with which a harder generation must soon dispense.

Very much more time must be hereafter given to those practical portions of the examinations which afford the only true test of a man's fitness to enter the profession. The day of theoretical examinations is over.

Permit me to refer to one or two other questions in connection with the Medical Boards. An anomaly which has been the source of no little irritation results from our close connection with the mother country. Any registered practitioner of Great Britain, under the present British Act, can claim registration in the colonies without further examination. For some years Ontario contested the right, but it was finally settled by the registration of Dr. E. St. G. Baldwin in 1879 and Dr. A. E. Mallory in 1880, since which time many have been entered on the register without examination. The Medical Bill, which was shelved last year in the House of Commons, contained a clause permitting the colonies to make any regulations they pleased concerning registration, and doubtless a similar proviso will appear in a future bill. The objections to receiving British registration are precisely those made against the reception of Canadian registration in Great Britain. The examinations are conducted by corporations with varied standards, of whose proceedings nothing is known, and over which no control can be exercised. But in Ontario the shoe pinches badly in another way. After graduating, students are enabled to give the Board the slip by taking an English or Scotch qualification and registering in Great Britain, when they return and are entered upon the register without further examination. The objection to this lies in the fact that many men have evaded the just regulations of their province and returned with British enregistration, when even they could not have qualified for examination at the Ontario Medical Board. With few exceptions, Canadians seek in Great

Britain the easier qualifications, particularly the license of Edinburgh colleges. At some of these the custom has been, with Canadian graduates, to examine the parchment, accept the University degree, and admit the candidate to examination without any further inquiry. To avoid an injustice, the British licensing bodies must examine the matriculation certificate, and have satisfactory proof by class tickets that a student has spent four years in the study of medicine. Under these conditions registration in Ontario on a British certificate would be no hardship, though there would still be the unfair discrimination against local institutions.

Through the kindness of Dr. Pyne, the Registrar, I am able to give you some figures bearing on this question. In the past five years 378 men have registered in the Province of Ontario, and of these there were 93 Canadians who did so on their British registration—that is to say, about one-fourth of the number have avoided the enactments of the Board by proceeding to Great Britain and passing at one of the colleges. No one can doubt that these 93 men were greatly benefited by the period of additional study and by contact with men of other schools and countries, but they would have been still more benefited if they had first conformed to the requirements of their own province, and aided the profession in maintaining regulations the benefits of which are universally recognized.

The fees demanded by the Boards excite a good deal of grumbling on the part of students and practitioners. A sum of \$70 is charged by the Ontario Board for the three examinations, matriculation, primary and final; and in Quebec the registration fee is \$20 and the matriculation \$10. It is the old story, those who are best treated often complain the most. In the matter of fees, the medical students of Canada are in too easy a position, and they must expect changes in the near future. While the expenses of conducting a medical school have quadrupled in the past twenty-five years, the fees have not increased 10 per cent. The charges of the Boards are just and reasonable, as well as necessary to meet expenses. The annual tax on physicians of \$1 in Ontario and \$2 in Quebec is often spoken of as irksome, but surely it is but a trifling contribution to the general welfare of the profession.

It seems extraordinary to outsiders that in a country like Canada, with scarcely five millions of inhabitants, there should be so many licensing boards; and a still greater anomaly, that a licentiate in one province cannot practice in another—that there should be no reciprocity. So it seemed also to many earnest minds a decade or so ago, when in this Association a strong attempt was made at several meetings to frame a Dominion Medical Bill. It failed, as will, I think, subsequent ones, should they be made. Only one remedy remains—the Boards of the various provinces may in time so assimilate the curriculum and examinations that reciprocity may become possible; but this we cannot expect for some years. For certain purposes a Dominion Registration Bureau at Ottawa seems specially indicated; thus the surgeon of a Quebec regiment doing duty in Ontario would be practising illegally, and in the marine, the surgeons sailing in the passenger steamers must be registered in the province of the port from which the vessel hails. There would be great if not insuperable objections raised to any such Bureau, though it might be feasible to devise a plan for the military surgeons and those belonging to the mercantile marine.

I have dealt thus fully with the constitution and functions of the medical boards of the provinces, because I feel convinced that the safety of the profession rests with them. Of inestimable service in the past, their work in the future will be even more beneficent. Do arouse to a sense of your professional advantages. Where else do the medical men of a country enjoy the rights of conducting their own affairs in their own parliament? Look at Great Britain, where our mighty sister Association, with all her influence, and backed by eleven thousand members, could not force the principle of professional representation into the last medical bill, and at the best was only able to secure three or four members from the profession at large. Rest content, when in each province of this Dominion you have (1) an elective representative assembly (medical board, council or college), with members from each teaching body; (2) absolute control of preliminary qualifications, curriculum, and examinations for the license to practice; (3) appropriate accommodation for the



meetings of the boards, for the conducting of examinations, and for preservation of the local and general archives of the profession. The full development of the Acts of 1788 and 1815 will not be reached until these things are accomplished. The first two you have already won in a majority of the provinces, the last will perhaps be the most difficult of accomplishment; but I feel confident that the day is not distant when, in the capital of each province, the incorporated profession will have a stately Æsculapian temple worthy the traditions and aspirations of our high calling.

And here I may reasonably conclude this portion of my theme, which is concerned particularly with the relations of the profession and the community, but I will dwell upon one point. I began by saying that in a well ordered State every citizen should feel that he has near at hand well-trained men, to whom in the hour of need he may turn with confidence, and ask aid for himself, his wife, or his little ones. That throughout Canada this condition exists, that the community is to-day served by capable and well-trained men, that within reach of the poorest within our smallest villages there is an honest, capable physician, that impostors and charlatans are few; these, gentlemen, are some of the blessings for which we may, lifting both hands to heaven, thank our medical boards.

To another important relation of the medical profession to the community I can but briefly refer. One of the most remarkable developments of modern medicine has been the direction of the study of the causes and mode of prevention of epidemic diseases. The principles of preventive medicine have been gradually receiving due recognition on the part of the public, and the necessity for organized effort is generally acknowledged. In this province these efforts have resulted in the establishment of the Provincial Board of Health, which is doing a great work, and should receive the active support of the public and the profession. The successful course which it has pursued during the past four years affords a stimulus which the other provinces must sooner or later feel, and sets an example which for very shame they must follow.

2. *The Medical School.*—In the progress and development of a profession, the medical school plays an important and essential part. The primary object is the training of young men in the science and art of medicine, to supply the community with fit and proper persons to take charge of the sick and injured, and it is with this aspect of a medical school that the public is naturally concerned. In most European countries the State, as guardian of the public weal, undertakes the control of medical education and subsidizes largely the medical faculties of the universities. In Great Britain this is also done to a slight extent, but everywhere on this continent the schools have arisen as a result of private enterprise. The origin and evolution of the medical school in this country are quite easy to trace. For many years private tuition was the sole means of obtaining a medical education, and the system of apprenticeship prevailed to a large extent. In a series of “grinds” or “quizzes” the preceptor would take his pupils over the whole range of medicine and surgery, and a knowledge of anatomy was obtained by private dissection, which was carried on extensively. The office practice and the daily round furnished clinical material. The student was much with his preceptor, became his friend and companion, and in the course of four or five years, sometimes less, grew really very proficient in the practical working of his profession, and felt prepared to present himself before the Provincial Board. Some of the very best practitioners we have had in Canada received their medical education in this way. Take the Medical Register of Ontario or Quebec and seek out the names of the men who have simply Lic. of the Med. Bd. of Upper Canada or of Lower Canada after them, and we find among them many of the men we know best and respect the most highly. Without doubt, in good hands, the old system had great advantages; the essential, useful, and practical details of professional life were well taught: for the refinements and superfluities, the busy physician found no time. Among the private teachers, before medical schools became generally accessible, were some notable men, whose names deserve to be mentioned in grateful remembrance. Dr. James Douglass, of Quebec, was a remarkably successful as

well as popular teacher, and his pupils had the great advantage of the Marine Hospital. He still lives in peaceful retirement, one of the few links uniting the profession of Quebec to a generation long past. The late Dr. Rolph, from the date of his removal to Toronto in 1831 until the foundation of the Toronto School of Medicine in 1843, was one of the most energetic and successful private teachers, and many of his pupils of that date now occupy prominent positions among us. Even after the troublous times of 1837, when he had to cross the border, the students followed him to Rochester.

The organization of the first medical school arose from the association of two or three men engaged in private teaching, who thought that it would be more advantageous, and save time, if each one taught one or two branches. In 1824, at Montreal, Drs. Stephenson, Holmes, Caldwell and Robertson gave the first definite course of lectures in medicine delivered in this country. This, "Medical Institution," as they called it, became, in 1829, the medical faculty of McGill College, and remained for many years the only medical school in the country. The next attempt was a much more ambitious one. As early as 1835-6 efforts were made to induce the government of Sir John Colborne to establish a faculty of medicine in King's College, Toronto, and elaborate plans were prepared, but nothing came of it until 1843, when a faculty was organized with a full and able staff. A more favorable inauguration of a medical school could not have been devised; with State aid, well-trained and efficient professors, who were in the receipt of salaries ranging from £225 to £350—fine emoluments for those days. From all I can gather, the school was a thoroughly efficient one, and did good work in medical education, but the professors made certain mistakes for which they paid heavily. In opposing the incorporation of the Toronto School of Medicine, which had been organized by Dr. Rolph in 1843, they acted most injudiciously, laid the foundation of future trouble, and too many of them were hostile to the profession in their desire for a better medical act. After an existence of ten years, an act of the Legislature left the University of Toronto with only the academical depart-

ment, and swept away a medical school which, whatever its faults, had in it the elements of ultimate success, and left the profession and the public at the mercy of irresponsible schools without foundations and dependent on private enterprise. There can be no doubt that the abolition of the faculty of medicine of the University of Toronto retarded seriously the growth of the profession in this country. The establishment of a well-equipped institution would have been an example and a stimulus to others, and as years passed, the difficulties inevitably associated with the first few years of existence would have vanished.

In 1843 the Montreal School of Medicine and Surgery was founded, and continues as the largest French school in the Dominion. About the same time the St. Lawrence School was started in Montreal in opposition to McGill College, but it had a short life and soon expired. The Quebec School of Medicine next started, and became, and continues as the medical faculty of Laval University. In Toronto a third school was added to the existing ones in 1850 by the establishment of the Upper Canada School of Medicine, which, in its first session, became the medical faculty of Trinity College, and after an existence of three or four sessions, ended by the resignation of the professors, who refused to submit to certain vexatious test enactments of a religious nature demanded by the corporation. The faculty of medicine of Victoria College was next established in Toronto, for years known as Rolph's School; it terminated its existence in 1869. The Kingston School, organized as a faculty of Queen's University, is now known as the Royal College of Physicians and Surgeons. The faculty of medicine of Bishop's College, Lennoxville, P.Q., was organized in Montreal in 1870. In the same year the faculty of medicine of Trinity College was re-organized, and exists now as a separate corporation known as Trinity Medical School. The Medical School at Halifax is the only one which has been started in the Lower Provinces.

The most recent additions to our list have been the Branch of Laval Medical Faculty at Montreal, 1877; the faculty of medicine of Western University, London, Ont., and the faculty of the University of Manitoba, both organized within the past

few years ; and in 1883, as the outcome of an unfortunate *contretemps* at Kingston, a School of Medicine for women was started in that city, and followed by the establishment of another for the same purpose in Toronto.

