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GOITRE AND ITS TREATMENT.*

BY GEO. A. BINGHAM, M.B., TORONTO.
Associate Professor Clinical Surgery, University of Toronto.

Four years ago at the request of the Committee on Papers I made a report to this Association based upon my experience with 33 cases of goitre operated upon. This year, in casting about for a subject upon which to address you, I thought it might be useful to omit those questions of medical politics which have been so thoroughly threshed out by my predecessors in this chair and to detail very briefly a second report on goitre and its treatment, founded on a series of 82 operations in all.

As pointed out by C. H. Mayo[1] the rapidly increasing number of cases operated upon during quite recent years does not mean that goitre is on the increase, but that nowadays, it is recognized that a comparatively early operation for goitre is, as a rule, followed by results most gratifying to both surgeon and patient and is accompanied by an extremely small mortality rate. Indeed, I would now go so far as to say that in cases where as yet no pressure symptoms have developed, the patient, in view of future development and even for esthetic reasons, has a perfect right to claim the benefits of an operation which, in careful hands, should be as free from danger as appendicectomy.

*President's Address, Ontario Medical Association.

The Parathyroids.

The anatomy and functions of the parathyroids and their relations to the thyroid gland have been matters of keen interest to the surgeon of late years and much experimentation has been carried out. But much remains still to be done before the riddle of these curious bodies shall be interpreted aright. First noted by Sandstrom, in 1880, and described by Horsley in 1884, many experimenters have since labored to ascertain their functions. They found that the thyroid and parathyroids were separate and distinct entities; that while complete removal of the thyroid interfered with assimilation and metabolism producing a chronic condition known as myxedema, on the other hand, complete removal of the parathyroids induced a very acute state of tetany, somewhat resembling the symptoms of Graves's disease, and from which the patient usually succumbed. Roswell Park[2] thus sums up the knowledge so far conveyed to us by the experimenters:

"1. There are two quite different sets of tissues involved in the thyroid and parathyroids.

"2. They are not completely independent of each other, for the removal of either one caused changes in the others.

"3. There is reason to believe that myxedema follows removal of the thyroid and tremors and nervous symptoms, including tachycardia, result from extirpation of the parathyroids.

"4. It would appear, further, that failure of the parathyroids is followed by enlargement of the thyroid. If this be true, Graves's disease seems to be explained, since the former would account for the enlargement of the thyroid sometimes so conspicuous, while the increased secretion afforded by this enlargement will account for the exophthalmos."

This relation of the parathyroids to Graves's disease, however, would appear to be pretty thoroughly disproven by the careful dissections of Benjamens, MacCallum and others who found that the parathyroids were perfectly normal in cases of exophthalmic goitre examined and therefore could have nothing to do with the production of the disease. These little ductless glands, which have received so much attention of late (and to the study of which I beg to direct the efforts of my younger scientific friends in the profession), are usually four in number, two upper and two lower, and, as a rule, lie behind the thyroid, often in the neighborhood of the entrance to the gland ot the superior and inferior thyroid arteries, from which vessels they

receive their blood supply. They have been found most frequently in the areolar tissue behind the gland, sometimes in contact with the gland capsule and rarely within the capsule embedded in the thyroid tissue itself. They are elliptical in shape and homogeneous in appearance, and they are much softer in consistence than either thyroid or lymphatic tissue[3].

Let us now ask ourselves the question—Of what value to the operating surgeon is this somewhat vague and indefinite knowledge of the situation and function of the parathyroids? Here I think we must all agree that in operations upon the thyroid, we should endeavor to leave intact a part and, if possible, all of the parathyroids, as it has been shown that the severity and danger of the tetanic condition resulting from their extirpation is in direct proportion to the amount of parathyroid tissue removed. The only difference of opinion will be as to how, during an operation, the safety of the parathyroids may be best conserved.

It has been suggested by Park[4] that this end might be most effectually attained by opening up the thyroid capsule and enucleating the gland, thus leaving behind the capsule and, of course, the parathyroids in contact with it. To this method I must object for several reasons, some positive and others negative:

1. The hemorrhage resulting is always severe and makes the operation an unsatisfactory one.

2. In thyroidectomy, I almost invariably leave one lobe intact and, consequently, at least two of the parathyroids are preserved and, in man, it seems fairly certain that two normal parathyroids are sufficient.

3. While the parathyroids in dogs are quite often found within the thyroid capsule, I have never found it so in man, nor, so far as I know, have others of much greater experience and opportunity of observation.

4. It would seem that by exercising care during an operation upon the thyroid, the parathyroids may often be distinguished, avoided and their blood supply preserved.

5. Finally, by working very close to the outer surface of the thyroid capsule and by ligating the vessels at a point as close as possible to the gland, it would appear very probable that the parathyroids would be preserved even though not recognized during the operation.