Of this latest development, there cannot but be a feeling of regret that our friends in these cities should have entered upon undertakings so needless in this country. It is useless manufacturing articles for which there is no market, and in Canada the people have not yet reached the condition in which the lady doctor finds a suitable environment. Look at the facts as they are ; even the larger cities can only support one or two ; in fact, Quebec and Montreal have none, and in the smaller towns and villages of this country she would starve. For the sake of educating six or eight women annually, of whom at least three or four will go abroad, two more medical schools have been established, with full staffs of professors and teachers. We can but hope that at the expiration of the five years for which kind friends have guaranteed the expenses, the promoters of these institutions will be in a position to place their energies and funds at the disposal of the schools devoted to the sterner sex. Do not understand from these remarks that I am in any way hostile to the admission of women to our ranks ; on the contrary, my sympathies are entirely with them in the attempt to work out the problem as to how far they can succeed in such an arduous profession as that of medicine.

Exclusive, then, of the schools for women, there are existing eleven teaching bodies throughout the country, three French and eight English, a goodly number to supply the wants of about five millions of people. In Great Britain, with a population of 36 millions, there are about 30 medical schools ; and in the United States, with a population of fifty millions, there are 139 schools conducted in the interests of the regular profession, so that in comparison with these countries we are very abundantly supplied.

The youngest among us may have watched the incubation and birth, and many of us the gradual growth and development, of a medical school. With scarcely an exception, every one which

has started owes its origin to the individual exertions of members of the profession. There are men present who could tell us that the task is not a light one to-day, but what must it have been to those who began the work fifty or sixty years ago? It was an unending struggle against serious obstacles and difficulties. Money had to be raised for buildings and apparatus, and with but few students and small returns, the marvel is not that only four have succumbed in the struggle, but that so many have survived. The internal difficulties are often the most serious; the brunt of the work in such enterprises always falls on one or two zealous men who have to carry the chief part of the load, and the dead weight of lethargic colleagues has been the heaviest burden to many an ardent spirit.

Debt is the millstone which keeps the young schools under for many years; borrowed money furnishes the appliances, etc., and even in the older schools each addition to the buildings means so much more interest to pay. In only one or two of the faculties connected with universities have the governors even furnished suitable accommodations. The financial condition is for years oppressing, and from session to session the school drags on, living from hand to mouth, barely able to meet liabilities and pay the teachers—at this stage most probably not at all. As the number of students increases, so do the finances improve, and, if a school proves popular, the debts may be paid off and the professors receive fair remuneration; but so long as the attendance is limited, the receipts are only such as will barely meet the expenditures. A difficulty which under the present circumstances seems insuperable, is the fact of absolute dependence for success upon the number of students; small classes mean restricted capabilities for teaching, spiritless instruction, low-spirited professors, and general discontent, particularly on the part of the faculty. Large classes mean, perhaps, the opposite of all this, but not always; still there is a cheeriness about a professor the benches of whose class-room are well filled. I have known a small entry depress for the session the spirits of a man whose estimation of everything was numerical.

Let us glance at the facts as they stand. I estimate that last

season there were in the eleven Canadian schools about 900 students, from whom, with trifling exception, the entire support of the institutions was derived. Four of the eleven institutions are greedy enough to attract at least 700 students, leaving about 200 to be divided among the seven other schools. With the low scale of fees at present in vogue, I doubt if each student paid more than an average of \$80 per annum for instruction, so that the total receipts at the number of students above mentioned would be about \$70,000, of which at least \$55,000 goes to four of the schools, leaving a balance of not more than \$15,000 to be divided among the remaining seven. Now, a modern school of medicine is a serious affair to undertake and equip; there are branches to be taught which require, even in the smallest schools, plenty of room and good apparatus. Laboratories for the practical teaching of chemistry, histology, anatomy, pathology and physiology must be provided, and arrangements made for library and museum purposes. Personal expenditure on the part of members of the faculty can alone supply these in some of the schools, and in almost all, the rule has been that each lecturer from his fees shall provide his own teaching outfit. Where the teacher has enthusiasm and a purse this may work well, and, indeed, does so sometimes, for I know of an instance of an outlay of over two thousand dollars in apparatus, and of another in which the personal laboratory expenses were always between five hundred and one thousand dollars annually. As matters have been in our schools heretofore, without personal expenditure laboratory equipment has been defective. The remarkable impetus which has been given of late to practical teaching has increased very much the expense of conducting a school, for not only have the laboratories to be provided, but special men must be forthcoming with special training. The general practitioner who has for eight or ten years been busy at practical medicine and surgery may step into the professor's chair and give a good, sensible course of lectures; but to conduct laboratory work demands careful and prolonged training, which costs much money, and when obtained has a market value.

One great evil which results from this condition is the com-

petition for patronage among the schools, which I have already alluded to as a danger to be carefully watched by the profession. Too many of the students enter upon the study before they have means sufficient to carry them through the entire course, and they seek special inducements, reduction in fees, exemption from attendance until Christmas, and will often in letters set off one school against another in a most amusing way. Think, gentlemen, to what the unrestricted competition among eleven schools for 900 students might bring the profession! It would be a struggle for existence, in which the public and the profession would certainly be the losers, but with the wise regulations already referred to, existing in each province, the competition is reduced to reasonable limits, as all students, irrespective of their schools, must virtually pursue the same plan of study and for the same length of time.

What is the remedy? The small schools have rights equally with the large; they cannot be asked to immolate themselves in the interests of more favored institutions. It is plainly within the duty of the provincial boards to inquire into the equipment of the teaching bodies, and they should refuse recognition to those which have not appliances fit to conduct a modern medical course; or, what would be better still, the medical boards should have the power of prohibiting the establishment of a new school until satisfied that its promoters had money sufficient to begin such an enterprise, and had suitable buildings and hospital accommodation. In the future one of two things will take place: either a considerable number of the small schools will die of starvation—for it is quite evident, on the above financial statement, which is approximately correct, that there are seven existing on class fees which could only support one, and that in a not very flourishing manner—or means must be devised to secure funds from other sources. That there are superfluous schools in the country no one can deny, and the death of three or four under present circumstances would be no loss to the profession or the public; but if all could be furnished with suitable clinical and scientific equipments, they would then prove a source of strength, not of weakness. Dependent solely



on class fees, the smaller schools, even with the self-sacrifice of professors which I know of, in many instances, cannot hope to keep up with the modern requirements in medical teaching, and in the larger schools, with their increased expenses and increased salaries, are really not much better off. The time has come when we should lay clearly before the public the needs of higher medical education. The full development of a school cannot be reached without extraneous aid. To build laboratories and provide costly apparatus require sums quite outside the power of the faculties or the professors to supply. We should learn a lesson from our brethren of the clergy. Ask in Toronto and Montreal the purpose of so many beautiful and costly buildings clustering about the universities of these cities, and we are told they are the divinity schools, in many instances erected at the cost of individual donors. The number of men in this country is rapidly increasing who have money to give where they see it is needed and will be profitably employed; and if those interested in medical education bestir themselves actively, suitable endowment can be obtained. We have not asked before—in careless unconsciousness of our needs—but we must ask now and ask earnestly. The successful appeal for \$100,000 made last year in Montreal is at once an indication and an encouragement. There are strong, enlightened men among us, like the Hon. Donald A. Smith, who feel, with Descartes, that the hope of the amelioration of many of the ills of humanity lies within our profession, and that it is a public duty and privilege to assist in making our colleges true seats of learning, as well as schools of sound instruction.

3. *The Medical Society.*—In a young country the organization of the medical societies is associated with serious difficulties. In cities, practitioners can easily meet together; but in communities scattered over a wide extent of territory, like Canada, general societies are not readily established. Thus we find that several attempts were made to organize a Canadian Medical Association, but without success until the confederation of the provinces in 1867. In 1845 the Medico-Chirurgical Society of Montreal sought to secure a Provincial Medical

Association, and called a conference of delegates from the societies in the city and district of Quebec and the district societies of Niagara and Toronto. A meeting of the delegates was held on the 20th of August, but the scheme was unfortunately frustrated. In 1850 the same society again sought to unite the profession of Canada in a British-American Medical and Surgical Association, and on July 10th, at Three Rivers, a preliminary meeting was held, at which a constitution and a short code of by-laws were adopted. Dr. Morrin, of Quebec, was elected president, and Dr. Hall, of Montreal, secretary, and the first general meeting was arranged to take place in Kingston on the second Thursday of May, 1851. I do not know that it was ever held; the journals of the day are silent on the subject.

At the instigation and call of the Quebec Medical Society, a meeting was held at Laval University on October 9, 1867, to consider the advisability of establishing a Canadian Medical Association. The organization was successfully effected, and the first meeting was held in Montreal in 1868 under the presidency of Doctor, now Sir Charles, Tupper.

Among the objects which the promoters sought to effect by united effort was satisfactory and harmonious medical legislation, and we find that, for the first four sessions, the time of the association was chiefly occupied with the framing of a Dominion medical bill, which ultimately proved an impracticable measure, and was dropped. The subsequent meetings have been devoted to more legitimate topics of discussion, and we have reached a truer conception of the objects of our annual gatherings. We are all agreed, I think, that the highest work which an association such as ours can undertake is the promotion of the scientific and practical aspect of the profession. To these meetings the best minds among us should bring their best thoughts, that, by the reading and discussion of papers, we may be mutually benefited. Every member can bring something. One great attraction in our profession is its freshness and novelty. Each one of us has had, since our last meeting, opportunities for the study of problems in disease, new, perhaps unexpected, and which may not occur to us again. Material

for original work and research lies in the daily round of each one, awaiting only the spirit of patient and earnest inquiry, lacking which we cannot wonder that men deem the practice of medicine dull, stale and flat. Every one should come to learn, and of necessity bring with him something he can teach, for in some points his experience supplements what is wanting in another's. To our gatherings all teachers in our schools should come to meet their brethren and give to them an account of their stewardship—for do they not hold their positions in trust?—and show by their work and ways that they merit the confidence reposed in them. The more we foster the scientific features of our gatherings, the more successful will the association be. It has been so with our sister associations in Great Britain, and in France and Germany the corresponding societies form sections of the general associations for the advancement of science, and the meetings are devoted exclusively to work.

By no means the smallest advantage of our meetings is the promotion of harmony and good-fellowship. Medical men, particularly in smaller places, live too much apart and do not see enough of each other. In large cities we rub each other's angles down and carrom off each other without feeling the shock very much, but it is an unfortunate circumstance that in many towns, the friction being on a small surface, hurts and mutual misunderstandings arise to the destruction of all harmony. As a result of this may come a professional isolation with a corroding influence of a most disastrous nature, converting a genial, good fellow in a few years into a bitter old Timon, railing against the practice of medicine in general and his colleagues in particular. As a preventative of such a malady, attendance upon our annual gatherings is absolute, as a cure it is specific. But I need not dwell on this point—he must indeed be a stranger in such meetings as ours who has not felt the glow of sympathy and affection as the hand of a brother worker has been grasped in kindly fellowship.

There is special need in this country for such an association. With scattered and isolated provinces, self-governing, and regulating their own affairs, this organization is the sole bond of professional union. At these meetings we are neither of Ontario,

nor Quebec, of Manitoba nor Nova Scotia, but of Canada, and the narrower provincial spirit is lost in a wider national feeling. In the future development of the profession this body must take an ever-increasing share. It has difficulties to contend with of a geographical nature, as the distances between our provinces are so great, but these must not be considered. A peripatetic association always labors under certain disadvantages, but these we have in common with similar bodies in other countries. The provincial medical societies which have been established supplement the work which we do, and are a source of strength. We regret that there are still one or two provinces without such organizations. The district societies throughout the country are becoming more and more vigorous, and physicians are everywhere recognizing the advantage of coöperation in the study of our profession.

Let me refer to two other matters in-conclusion. In selecting the place of meeting the association should be guided by what is thought best for the interests of the profession, and it should be distinctly understood that when we meet at any place the sole business of the local profession is to arrange suitable accommodation; and this association must set itself strongly against past practices by which the profession of a place has been heavily taxed for entertainment. In this we should follow the practice of the British Medical Association, at the meetings of which all the members subscribe to an association dinner, and I should ask for the re-appointment of the committee to revise the by-laws and constitution, as there are certain changes which will facilitate the work of our meetings and which should be brought up for discussion at as early a date as possible.

And now, gentlemen, I have done, and there remains but the expression of my thanks for the kind attention you have given to a very matter-of-fact address; but I cannot part with you on this occasion without assuring through you, my brethren in Canada, that, although no longer of them, I am still with them in spirit, with them in their persistent efforts to advance the higher interests of our profession, and united with them by a thousand bonds of fellowship and friendship, which absence shall not weaken nor time efface.

## Correspondence.

VIENNA, August 4, 1885.

A stay of two months in Vienna, especially if the time be devoted to attendance on courses on a special subject, affords a fair insight into the principle on which the clinical teaching is conducted.

The writer was the fortunate possessor of letters of introduction to the leading laryngologists, which proved of service in many respects.

Of the four kliniks for diseases of the nose and throat, three are situated in the Krankenhauses, and the remaining one is held in the neighboring Poliklinik. The hours of attendance are so arranged that they do not conflict in any way. From 8 a.m. to 1 p.m. may be spent by the student of laryngology in almost uninterrupted attendance on these courses. The supply of material is varied and apparently inexhaustible, though, after some weeks, one perceives that the same patients constantly return, at regular intervals. This is accounted for by the fact that especial attention is paid to the requirements of the student, and cases presenting the more interesting types of disease are encouraged to make frequent visits. The class of cases are of a more aggravated nature than are ordinarily seen at the Throat Clinic of the Montreal General Hospital. Nasal disease (if we except growths, syphilis and lupus) is much less common than in Canada, where a very large proportion of all pharyngo-laryngeal disease depends for its permanent relief upon the treatment of unhealthy conditions of the nose or its lining membrane. Laryngeal phthisis is of frequent occurrence; indeed tubercular consumption is considered *par excellence* the disease of Vienna. The great daily variations of temperature are held to produce this unfortunate tendency, and this is no doubt aggravated by the prevalence of unpleasant winds carrying before them clouds of fine dust, which is found to be particularly irritating to the respiratory mucous membranes.

The instruction at the Vienna Klinik is of a most painstaking and practical character. The blackboard is used freely, as are also models and anatomical as well as pathological specimens.

The almost entire absence of didactic teaching is noticeable, and the substitution therefor of case teaching is equally remarkable. The Germans possess a facility for illustration almost peculiar to themselves, and one which teachers of other countries would do well to cultivate. The teacher seems to know exactly what the student wants and how he wants it, and practically puts himself in his place.

The Vienna laryngologists excel in point of diagnosis, as also in an ultimate knowledge of the pathological conditions to be met with. In the matter of scientific labor-saving apparatus, and in the treatment of affections of the nose and throat, it may be fairly conceded, however, that the American school is not second. Perhaps the great manipulative skill of our German colleagues may to some extent render more elaborate appliances unnecessary.

One cannot but observe, on the part of professors and assistants here, an absence of roughness or violence in handling that is particularly gratifying. This gentleness is not, it is said, a characteristic of the German school in other departments, but it is a lesson that all laryngologists must learn if they seek success. Cocaine is not extensively resorted to in the nose and throat clinics, probably on account of its cost. When used in the larynx, a 20 per cent. solution of the hydrochlorate is employed, and Merck's preparation is preferred. Education of the parts to tolerate instruments is generally adopted, and no apparent regard for the length of time necessary for the accomplishment of this is entertained. The line of treatment, generally speaking, is less radical than in America, where patients are more restless under cure than in the more easy-going European centres.

There also seems a general absence of *detailed* record of a vast amount of material which, if published, would greatly enrich our, in some respects, meagre laryngological literature. The amount of work imposed upon the staff will account for this, as also, perhaps, a disinclination to emulate what they so unsparingly condemn in their Transatlantic brethren—the cacoethes scribendi.

G. W. M.

## Reviews and Notices of Books.

**The Climate of Canada, and its Relations to Life and Health.**—By W. H. HINGSTON, M.D., D.C.L., &c., Member of the Imperial Leopold Academy, &c. Montreal: Dawson Bros.

This subject is one to which it is known that the author has been giving some attention for several years. The actual meteorology of the various sections of this country has had many observers, and the first part of the book is devoted to a resumé of the most reliable accounts which have, at various times, been published. To give a clear account of the climate of such a country as this, covering, as it does, an enormous extent of the earth's surface, and at the same time including parts so utterly dissimilar as Nova Scotia and Manitoba, is by no means an easy task. We have here, however, a fair presentation of the general character of the varying seasons throughout the Dominion. To foreign readers it will no doubt convey a good deal of interesting information. Part the Second, which deals with the influence exerted by this climate upon the inhabitants, involves a discussion of many matters of much greater difficulty. It requires careful and extended observations over a series of years, with masses of statistics, to determine with any accuracy the effects of climate upon the health and longevity of the inhabitants. The general conclusion is that Canada is a healthy country, that the present occupants are probably, as a race, an improvement upon their forefathers, and may improve still further. We may admit these general statements, but can hardly believe that a few experiments instituted by the author demonstrate that the French-Canadian race surpass in physical power their English-speaking compatriots. Whilst agreeing in the main with the remarks made anent the various diseases which prevail in this country, there are some inaccuracies which we cannot allow to pass unnoticed. The author, although in connection with the largest French hospital in the country, makes this statement: "There is an affection to which at least the French-Canadian portion of the population of Canada

is a stranger—hysterical affections.” Now, in our experience, the contrary is the case, for the most aggravated cases of hysteria we have ever met with have been amongst French-Canadian women, and these are, as a class, we think, more than most others liable to various hysterical disorders. Again, we cannot agree with the writer in attributing such evil consequences to cold affecting the foot. He says: “I have many times known fatal laryngitis to follow quickly on the sudden exposure of the bare foot to severe cold.” In this country, as elsewhere, fatal acute laryngitis (simple) is a very rare disease, and the part played by cold applied to the soles of the foot is surely problematical. The same affection is also said to have followed “deep inspiration of air of a very low temperature,” but only when the person has drawn the air through the mouth and not through the nostrils! We are not aware of the facts upon which these statements are based. We cannot help thinking that to persons outside of Canada, they are calculated to convey a very erroneous impression of the effects witnessed during our winter weather. Dr. Hingston wages war upon drinking and smoking, upon the amount of strong food daily consumed and the rapidity with which it is swallowed, and various other bad habits to which this community is more or less addicted. Amongst the peculiarities of the French-Canadian is mentioned his *penchant* for physic. With them, it is said, “a brisk purgative is a necessary preliminary to other treatment.” Except the physician instantly prescribes a cathartic, “confidence cannot be retained!” Amongst other points in which our French-Canadians are said to excel all other nationalities is their capability of taking and requiring enormous doses of physic—the explanation given being that the “dryness of the tissues has much to do with this tolerance of cathartics.”

Whilst we think that a complete account of the climates of Canada—for there are several—remains yet to be written, this contribution will be found of interest, introducing many subjects which are treated of from the point of view of a Lower Canadian and an admirer of the French-Canadian portion of our population.



**Minor Surgical Gynæcology.**—By PAUL F. MUNDE, M.D.

Second edition ; revised and enlarged. New York : Wm. Wood & Co.

Dr. Mundé is well known as the able editor for many years of the *American Journal of Obstetrics*, and the contributor of numerous valuable papers to that and other medical journals of the day. Subscribers to Wood's Library will remember the first edition of this work as one of the series for 1880. Dr. Mundé's book at that time filled an important gap in the literature of the specialty, at least so far as the English language is concerned. In German, Chrobak's *Untersuchen der Weiblichen Genitalien und Allgemeine Gynäcologische Therapie* had already met the necessities of the case. To this work Dr. Mundé expresses his obligation for aid in the preparation of his own book. Of textbooks and larger treatises on the diseases of women there have been no lack, but rather the contrary, for many years, but they nearly all failed to give instruction in a multitude of details of diagnostic and therapeutic manipulations. Our author, like every man imbued with the proper spirit, believes that attention to details is the secret of success. Hence his motto, a quotation from Emmet, in the preface of the first edition : "Success in the treatment of diseases of women lies wholly in attention to minute details." The object, then, of the work is to instruct men who have never had practical experience at hospitals or clinics for women, in many little matters of examination and treatment. And this is the lot of all but a favored few. It is a difficult and laborious matter to teach gynæcology practically. It is hard to get the material, and it is laborious in the extreme for the teacher, because of the time it takes to do justice to the average student. Dr. Mundé's book, faithfully studied, will greatly ease the task of teacher and pupil. We are much impressed with its value, and are not surprised to hear that such was the opinion of many others, as shown by the rapid sale of the first edition. The first part of the book is devoted to case-taking, methods of examination, position of patient, examining tables, &c. Every means of diagnosis, without and with instruments, is carefully explained and copiously illustrated. In this

part of the work we are pleased to see that in the present edition the author has omitted reference to, and illustration of, many of the plurivalve specula so treated in the first, and that, on the other hand, more attention has been given to the incomparable instrument of Sims and some useful modifications of it. One of these, the Mann's or Thomas's, which we have used for several years and find very valuable, is not alluded to by the author. The second part of the work includes a description of minor gynæcological manipulations and applications, catheterization, dilatation of urethra, vesical injections, applications to vagina and cervix, vaginal injections, tamponade of vagina, applications to the endometrium, dilatation of the uterus, curetting of the uterine cavity, local depletion, injection of medicines into the tissues of cervix and vagina, replacement of uterus and ovaries, pessaries, and hypodermic injection of ergot. Each of these subjects is carefully, minutely and, in general, we believe, judiciously discussed. The third part (added in the present edition) includes a general and most sound discussion of the subject of gynæcological operations and a thorough consideration of the subjects of lacerations of the cervix and perineum, of rectocele, cystocele, and prolapsus of uterus and vagina, and of the best approved operations for their relief or cure. These articles, especially those on the cervix and perineum, are nearly, if not quite, the best we know of. The significance of ruptured cervix is a subject about which there is still a wide divergence of opinion. That the operation for its cure has been and is still by many performed unnecessarily must be admitted by all judicial minds conversant with the subject. A careful study of Dr. Mundé's chapter will, better than any other description (Dr. Emmet's own not excepted), enable the practitioner, so far as books can teach him, to take the right course. The details of preparatory treatment and of the mode of performance of the operation are given more minutely and intelligibly than by the distinguished master himself.

The book consists of 539 pages octavo, and there are no less than 321 illustrations. These are tolerably well executed in the great majority of cases. Many are original by the author, and

of great merit. The descriptions of the numerous procedures are remarkably clear, and the whole literary style of the book is admirable. No medical man practising gynæcology can afford to do without this work. Not only is he therein taught much of what to do and how to do it, but he is warned by no uncertain sound when to refrain from procedures which, under certain circumstances, may endanger the life of his patient, or make her last state worse than the first.

**A Text-Book of Physiology.**—By M. FOSTER, M.A., M.D., F.R.S. Third American from the fourth and revised English edition. With extensive notes and additions by EDWARD T. REICHERT, M.D. With 271 illustrations. Philadelphia : Lea Brothers & Co.

Dr. Reichert has supplied what Foster's work, unequalled as a scientific treatise on physiology, required to make it better suited to medical students, inasmuch as the latter generally commence the study of physiology with either none or the most limited knowledge of general anatomy and histology. The American edition is all that the English edition is, plus these valuable and almost indispensable additions of anatomy, coarse and fine, well illustrated by plates. The book is also in more portable form than the English work, and for these and other reasons will be received by both teachers and students in this country with unusual satisfaction.

**The Essentials of Histology, descriptive and practical; for the use of Students.**—By E. A. SCHAFER, F.R.S., Jodrell Professor of Physiology in University College. London : Longmans, Green & Co.

The present book is all it pretends to be, and is in every way worthy of its learned author. It furnishes exactly what the student of histology requires ; and while sufficiently full, up to date, and accurate, is not unduly burdened with details either histological or technical. The plates are excellent, and the book attractive in appearance, suggesting neatness and solidity. It seems to us by far the best book for students that has yet appeared on this subject.

## Books and Pamphlets Received.

CLINICAL STUDIES ON DISEASES OF THE EYE. By Dr. Ferdinand von Ritter Arlt. Translated by Lyman Ware, M.D. Philadelphia, P. Blakiston, Son & Co.

SIX LECTURES UPON SCHOOL HYGIENE. Delivered under the auspices of the Massachusetts Emergency and Hygiene Association to teachers in the public schools. Boston, Ginn & Co.

THE MANAGEMENT OF LABOR AND OF THE LYING-IN PERIOD. A guide for the young practitioner. By Henry G. Landis, A.M., M.D. Philadelphia, Lea Brothers & Co.

INSOMNIA AND OTHER DISORDERS OF SLEEP. By Henry M. Lyman, A.M., M.D. Chicago, W. T. Keener.

THE WASTING DISEASES OF INFANTS AND CHILDREN. By Eustace Smith, M.D., Lond. Fourth edition. New York, Wm. Wood & Co.

KIRKE'S HANDBOOK OF PHYSIOLOGY. By W. Morant Baker, F.R.C.S., and Vincent Dormer Harris, M.D., London. Eleventh edition. Vols. I. and II. New York, Wm. Wood & Co.

ON RENAL AND URINARY AFFECTIONS. By W. Howship Dickinson, M.D., F.R.C.P. New York, Wm. Wood & Co.

A PRACTICAL TREATISE ON NASAL CATARRH AND ALLIED DISORDERS. By Beverley Robinson, A.M., M.D. Second edition. New York, Wm. Wood & Co.

ELEMENTS OF MODERN MEDICINE, including Principles of Pathology and Therapeutics, with many useful memoranda and valuable tables for reference. By R. French Stone, M.D. New York, D. Appleton & Co.

INEBRIISM, a Pathological and Psychological Study. By T. L. Wright, M.D. Columbus, O., Wm. B. Hubbard.

URINARY AND RENAL DERANGEMENTS AND CALCULOUS DISORDERS. Hints on Diagnosis and Treatment. By Lionel S. Beale, M.D. Philadelphia, P. Blakiston, Son & Co.

POISONS, THEIR EFFECTS AND DETECTION. By Alexander W. Blyth, M.R.C.S. New York, Wm. Wood & Co.

A TREATISE ON ASIATIC CHOLERA. Edited and prepared by Edmond C. Wendie, M.D. New York, Wm. Wood & Co.

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## Society Proceedings.

### CANADIAN MEDICAL ASSOCIATION.

The eighteenth annual meeting of this Association was opened in Christ Church Sunday School, Chatham, Ont., Sept. 2nd, at 10.30 a.m. Letters of regret were read from Dr. Brodie, the President of the American Medical Association; from Drs. Campbell of Seaforth, D. Clarke and Geikie of Toronto, Hingston and Alloway of Montreal, Kerr of Winnipeg, Vaughan of Ann Arbor, and Nattress of Toronto.

The retiring President, Dr. Sullivan, introduced the President elect, Dr. Wm. Osler of Philadelphia.

Dr. Bray, chairman of the Committee of Arrangements, welcomed the Association on behalf of the profession of Chatham, and Mr. Woods on behalf of the citizens of Chatham.

The minutes of the last meeting of the Association were read and confirmed.

Drs. Lundy, Connor and Walker of Detroit, delegates from the American Medical Association, were cordially welcomed and invited to take part in the active scientific work of the Association.

The following gentlemen were elected members of the Association: Drs. Fleming, McKeough, Hall, Sievewright, Backus, of Chatham, Caw of Parkhill, Patterson of Harrowsmith, Stewart of Wallaceburg, Brooks of New Hamburg, Hunt of Williamstown, Hoare of Strathroy, Ellis of Tilbury, Duncan of Toronto, and Ferguson of Merlin.

The report on Climatology and Public Health, by Dr. Yeomans, the chairman of the Committee, was read by the Secretary.

#### AFTERNOON SESSION.

The President took the chair at 3 p.m.

The minutes of the last meeting were read and confirmed.

The President then delivered his address.. (See page 129.)

Dr. Grant of Ottawa moved, and Dr. Thornburn of Toronto seconded, that the thanks of this Association be tendered to Dr. Osler for his able address. *Carried.*

The following gentlemen were unanimously elected members of the Association: Drs. Abbot of Comber, McCully of Buck-

horn, Wilson of Bothwell, Sampson of Blenheim, Pickard of Thamesville, O'Keefe of Tilbury, Teskey of Toronto, Haig of Oshawa, McAlpin of Parkhill, R. A. Clark, Pomeroy, Irving of Kirkton, and Eberts of Chatham.

Moved by Dr. Sullivan, seconded by Dr. Edwards, that the Nominating Committee be composed of Drs. Ross and Wilkins, Montreal; Drs. Reeve and Sheard, Toronto; Dr. Grant, Ottawa; Drs. Tye and Fleming, Chatham; Dr. McDonald, Hamilton; Dr. Burt, Paris; Drs. Eccles and Edwards, London; Dr. Harrison, Selkirk; Dr. Lumley, Glencoe; Dr. Stevenson, Strathroy; Dr. Sloan, Blyth; Dr. Sullivan, Kingston.

The meeting divided into medical and surgical sections.

#### MEDICAL SECTION.

Dr. Harrison in the chair.

Dr. Grant, of Ottawa, read the report of an interesting case of *Aneurism of the Aorta*. The patient was an old soldier who had suffered from thoracic pain and other symptoms. The disease was readily diagnosed, and he was under observation for a long time, during the greater part of which he was able to do light work. A large projecting tumor was watched, bulging the sternum and costal cartilages, and ending by eroding these and forcing itself forwards as a mass as large as two fists. He finally died from cerebral embolism.

Dr. Geo. Ross remarked upon the fact that this man had lived a long time—nearly five years—from the onset of symptoms. In the treatment of the case moderate exercise had always been allowed. Dr. Ross believes strongly in insisting upon complete rest for a sufficient length of time, although the present example shows that this is not always necessary to secure a remarkable degree of longevity. The reason here for the long time the man lived was plainly that the aneurism grew from the front of the aorta and pushed forwards, thus avoiding the important centrally-situated structures. Dr. Ross inquired if the physical sign of “tracheal tugging” had been observed.

Dr. Grant said it had not been looked for.

In answer to a member, Dr. Ross explained the method of examination to detect “tracheal tugging,” and said that he

considered the sign one of great value in the diagnosis of aortic aneurism. If present, it seemed to be almost pathognomonic, for he had examined for it in a great number of hospital patients, and had never found it distinctly marked in any one who was not the subject of this disease. It is quite true, however, that it is absent in many cases of aneurism, for the conditions necessary for its production are, that the tumor bear against the trachea or a large bronchus, and, secondly, that it be not completely solidified.

Dr. Sheard spoke of a case recently under his care. The tumor sprang from the first part of the arch, and the symptom most marked was dyspnoea in severe paroxysms from spasm within the larynx. Prolonged rest appeared to have had a very beneficial effect; this was strictly enforced for three months. Dr. Sheard had used the potass. iodid. in pretty full doses, but its employment was always followed by marked depression and lowering of the pulse—so much so that it had to be discontinued. He thought this action of the drug unusual. Dr. Sheard also gave the particulars of a case of aneurism in the descending thoracic aorta which produced plugging of all the great vessels beyond its point of origin.

Dr. Osler remarked upon the importance of considering the question of prognosis in these cases. Dr. Grant's case, for instance, had lived five years and a half, and he had known men with large tumors live ten years and more. On the other hand, a small aneurism may quickly burst and prove fatal; so much depends upon the location of the growth—those growing anteriorly may attain large dimensions before producing symptoms, and even then life may be prolonged, whilst a small tumor centrally situated generally soon makes its presence known, and is apt to kill within a short time. Those growing from the transverse arch and backwards are likely to produce early symptoms, and quite frequently early death. Those, again, involving the descending part of the arch may last very long. He would also in this case notice the coexistence of disease of the aortic valves, which was by no means common. The absence of any marked degree of hypertrophy of the ventricle was in accordance with what is generally seen. As regards

iodide of potassium, he was satisfied of its great power in relieving the pain so frequently present, but has great doubts as to its assisting in the consolidation of the tumor.

Dr. Wilkins spoke of the necessity for limiting the amount of fluid to be allowed to these patients, and alluded to a case of his own in which this principle had been acted upon, and where the man had lived between four and five years. He would advise reducing the allowance to half a pint *per diem*. He thinks that the necessary result of free imbibition of fluids is distension of the sac for the time being, a condition, of course, unfavorable to cure. In the case alluded to the "tracheal tugging" had been a marked sign, and the patient died from rupture into the trachea.

Dr. Eccles alluded to a case where he had been obliged to omit the use of iodide of potassium on account of its always rendering the pulse very small and frequent.

Dr. Worthington then reported some cases of *Epidemic Cerebro-Spinal Meningitis*. He remarked that though the cases he related were indicative of a cerebro-spinal fever, and seemed identical with the so-called epidemic form, they were not sufficiently numerous to show that the disease was extensively prevalent. The notes were then read *in extenso*. The first showed a markedly intermittent type, and it was thought that here, as according to Dr. Radcliffe sometimes occurs, the specific disease was complicated with ague. The other cases were characterized by rapid onset, rigors, headache, rachialgia, convulsions, spasms and delirium, and later on somnolence and diplopia. They presented a considerable degree of similarity. The treatment consisted in mercury and iodide of potassium, with application of cold. In later stages, quinine and stimulants.

Dr. Harrison said that it was somewhat remarkable how this disease showed itself in certain restricted localities. He had had six cases, and Dr. Stack, in his neighborhood, seven, four of which had proved fatal.

Dr. Osler said that in the absence of *post-mortem* records, it was impossible to be certain of the diagnoses. The cases he had met with in cities and elsewhere were all *sporadic*. Those



which he had examined autopsically he found to belong to one of two classes, (a) simple and (b) tubercular. The former were rare; the latter were distinguished by a more prolonged course, and by being sometimes actually latent. He had recently had charge of a sailor, who having fallen heavily upon the deck of his ship, soon after developed spinal symptoms which were supposed to be due to the injury. The autopsy, however, showed tuberculation of the spinal and cerebral meninges, almost certainly of pretty long duration. The specific fevers also not unfrequently simulate cerebro-spinal fever, especially the malignant form of smallpox and of typhoid fever. The symptoms in all these cases are almost, if not absolutely, identical, and an autopsy alone can set a doubtful case at rest.

Dr. Teskey related a case of tubercular trouble he had lately had which might, during life, have readily passed for one of cerebro-spinal fever. It began with convulsions, followed by opisthotonos and then coma. The necropsy showed tubercular meningitis complicated by an abscess in the occipital lobe of the brain.

Dr. Macdonald, of Hamilton, spoke also of the necessity for *post-mortems*, and deplored the tendency amongst country people to object to this proceeding. During epidemics of cerebro-spinal fever in Hamilton, he had a number of autopsies. Whenever the diagnosis proved correct, he had found distinct evidences of inflammation of the cerebral and spinal meninges without any tubercle. In several cases the negative conditions discovered pointed to some specific febrile poison as having caused the symptoms.

Dr. Arnott, of London, Ont., read a paper on *The Sources of Malaria*. The existence of malaria is very generally taken as equivalent to presupposing the existence in the same place of a certain germ. It is commonly accepted that one of the chief requisites for malaria is decomposing vegetable matter. The only circumstances required for this to take place, and, therefore, for the generation of malaria, are thought to be the presence of water, exposure to air, and a certain temperature. Dr. Arnott thinks that decomposing vegetable matter is *not* necessary, but that with water and the necessary degree of

heat the germ of malaria will be propagated. He thinks, therefore, it is conceivable that this might take place even in distilled water. Many arguments were deduced in support of this view. In different districts the prevalence of ague is not at all proportionate to the amount of vegetable matter in a decaying state. One may find the latter in great abundance with hardly any intermittent, whilst, *vice versâ*, malaria may abound where decaying vegetable structures may be said not to exist, or to be very sparingly present. Loomis believes that malaria is proportionate chiefly to the heat and moisture without reference to the organic matters. The effect of drainage of land is well known. Phthisis and cholera will thrive under the same physical conditions as give rise to malaria. The writer again emphasized the opinion that heat and moisture are really the only essentials required to propagate malaria independent of the presence or absence of organic matter.

Dr. Ingalls, of Detroit, remarked upon the conditions present in that city. There, the parts built upon consist of a black organic mould, six or eight inches deep, underlaid by a heavy clay subsoil. The superficial drainage is very often defective, and moisture is retained beneath the houses for a long time. This gives rise to many diseases of a malarial type: true intermittent fever, phthisis, diphtheria. Sunlight probably plays but a small part. These malarial diseases prevail when the damp, decaying vegetable loam lies under the houses, obtaining only the heat from the general atmosphere. Do we not often fail to recognize malaria in the causation of phthisis, overlooking altogether the miasmatic origin of the latter?

Dr. Teskey said, as regards the bacterial origin of malaria, the points chiefly urged in favor of the view were, that successful inoculations had been made upon animals; and that upon curing the disease with quinine the bacteria had disappeared. The natural history of bacteria in general bore upon the subject under discussion. To cultivate bacteria, heat, moisture, and some nitrogen-bearing substance are necessary. Some get it from the atmosphere, some from albuminous bodies (broth, etc). Then, in almost every stream we should find spores and albuminoid bodies of some kind. When there is much vegetable

matter, there is generally much albuminoid matter. There is certainly much yet to be known of the natural history of these particular germs.

Dr. McCully alluded to the persistence with which malarious affections stick to certain houses. There is always some one sick in them. Often, on examining such premises, one finds decaying timbers and low sills. In these places typhoid fever and diphtheria may alternate with the true malarial affections.

Dr. Baker, of Detroit, spoke of the system in vogue in the State of Michigan. The Board of Health receives reports regularly from one hundred physicians in different sections. On comparing these it is found that malaria prevails most when the fluctuations of temperature are greatest, therefore temperature alone seems to control intermittent fever. The difference between the day and night is greatest in summer—it increases as you go south. In the northern part of the State there is no ague. He would strongly urge their system of collecting facts bearing on this disease; it is the only way in which our knowledge can be helped on. He does not consider that the bacillus can yet be accepted as proven.

Dr. Harrison said that in old times, in his part of the country, all the cases of pneumonia had a malarial tendency. Now this was not observed, and there was no ague there.

Dr. Stalker mentioned the occasional occurrence of severe attacks of ague during the greatest cold of winter, as opposed to the view that a certain temperature is necessary.

Dr. Geo. Ross held that to benefit by this discussion we must restrict it to that of malaria alone. Such affections as some had spoken of, phthisis, typhoid, and diphtheria, were all believed now-a-days to be produced by special organisms, having a natural history of their own. In many places these prevailed to a very considerable extent, whilst malaria was unknown. It was clear, therefore, that it would not do to quote their existence as indicative of miasmatic or malarial, although certainly of unwholesome, conditions.

Dr. Clark said that he had observed these facts in his neighborhood. Near Oakville there is neither phthisis nor malaria. In Oakville they both prevail. The temperature on the lake

shore is low, whereas two miles or so away inland it is comparatively warm.

Dr. Arnott, replying, said that the recent views of Loomis, quoted, showed that the current of general opinion is towards the view that the factor of decaying vegetable matter in the production of malaria is not an *essential* one. As regards occurrence of an attack of ague in midwinter, he thought that such cases are to be explained as showing the possibility of prolonged *latency* of the poison, the attack being induced by the depressing action of intense cold.

Dr. Holmes, of Chatham, read a paper entitled *Observations on Puerperal Mania*. The paper alluded first, in a general way, to the causes to which an attack of this kind may be attributed. They are chiefly heredity, anæmia, and moral influences. To these he would add another, viz., *laceration of the cervix uteri*. Some objections to admitting this would occur at once. Such as, lacerations are very frequent without the occurrence of mania, which is rare. Recovery from mania often takes place without laceration having been cured. True, but most lacerations heal of themselves, or, at any rate, without treatment, become covered with mucous membrane. Dr. Bucke has taught that the central sympathetic nervous system governs man's moral nature. Abdominal disease commonly produces great depression, in marked contrast to the hopefulness of those with thoracic disease. The pregnant woman is really like dry fuel, waiting only the application of a match to burst into flame.

Case I.—Mania three days after confinement; put under restraint; moderate laceration of cervix; died insane after two years. Case II.—No heredity. Easy labor; after five days, melancholy and morose; after three months, much worse; suicidal; a laceration which was discovered was treated, and the mania disappeared rapidly. Case III.—Very violent; after two weeks was sane; remained despondent for two years; then laceration was found; restored to health. Case IV.—Became insane twenty days after labor; extensive laceration; treated with hot water douches, etc., and a rapid cure effected. Case V.—Was seen eight months after confinement; was weak, mind affected, melancholy; slight laceration treated; after four

months this was entirely healed, and she was quite well. Case VI.—Was in an asylum; after the cure of a bad laceration was well and went home. Twelve cases in all were presented, of which the above are fair specimens. Dr. Holmes concludes that he believes laceration of the cervix to be a frequent cause of puerperal mania, and one which has been hitherto overlooked. He thinks it is of much importance that there should be a gynecologist to every asylum for the insane, and that their investigations into this subject might throw much light upon the somewhat obscure etiology of this affection.

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#### SURGICAL SECTION.

Chairman, Dr. Edwards of London, Ont. Secretary, Dr. Burt of Paris, Ont.

Dr. Carstens of Detroit read a paper on two cases of "*Removal of Uterine Fibroids.*" The first case was that of a woman aged 40, in whom uterine fibroid within the broad ligament was diagnosed, and abdominal section determined on. The operation was performed with strict antiseptic precautions. On opening the abdomen, one large tumor was discovered within the broad ligament of right side and one small one. The ovaries were very adherent, and were removed. The pedicles were ligatured and the tumors taken away. There was considerable hemorrhage, and some twenty vessels had to be tied with silk and catgut. The patient for the first few days had considerable vomiting. On the fourth day she asked for lager beer, which was given, and had the effect of controlling the vomiting. The temperature up to the eleventh day never reached 100°F., but then rose to 102°. This elevation was caused by a small abscess, which formed in the course of one of the ligatures. The patient did well after this, and was discharged, cured, five weeks after the operation. The second case was that of a married woman, aged 45, who had had enlargement of the abdomen for several years, with repeated uterine hemorrhages. Dr. Carstens, on examination, found a submucous fibroid. The os uteri dilated with great difficulty, so a posterior incision had to be made. The tumor was enucleated and removed with an *écraseur*, and the

wound in the cervix sewed up with silk ligatures. The patient was able to sit up in six days.

Some remarks were made on the cases narrated, in which the reader of the paper strongly insisted on the necessity of an abdominal section in many of these cases, and said that, until the abdomen is opened, it is impossible to tell what may be the character of the operation it is necessary to perform.

In the discussion which followed, Dr. Gardner of Montreal said that in incising the cervix he preferred the bilateral incision to the posterior, and that in the cases performed by him he has avoided sewing up the wound thus made. After removal of the tumor, he is in the habit of irrigating the uterus with two tubes, which are kept in position by stitching to the cervix. He washes out the uterus through these tubes every two hours. In certain cases he is in favor of removing the ovaries, but not in all, as is advocated by Mr. Lawson Tait.

Dr. Carstens, in reply, said that section of the cervix is seldom necessary, as it can generally be sufficiently dilated to remove any ordinary tumor, and he has made a posterior incision only because it was most convenient in that particular case. If abdominal section was performed for uterine fibroid, he preferred excision of the tumor to removal of the ovaries and appendages, as by the latter method the growth of the tumor is frequently not arrested. He strongly insisted on the necessity of folding in the peritoneum after the excision of the tumor, as by this means blood is prevented from entering into the peritoneal cavity.

Dr. Fulton of Toronto then read a paper on "*Subperiosteal Amputation.*" This method of operating was advocated by Walthier seventy years ago; in 1859 it was advised by Ollier Lyons; and lately many surgeons have recommended it. Dr. Fulton has performed many amputations recently by this method, and is strongly in favor of it, especially in amputations for diseased bones and joints. After carefully describing the operation, Dr. Fulton mentioned its advantages, the chief of which is that the cut end of the bone is brought into contact with the tissue most suited to it; also, the bone does not become adherent to the end of the stump, and the medullary canal is closed by new bone. The operation is especially suitable in cases where the

contents of the medullary canal are soft and in an unhealthy condition. The only objection is the possibly too great development of osseous tissue about the end of the bone. The reader of the paper, however, had never seen any osteophytes result from the operation. Cases were related showing the advantages of the operation.

Dr. McGraw of Detroit remarked that Langenbeck had performed subperiosteal amputation in 1862; but, as the case did not turn out very well, he did not continue to adopt this procedure in his amputations. Dr. McGraw believed that it is most important in amputations to draw together similar tissues, and he always sews periosteum to periosteum, muscle to muscle. In this way the wound is completely closed and no cavity left. He strongly approved of the subperiosteal method of amputating.

Dr. Donald McLean of Detroit said that many of the so-called advances of modern surgery are of very questionable benefit, but the one recommended by the reader of the paper seemed to have much to recommend it. It is the duty of the surgeon to pay more attention to the details, not only of the operation, but of the after-treatment, and to make the path of the surgical patient as smooth as possible by doing everything to avoid unpleasant after-results.

Dr. Davidson of Toronto thought the operation should be more practised than it now is. He thought that in performing the operation the periosteum should be reflected back before the bone is cut, thus necessitating only one division of the bone. The occurrence of osteophytes is certainly an objection to the operation.

Dr. Sampson of Blenheim, Ont., said that country doctors are not always able to carry out all the minute details of modern surgery, and yet get very good results. He mentioned a case in which he had lately amputated the thigh, and the patient was going about on crutches within three weeks.

Dr. Shepherd of Montreal said that in his experience the results obtained in amputations performed with periosteal flaps are no better than in those performed without them; that if amputation be done with proper antiseptic precautions, union occurs by first intention, and the result is that the skin is freely movable over the end of the bone. In the last twenty major

amputations he had performed, only one did not unite completely by first intention. He thought that the suturing of muscle to muscle, as recommended by Dr. McGraw, is not necessary, as the same result can be obtained by dressing the stump with pads of jute, or some other elastic substance, and keeping them in place with an evenly and firmly applied gauze bandage.

Dr. Shepherd then read a paper on "*Excision of the Tongue by Scissors, with preliminary ligature of the Lingual Arteries.*" He said that in excising the tongue for malignant disease, besides the necessity for avoiding hemorrhage, it is important that structures in the neighborhood which had become involved should be removed, and he held that the operation of excision of the tongue with preliminary ligature of the linguals facilitates the removal without adding much to the risk of the operation. Whatever operation for excision of the tongue is practised, the mortality in a given number of cases is about the same, and the method of operating seems to have less effect on the results than the after-treatment. Still, certain operations are more favorable than others as regards the recurrence of the disease, as the more completely the disease is removed the less likely is it to return. He considered that in excision of the tongue it is as important to excise diseased glands in the neck as it is to remove diseased axillary glands in extirpation of the breast. The operation was described, and the difficulties met with in ligaturing the linguals especially dwelt on. The advantages of the operation are:— 1st, The diseased structures, and especially the glands, are easily discovered and removed through the incisions made for ligaturing the arteries. 2nd, The removal of the tongue is bloodless, and there is little fear of secondary hemorrhage. 3rd, Drainage of the mouth can be more thoroughly carried out by means of the incisions in the neck. 4th, The operation is performed with few instruments, and only those possessed by every surgeon. 5th, The tongue is more completely removed by scissors than in any other way, and the tissue is not bruised as when the écraseur is used. Dr. Shepherd related three cases of malignant disease of the tongue with involvement of the glands of the neck (and in one case of the right tonsil), in which he had performed this operation. The after-treatment is important, and



Billroth's method of stuffing the mouth with iodoform-gauze was strongly advocated by the reader of the paper.

Dr. McLean of Detroit said that in certain cases the operation described by Dr. Shepherd was the proper one, but when there is no involvement of the glands of the neck he prefers removing the tongue with the *écraseur*. The great danger of all the operations for the removal of the tongue is septic disease of the lungs.

Dr. Grant of Ottawa had listened to the paper with great interest, and intended, when a proper case presented itself, to practise the operation. He related a case of deep-seated abscess of the tongue which had lately been sent to him as one of malignant disease.

Dr. Atherton of Toronto did not think ligature of the lingual a very simple operation. He advocated the performance of preliminary tracheotomy in excision of the tongue, as by this means the wound is kept aseptic and septic involvement of the lungs prevented. There is also less fear of hemorrhage, and greater facility in arresting it.

Dr. Shepherd, in reply, said that he doubted whether diseased glands in the neck could be always discovered by external manipulation, and that only in cases seen very early should the neck incisions be omitted. He could not help thinking that preliminary tracheotomy added to the risk of the operation, and, besides, it is not necessary if the after-treatment with iodoform-gauze be carried out in the way recommended by Prof. Billroth, who has had no deaths or serious complications in his last seventeen cases.

Dr. Wm. Gardner of Montreal now read the report of a case of "*Double Uterus with Atresia and Hæmatometra of the left chamber.*" The patient, a tall, slim, unhealthy-looking maiden, aged 18, was admitted to the gynecological department of the Montreal General Hospital with a history of intense periodic pain in the loins, hips and hypogastrium. She had always been healthy till two years previous, when she began to grow rapidly and to menstruate. Catamenia always scanty; intervals three to six weeks. The flow attended with moderate pain. Nine months previous to entering the hospital she began to suffer from

the pains described. The pain came on each afternoon or evening, and lasted several hours, with an interval of complete relief. Had noticed for some time a swelling of the lower part of the abdomen. No bladder symptoms; appetite small; no vomiting; constipation troublesome. On palpation of abdomen, there is an elongated, smooth, very firm tumor extending from the left anterior superior spine of ilium to pubes. Two smaller projections attached to the larger one extend towards the right side of the pelvis. Patient etherized for vaginal and rectal examination. Hymen entire, but perforate. Immediately on entering the vagina the finger meets a very firm, smooth, at one point slightly elastic, mass, evidently the lower part of the hypogastric tumor described. On the left side the vaginal wall is pushed down by the tumor to near the orifice. On the right side and behind, the finger can be swept around the tumor to the upper part of the pelvis. No trace of vaginal portion to be detected. The only evidence of an opening is a slight linear furrow. An aspirator trocar was introduced, when a small quantity of thick chocolate-colored blood escaped, thus clearing up the diagnosis. A bistoury was introduced and a free incision made. Fifty fluid-ounces of thick, tarry blood escaped. After partial emptying of the sac it was easy to feel the os uteri of the left patent chamber of the uterus. Double drainage-tubes were inserted within the opening and stitched to the edges, the ends protruding from the vagina. Irrigation every two hours with weak carbolized fluid was ordered. Within the first twenty-four hours the temperature ran up to  $103^{\circ}$ , but at the end of another day became normal. Very little pain. Patient did perfectly well for a week, but on the eighth day the tubes ulcerated out. Within twenty-four hours the temperature slowly rose to  $101^{\circ}$ . The patient was again etherized, a portion of the wall of the sac excised, the tubes again inserted, and irrigation resumed. But the temperature and pulse continued to rise. Three days later there was a rigor, followed by profuse sweating; then increase of pain, abdominal distension, left infra-mammary pain and pleuritic friction; vomiting, at first of mucus, then of coffee ground-like fluid; death nineteen days after operation. At the autopsy, general recent peritonitis with profuse exudation of

lymph. Bicornuate uterus: left chamber measures  $1\frac{3}{4}$  inches; the interior of the right chamber contained the thick menstrual blood-stained brown fluid. Right ovary somewhat enlarged, otherwise healthy. Left Fallopian sacculated, the sacculi containing the same tarry fluid. A similar sacculated collection of the size of an orange, the walls of the sac being formed by the fimbriated extremity of the tube, the broad ligament, and false membrane. Other smaller hæmatoceles were found about the left broad ligament and left border of the uterus. The left ovary could not be distinguished.

Dr. Gardner remarked upon the great rarity of the case. Professor Olshausen of Halle, Dr. Galabin of London, and Dr. John Homans of Boston, had, however, reported exactly similar cases. The prognosis in all such malformations is grave. The treatment, so far as it went, he believed to be the best that could have been adopted, but he regretted that when the condition of the patient became so desperate, he had not opened the abdominal cavity, removed the left Fallopian tube and ovary, opened the other hæmatocele collection, and drained the abdominal cavity. In view of certain recently published remarkable cases of acute and chronic peritonitis, similarly treated with success, he believed it possible that the patient might thus have been saved. Olshausen's case was treated by three successive tapplings of the tumor through the vagina. Mild peritonitis resulted, but the patient recovered perfectly, and subsequently married and bore three children. In Dr. Homans' case, there being doubt as to the nature of the tumor, he opened the belly, clamped and removed the closed uterine chambers containing the altered blood, together with a diseased and distended Fallopian tube and ovary, and introduced a drain. The patient recovered. Dr. Galabin's case was treated similarly to Dr. Gardner's, but less efficiently on account of the intractability of the patient and her friends. She died within a fortnight.

Dr. Roswell Park of Buffalo reported a successful case of *Extirpation of the Larynx for Malignant Disease*, and exhibited the specimen, as well as a model of an artificial larynx after Gussenbauer's pattern. The case was that of a man aged 64, who for many years had been troubled with hoarseness. For a

year past he had lost his voice altogether ; consulted a specialist last fall, who diagnosticated papillomatous disease of the larynx undergoing cancerous degeneration. Had previously undergone several operations for removal of the papillomatous growths. He was seen by Dr. Park on the 14th of last June, and at that time tracheotomy was performed to relieve the difficulty of breathing. After some days the granulation tissue about the tracheotomy wound was so exuberant that it forced out the tube, so extirpation of the whole larynx was advised and agreed to by the patient. The operation was performed on the 28th of last June. It was very tedious, but attended with but little hemorrhage. The epiglottis was left behind, and the first ring of the trachea removed with the larynx. The wound was packed with iodoform gauze and healed rapidly. The patient was fed for the first few weeks by a tube passed through the wound. Since then he has taken all his nourishment by the mouth. He is now wearing an artificial larynx, and can swallow well and talk with ease. The removed larynx was exhibited and showed the malignant disease completely blocking up the rima glottidis. The affection was apparently confined to the larynx. Dr. Park said that up to the present time 94 extirpations of the larynx had been reported, and that this was the 95th, and the third extirpation that had been performed on this continent.

Dr. Atherton of Toronto then read a paper on two cases of "*Laparotomy performed for Uterine Myomata.*" In the first case the tumor was of considerable size and intra-ligamentous. The pedicle was first transfixed with pins and compressed with a rubber bandage ; the tumor was then removed by a wedge-shaped incision. The vessels were ligatured and the pins and bandage removed. The two edges of the stump were then sewed together and the abdominal wound closed with silk and catgut ligature and drained. The patient did well, recovering perfectly. There was a little suppuration about the wound. The operation was performed under the spray.

The second case was that of a young lady aged 35, who had had an enlargement of the abdomen for some years, with recurrent hemorrhages. The case was recognized as one of uterine fibroid. Medical treatment proving of no avail, the patient re-

requested that operative procedures should be undertaken for her relief. Dr. Atherton, on opening the abdomen, found a large tumor filling up the posterior part of the pelvis and firmly adherent. It was transfixed with needles and a rubber tourniquet placed below them; the adhesions were separated with the finger, and as the tumor was freed the rubber tourniquet was pushed further down. The adhesions were very extensive, and the hemorrhage troublesome. The tumor was removed by a wedge-shaped incision, as in the former case, and the edges of the wound brought together with silk and catgut. When the rubber tourniquet was removed there was free bleeding, and the patient suffered considerably from shock after the operation. The abdomen was closed in the usual way and a glass drainage-tube introduced. The operation was performed under the spray, and the wound dressed with carbolized gauze. The patient did badly, and was in such a weak condition on the third day that transfusion was performed, and the abdomen washed out with a 1 to 40 solution of carbolic acid, but she continued to sink after a short rally, and died on the fifth day after the operation. At the autopsy, gangrenous patches were found on the sigmoid flexure of the colon and the rectum. The uterine stump looked well, and there had been no hemorrhage.

In the remarks made on the two cases, the reader of the paper said that in cases of uterine myoma, when remedial treatment fails and oöphorectomy has not caused the tumor to diminish, the removal of the growth is indicated, especially in those cases where the system of the patient is running down. He had hopes that in the future the result of operations for removal of uterine myomata would be as favorable as after ovariectomy. He suggested that before the removal of these tumors the cervix of the uterus should be closed by a preliminary operation to prevent the entrance of germs. This would be a more scientific method than the use of iodoform suppositories or iodoform gauze.

Dr. Gardner congratulated Dr. Atherton on the success of the first case, and said that everything possible had been done in the second. He thought the suggestion made by the reader of the paper of closing the cervix was a valuable one.

Dr. Eccles of London, Ont., had listened with great interest

to the case, and said that the removal of part of the uterus with a myoma is a dangerous operation, and gives rise to great shock. He had once removed the uterine appendages and a fibroid in a woman aged 59. There was great hemorrhage, which was with difficulty arrested. The tumor was removed with a wire *écraseur*. The abdomen was drained, but there was free suppuration, and the wound did not close for some time. She eventually recovered.

Dr. Jenks of Detroit never had a case of recovery where there were extensive adhesions in Douglas's cul-de-sac. He thought that in these operations the preparatory treatment is most important. The bowels should not only be thoroughly emptied, but tympanites should be guarded against. Ten to twenty grains of ox-gall should be given daily for a week before operation, and rhubarb and soda on alternate nights, and the night before the operation the bowels should be well washed out with enemata containing ox-gall. This method had been very successful in his hands in preventing tympanites.

Dr. Roswell Park related a case in which he had assisted to remove a large fibroid of the uterus, and where there was great hemorrhage after the operation. The abdomen was reopened, the hemorrhage arrested, and the cavity washed out with antiseptic solutions. The patient made a good recovery.

Dr. Fulton of Toronto said that he also had great faith in clearing out the contents of the bowels to prevent tympanites. He thought that the method of drainage into the vagina has not been sufficiently tried, and believed it a most scientific and rational procedure.

Dr. Rutherford of Chatham now read a paper on "*Suprapubic Urination.*" After giving the causes of complete retention and stricture, enlarged prostate, etc., he went on to describe the suprapubic tapping with trocars, and the introduction of a soft catheter. He described four cases in illustration, where the operation had been performed for retention following enlarged prostate. In one of the cases the patient had been comfortable for four and a half years, urinating through the suprapubic opening. In another case the patient, after urinating for some time through the artificial opening, was able afterwards to pass his water by the natural passage.

Dr. Burt of Paris, Ont., read a paper on "*Internal Urethrotomy*." He described the operation fully, and related cases in illustration. He used Maisonneuve's instrument. He said that he had never seen any evil results follow the operation, except in one case of penile stricture, where he had cut too deeply, extravasation followed. He had frequently operated most successfully in very severe cases and with permanent relief. He considered the operation to be easy of performance and safe, and that in most cases it was followed by permanent cure. He had operated on many cases of stricture after this method, and found that the cutting of these anterior strictures caused the spasmodic stricture of the deep urethra to disappear. The instruments used for detecting and cutting strictures were exhibited.

Dr. Shepherd said he could not altogether agree with Dr. Burt's views as to the necessity of internal urethrotomy in all cases of stricture. He himself had rarely found it necessary to perform this operation, as the cases needing it were few—such as penile stricture and resilient stricture. He preferred gradual dilatation in the treatment of stricture, and considered it a much safer procedure than internal urethrotomy, as the mortality in that operation, even in such skilful hands as those of Sir Henry Thompson, was 3 per cent. He did not believe in strictures that were detected by a No. 25 sound, and thought that Otis's urethrotome showed only that the urethra was less dilatable in some parts than others; and he thought that the good results following cutting in such cases are due to the moral effect of the operation in hypochondriacs.

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#### GENERAL MEETING—SEPT. 3.

The President took the chair at 10.30 a.m. The minutes of the last meeting were read and approved.

On a two-thirds vote, it was decided to consider the report of the Nominating Committee, which was then read by Dr. Sullivan. Their recommendations were:

*President*—Dr. Holmes, Chatham.

*General Secretary*—Dr. Stewart, Montreal.

*Treasurer*—Dr. Sheard, Toronto.

*Vice-Presidents*—For Ontario, Dr. Sloan, Blyth. Quebec,

Dr. C. Sewell, Quebec. New Brunswick, Dr. Earle, St. John. Nova Scotia, Dr. Wickwire. Halifax. Manitoba, Dr. Brett, Winnipeg.

*Local Secretaries*—Ontario, Dr. Wishart, London. Quebec, Dr. Bell, Montreal. New Brunswick, Dr. Lunam, Campbellton. Nova Scotia, Dr. Almon, Jr., Halifax. Manitoba, Dr. Good, Winnipeg.

#### COMMITTEES.

*On Publication*—Dr. Kennedy, Montreal; Dr. Fulton, Toronto; Dr. W. H. B. Aikins, Toronto.

*Medicine*—Dr. Cameron, Toronto; Dr. F. W. Campbell, Montreal; Dr. Saunders, Kingston.

*Surgery*—Dr. Kerr, Winnipeg; Dr. Kains, St. Thomas; Dr. Waugh, London.

*Obstetrics*—Dr. Holmes, Chatham; Dr. McKay, Woodstock; Dr. Campbell, Seaforth.

*Therapeutics*—Dr. Oliver, Kingston; Dr. Sloane, Blyth; Dr. Tye, Chatham.

*Necrology*—Dr. Fulton, Toronto; Dr. Graham, Toronto, Dr. J. C. Cameron, Montreal.

*Education*—Dr. Pyne, Toronto; Dr. Sheard, Toronto; Dr. Adam Wright, Toronto; Dr. Botsford, St. John; Dr. Allison, St. John; Dr. Arnott, London.

*Public Health*—Dr. Yeomans, Mt. Forrest; Dr. Grant, Ottawa; Dr. Harding, St. John; Dr. Robillard, Ottawa; Dr. Laberge, Montreal; Dr. Botsford, St. John; Dr. Playter, Ottawa; Dr. Covernton, Toronto; Dr. Oldwright, Toronto; Dr. Bryce, Toronto; Hon. Dr. Parker, Halifax; Dr. Kittson, Winnipeg.

Quebec was recommended as the next place of meeting.

The report of the Nominating Committee was unanimously adopted.

#### MEDICAL SECTION.

This section opened at 11.30 a.m., Dr. Harrison in the chair.

Dr. J. E. Graham exhibited a specimen of *Dissecting Aneurism*, and related the history of the case. The patient had been a soldier in the British Army and was wounded in the trenches, and soon after was invalided and told to avoid exertion as he might die suddenly. Aneurism at the time was evidently suspected if not diagnosed. He recovered health sufficiently to enable him to earn his living, though never strong.



He had been under Dr. Richardson's care in Toronto Jail on several occasions, and it was known that he was the subject of thoracic aneurism. A few days before his death there was hemorrhage from the lungs. The condition found post-mortem was as follows:—The ascending and transverse portions of the arch were much distended, and immediately beyond the orifice of the left subclavian there was a saccular dilatation adherent to the lung, and at the upper part was a laceration into the tissue which communicated with the bronchial tubes. At the distal portion of the sac were two openings, one of which communicated with the natural lumen of the vessel and the other with the dissecting aneurism. This latter was formed by the blood finding its way through the middle coat of the vessel and dissecting the inner portion of the media from the outer half of the media and the outer coat. This was continued in almost the entire circumference of the vessel, and extended throughout the thoracic and abdominal portions to the bifurcation, where by a large opening the dissecting aneurism again communicated with the lumen of the aorta. Some of the branches of the abdominal aorta communicated with the inner tube, others only with the outer dissecting aneurism. Among the remarkable features of the case are (1) the length of time which this has lasted, probably thirty years at least; the condition of the lining membrane of the dissecting aneurism shows it to have been long in existence—as it is smooth and firm almost like the normal lining membrane, only a little uneven. (2) The unusual extent of the aneurism, involving the entire length of the thoracic and abdominal portions.

Dr. Wilkins presented a series of microscopical specimens illustrating the *Bacilli of Tuberculosis*, and the fact of their communicability. The first of these were taken from the sputa of a patient suffering from chronic phthisis; the second from the lungs of the same person; the third from a rabbit, which had been inoculated with the tuberculous matter in the anterior chamber of the eye. In each case the bacilli were extremely well shown, and the demonstration was much appreciated by the section. Dr. Wilkins read some notes descriptive of the experiments he had made on this subject, and pointing out how strikingly such observations exhibited the contagious character of tuberculous matter, and the association with it in every case of the characteristic bacilli which have been so fully described.

Dr. J. E. Graham said that he had been much interested in this very satisfactory and complete demonstration of the micro-

organisms of tuberculosis. It was a fact that some of the profession were still sceptical concerning these tubercle bacilli, whereas an examination of such specimens as these would carry conviction even to the mind of a layman without any special knowledge of the subject.

Dr. James Stewart read a paper on *The Curability of the Chronic Form of Infantile Paralysis (Poliomyelitis Anterior Chronica)*. In his case, the development of the paralysis had been slower and less febrile than in many instances observed, and had been preceded by diarrhœa. The patient was treated with galvanism, and made a good recovery. Dr. Stewart thinks that cases of this character are more amenable to treatment than those with more rapid and acutely febrile onset. He advised persistent and careful treatment with galvanism, instead of consigning them, as is so often done, to the category of cases for which nothing can be done.

Dr. Holmes considered the case of value, as encouraging the general practitioner to persevere, in the hope of ultimately restoring limbs threatened with permanent paralysis. He inquired whether any other form of treatment in addition was serviceable; also what the reader's views were as to the pathology of the affection.

Dr. Stewart, in reply, said that galvanism is the only thing to be relied upon. It is not definitely known whether the changes are primarily inflammatory or purely degenerative. As regards prognosis, it is important to separate the acute from the subacute and chronic cases.

Dr. McKeough, of Chatham, read a paper on *The Use of Pilocarpine in Puerperal Eclampsia*. Three cases were detailed, the principal features of which were as follows: Case 1—Patient, when seen, had had twelve convulsions, was comatose, and greatly œdematous; the urine loaded with albumen; an attempt at venesection failed; then pilocarpine was given hypodermically. There was profuse sweating, but at the same time copious bronchial secretion, with loud rattling. The condition became alarming, and she died three hours after. Case 2—At eighth month. Considerable œdema present; passed only one ounce of urine in twenty-four hours; gave purgatives and potash citrate with digitalis; had vapor bath. Eclampsia supervened; gave ʒj fluid extract of jaborandi with good effect. Convulsions continuing, gave morphia sulphate gr.  $\frac{1}{4}$ . No more convulsions. Case 3—Convulsions occurred the day before confinement; found semi-comatose; no œdema; urine solid on boiling; gave gr.  $\frac{1}{8}$  pilocarpine hypodermically. At

night gave chloral. Next day had no return of convulsions, though she remained lethargic, and was successfully confined. Dr. McKeough considers the use of jaborandi in these cases only an experiment. Barker and Thomas think it is of doubtful service. The great depression it produces is against it, whilst in certain conditions the danger of pulmonary oedema and profuse bronchial secretion are great, as shown in Case 1. He thinks, from his experience, that it may prove of considerable benefit when used early in cases in which convulsions are likely to occur.

Dr. McLean said that, though most cases of puerperal eclampsia were uræmic, they were not all so. Some arise from peripheral irritation, and resemble the fits which children have from worms and other causes. A case of his illustrated this fact. A multipara, in whom the abdomen was much distended, had convulsions; there was no albumen in the urine. He gave chloroform and delivered; no more convulsions occurred. He considers chloroform the most valuable agent, as it allays irritation of the peripheral nerves and nervous system generally.

Dr. Whiteman was opposed to evacuation of the uterus. His practice is to leave the case to nature, except an emergency call for interference.

Dr. Geo. Ross said that the subject always commanded a lively interest. He thought that, in the treatment of puerperal convulsions, a wrong idea was often made its basis. It is said that the blood is poisoned by a foreign substance—urea, and this must be got rid of. This in itself is even yet an unproved hypothesis. At any rate, he believed that, convulsions existing, the primary object of the practitioner should be to allay the irritation of the nervous centres, independent of everything else; accomplish that, and the eclampsia will cease, and then you will have time enough to take steps for unloading the system and starting the action of freed kidneys. To allay this central irritation we must resort to narcotics, and especially morphia and chloral hydrate. On these principles, therefore, the employment of pilocarpine can only be looked upon as uncalled for, and in not a few cases actually dangerous. He agreed with McKeough, that it may be very useful in early conditions of albuminuria, or even after convulsions have ceased, but not as a treatment of the eclamptic paroxysms. He would draw attention to a point often omitted in text-books, viz., that prodromata of convulsions—early uræmic symptoms—should always be looked for and actively treated. These consist most frequently in severe headache and repeated vom-

iting. They can often be completely relieved by narcotic treatment, and convulsions *prevented*, whereas depleting measures do little good, except assisted by the narcotic. As regards emptying the uterus, it has been his practice in a number of cases to treat by opium, etc., and take no step to hurry the confinement. He has never had reason to regret this course.

Dr. Grant agreed with Dr. Ross that it was important to watch puerperal cases, with a view to preventing the serious complication of convulsions. He trusts, in cases with slight œdema, to a course of potash, especially the bitartrate. He is in favor of the narcotic treatment of the actual eclampsia.

Dr. Davidson objected to the use of pilocarpine on account of the pulmonary dangers. He saw one case where great lividity was produced, with marked frothy exudation in the bronchi.

Dr. Thornton spoke of the value of pilocarpine in cases of general anasarca, especially those of a chronic kind. He considers its use in puerperal cases somewhat problematical. The treatment of puerperal convulsions, he thinks, should not be uniform, but must be based upon the nature of the probable exciting cause.

Dr. McKeough, in reply, said he claimed no special value for the drug, but brought the cases before the Association as observations of some interest, and he was pleased with the discussion they had elicited. He thought his cases were all of uræmic origin, as they generally are.

Dr. Osler then read a paper on the "*Clinical and Pathological Relation of the Cæcum and Appendix.*"

Dr. Whiteman, of Shakespeare, read a paper on "*Pelvic Peritonitis and Pelvic Abscess.*"

#### GENERAL MEETING—AFTERNOON SESSION.

The President took the chair at 1.30 p.m. The minutes of the last general meeting were read and confirmed.

The committee named at the last annual meeting of the Association to revise the by-laws were reappointed, and requested to report progress at the Quebec meeting.

Moved by Dr. Fulton, seconded by Dr. McLarty, that the following members of the Association be appointed a committee to confer with the Dominion Government to devise the best means of preventing the introduction of cholera into the country: Dr. Canniff, Toronto; Dr. Grant, Ottawa; Dr. Sullivan, Kingston; and Drs. Hingston and Rottot, Montreal.

Votes of thanks were tendered to the profession of Chatham, to the Steamboat and Railway Companies, to the Rector and Wardens of Christ Church, and to the citizens of Chatham.

CANADA

# Medical and Surgical Journal.

MONTREAL, OCTOBER., 1885.

## THE EPIDEMIC.

“How great a matter a little fire kindleth!” We have already written the history of the present outbreak of smallpox, and shall not repeat it. Enough to remember that the epidemic—which is now scourging this city and killing more victims in a few months than ever before fell in a year—undoubtedly originated from a simple case of varioloid. There has never been an instance in which a widespread contagious disease has been more clearly traceable to its source. Effect has followed cause, as in this world it always will. Failing to profit by the hard lessons of previous visitations, a numerous section of our population, densely and superstitiously obstinate, blinded by prejudice, and following the guidance of a stray false prophet, have for years entirely neglected, or rather refused to accept, that safeguard which science has *proved* to be of value. During the five years of respite from smallpox which the city has happily enjoyed there have grown up a multitude of French Canadian children—unvaccinated—who were ready to cause the smallest spark of variolous poison to burst forth into a general conflagration. They formed the finest kind of fuel, dried and ready for an epidemic to feed upon. The consequences have been truly appalling. Since April last some 850 deaths from smallpox have occurred! The vast majority of these are French Canadians. It is impossible to estimate the number of cases, but they do not fall short of many hundreds. For many weeks the progress of the disease has got quite beyond any approach to control on the part of the Board of Health. But, at last, the public seem to be fully alive to the gravity of the

situation, and decided action is being taken in the right direction. Too much time has been allowed to pass in attempts at moral suasion which it was certain beforehand would only fail. Compulsory vaccination and compulsory isolation are the only means which will ever effect an abatement of this gigantic evil. The Provincial Board of Health, hastily organized, has proclaimed the necessity for enforcing these measures, and, ably assisted as the local Board will be by active and capable citizens who are devoting their whole energies to the work, it is confidently hoped some immediate good will result and the spread of the plague be arrested. Every person in the city *must* be vaccinated. Every case of smallpox *must* be reported, and every such case *must* be isolated, either in the hospital or at home, as the Sanitary authorities may direct. No half measures will suffice. Do this faithfully and thoroughly, and just as ignorance, neglect, indifference and carelessness have caused the outbreak, so the opposite of these, applied to the well-known rules governing the management of smallpox cases, will equally effect its arrest.

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THE INTERNATIONAL MEDICAL CONGRESS.—The new committee met in New York early last month and proceeded to do the best they could with the class of professional material at their disposal. The nominations of new presidents of the sections seem, in the majority of instances, most extraordinary. We are near enough to the States, and familiar enough with American literature, to know pretty well the names of the leaders in the different departments of medicine and surgery, but of the seventeen names of chairmen of sections, there are twelve absolutely unknown to us as representatives in their different departments. We ask of many, in blank astonishment, Who are they? What have they done? Where do they live? Truly the committee is sunk low when it must place such men at the head of important sections in an international gathering. The contrast between some of the past and present nominees would be simply ludicrous, were it not painful. The Association is determined to have the Congress, and the remnant of distinguished men such as Flint, N. S. Davis, and Dalton, who

have cast their fortunes with it, may do much to save it from being an absolute failure, but the leaders of the profession, and the workers who have made American medicine and surgery known here and in Europe, are not in it. The play will go on, but with Autolycus disguised as Hamlet.

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—At the recent meeting of the American Laryngological Association, Dr. G. W. Major of this city was elected 2nd Vice-President. Dr. Major is expected to return from Europe early in October, when instruction at the General Hospital in his special department will be resumed.

—We regret to learn that the Halifax School of Medicine has temporarily suspended work, pending the adjustment of certain difficulties about the hospital.

—We are glad to learn that our friend Dr. Bucke, of London Asylum, who has been out of sorts for some time, has been granted four months leave of absence.

—We hear that Mr. Keith of Edinburgh recently paid a professional visit to Boston to consult with Dr. Homans. He did not operate, and only remained three days. Rumor makes the fee a fine figure.

—The following has been accidentally omitted from our report of the Canadian Medical Association meeting:—

The following papers were read by title:

“*Retroversion of the Gravid Uterus*,” by Dr. W. B. Geikie, of Toronto.

“*Micro-organisms in Puerperal Septicæmia: Prophylaxis and Treatment*,” by Dr. T. Johnson Alloway, of Montreal.

“*Field Hospitals and Climate in the North-West Territories*,” by Dr. Nattress, of Toronto.

“*Phlegmasia Dolens*,” by Dr. A. H. Wright, of Toronto.

“*Inebriety a Disease, the Result of Physical Causes*,” by Dr. Stephen Lett, of Guelph.

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### Obituary.

W. G. METCALFE.—Nothing could have been more sad than the untimely end of Dr. Metcalfe, the superintendent of the Rockwood Asylum, Kingston. As he was entering one of the wards a lunatic stabbed him in the abdomen, and though the bowels were not wounded, he died of shock and peritonitis after

an illness of three days. His death is a grievous loss to the asylum staff in Ontario and to the profession at large. One of Dr. Workman's ablest pupils, he had entered upon the study of lunacy in the true scientific spirit, and had, we all hoped, a brilliant career before him. He graduated at Toronto University in 1872.

**H. L. VERCOE.**—We should have noticed in our last issue the death of Dr. Vercoe at Toronto on the 28th of July. He had been ailing for some time past, and left Seaforth, Ont., where he had practiced for many years, and travelled south in pursuit of health. Returning last year somewhat better, he began practice in Toronto, when the symptoms of malignant disease of the bowel became manifest and ended fatally. Dr. Vercoe studied at McGill College, and was known as a most painstaking, industrious worker. He graduated in 1865, taking the prize for the best final examination. At Seaforth, where he practised, he won the esteem and confidence of the public, and among his professional brethren in that section of the country he was recognized as a widely read and able practitioner.

**JOHN R. VICAT**—a graduate of McGill of 1867—died last month in South Carolina. Dr. Vicat had practised for many years in Richmond, Que., where he enjoyed a wide popularity and the respect of the whole community. He was a well-informed and able practitioner, whose genial good nature always made him a favorite. He had for some time suffered from a severe bronchial affection, for the relief of which he had sought a southern climate. His death will be learnt with sincere regret by his many friends and former classmates.

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### Medical Items.

**THE RIGHT TO A NAME.**—Baron Liebig gave to Liebig's Extract of Meat Company (Limited), in 1865, the exclusive use of his name upon the most distinct engagement by that Company that all their extract should be submitted to the strictest control and analysis. No sooner was the success of this Company an undeniable fact than small competitors came forward, who at once tried to offer their extracts under the name of "Liebig's Extract of Meat." Law-suits ensued, and in France the judge emphatically stated that a man's right to dispose of his name was absolute and sacred. In this country, on the contrary, it was declared that Baron Liebig had no right to give to the Company the exclusive use of his name. The consequences in France are that no rival Extract of Meat can be called



“Liebig’s,” and the public are protected against buying articles other than the original and genuine extract. In this country, on the other hand, many extracts are offered as “Liebig’s,” though utterly repudiated by Baron Liebig.—*Globe*.

—Dr. T. G. Sheats of Shady Grove, Ga., says: I have had the opportunity of trying PAPINE in a few cases. I consider it a very valuable anodyne, perfectly devoid of the disagreeable secondary effects of opium or morphine.

—The Rumford Chemical Works, Providence, R.I., manufacturers of Prof. Horsford’s Acid Phosphate, have recently purchased a commodious building and warehouse near their present location, where they propose to remove their business a few months hence. This purchase has been necessitated by the demands of their large and increasing business, and it is pleasant to record such an evidence of well deserved success and prosperity.

—It is to be regretted that many mothers do not commence the use of Mellin’s Food until their infants are sick. It must be borne in mind that this Food is not a medicine, and is not intended primarily for sick babies, but is an excellent artificial food for healthy as well as for sick infants. Owing to the careful way in which it is manufactured, the whole of the starch is converted into dextrine and grape-sugar, so that the greater part of the work of digestion is performed before the food reaches the child’s stomach. Mixed with milk and water, the Food is, as a rule, readily digested by the youngest infant.

—Experience, the greatest of all teachers, has demonstrated that, in a large number of cases, Cod Liver Oil is beneficial for a few weeks, that the patient improves upon it, gains flesh and strength, but unfortunately this improvement does not continue; right in the midst of flattering prospects the patient comes to a halt, ceases to gain weight, or otherwise improve. Physicians have experimented for years in their endeavor to overcome this objection; it has finally been accomplished by Drs. G. Overend Drewry and F. C. Bartlett of London, England, who, by means of pancreatine, have succeeded in perfectly digesting or hydrating the oil, thus giving to the profession cod liver oil in a perfectly assimilable form, overcoming the only objection to its continued use. This hydrated oil is christened HYDROLEINE, and after nearly five years of extended trial it has been extensively approved of.