GRAVES'S DISEASE.

As has been pointed out by Kocher[5] the term exophthalmic goitre is misleading, inasmuch as the exophthalmos is not, as a rule, present at the beginning of the disease and, indeed, may not develop until the very life of the patient is threatened. Now, as the cure of the patient depends very largely upon an early diagnosis by the physician, it would seem wise to discard the term, "exophthalmic," at all events in connection with the earlier symptomatology of the disease. Every surgeon interested in this class of work has encountered cases differing greatly in severity. Kocher[6] classifies these types of varying degrees of intensity as follows:

Class A. Vascular Goitre.—This type develops rather suddenly as a soft and uniform enlargement of the gland. Exophthalmos is absent, but Graefe's sign is probably present. Tachycardia, tremor, enlargement of the vessels of the gland, with bruit and thrill, are nearly always symptoms of this variety of goitre from the beginning.

Class B. Struma gravesiana colloides.—Here an ordinary colloid goitre has existed perhaps for years when, suddenly or slowly, symptoms of Graves's disease make their appearance. Exophthalmos is often absent until the disease is well developed. All the other symptoms are present but are not so severe as in a typical case of Graves's disease. It is suggested that in these cases the colloid material present may, in some way, counteract the toxic effect of the hyper-secretion of the gland upon the sympathetic nervous system.

Class C. Typical Graves's Disease.—In this class, the symptoms of the disease develop slowly or sometimes suddenly, frequently with a history of previous long-continued nerve strain or a severe mental shock. Exophthalmos is present and all the other symptoms are well marked and severe. If this type of the disease be not early recognized and treated, it runs a rapid course and secondary changes soon appear in heart, muscle and vessel walls, which render impossible an operation which, if undertaken at an earlier date, would almost certainly have effected a cure.

Including these three classes of Graves's disease, I have operated upon 13 cases, 4 males and 9 females. Ten of these cases improved steadily after operation and to-day consider themselves cured. In regard to the three deaths, all belonged to the typical class of Graves's disease. The first was a male in good mental condition prior to operation. He died in a

severe maniacal condition 72 hours afterwards. In this case the operation was an easy one, the tumor was not large, though deeply placed and there was but little manipulation of the gland, the smaller lobe being left *in situ*, as has been my custom. I confess that this case has been a complete puzzle to me. The other two cases were females with the disease altogether too far advanced for operation. On neither of them, with my present experience, would I now operate. One of them died in an asylum three and a half months after the operation. There was a rapid recrudescence of the growth in the remaining lobe and she died of exhaustion. The other case died six hours after the operation of heart failure. Now, although thirteen cases of Graves's disease is but a small number from which to make deductions, yet the fact that 77 per cent. of them were cured has quite decided for me the question of the advisability of operation in these cases. The all important points are for the physician to make his diagnosis early, put the patient to bed and make his surroundings such that he will be in a condition of absolute rest, physical and mental. As for medicines, in addition to maintaining strictly the nutrition and functions of the body, I have used phosphate of sodium grs. V. t. i. d. with apparent benefit. Theoretically phosphorus in some form is indicated. Under such treatment some will be cured, others will improve up to a certain point, and the wise physician will soon see when his patient has reached that point and will hand him over to the surgeon long before the disease has advanced to such a stage as will render an operation useless. I believe that every case of Graves's disease, when seen early enough, should be submitted to this rest treatment for two or three weeks before operation.

The operation carried out on my cases, as a rule, has been the removal of the larger lobe and the isthmus, though in two cases when both lobes were equally enlarged, I removed the whole gland with the exception of a small portion of one lobe.

I have had no experience in other methods of operating for Graves's disease, such as ligating the thyroid vessels or sympathectomy. As to the former, if the thyroid veins were included in the ligature, one would expect an immediate increased absorption of the glandular secretion through the lymphatics, and a consequent exaggeration of the symptoms. Again, ligature of the vessels would expose the patient to the dangers of gangrene; and besides, the deliberate exposure and ligaturing of the thyroid vessels would be quite as serious an operation as thyroidectomy itself. As for sympathectomy, I cannot see

how the removal of the sympathetic ganglia can possibly cure a condition which (if my experience of 77 per cent. of cures by operation is of any value), must be caused by some abnormal activity of the gland itself.

Whether the disease be due to the secreting by the enlarged gland of some toxic substance other than the normal secretion as was long ago argued by Horsley; or whether Graves's disease be merely an expression of toxic poisoning by a hyperactivity of the gland and an over-production of its normal secretion is still a debated point. In favor of the latter theory I would point out a fact that is very generally known, viz., that by feeding a healthy subject upon thyroid extract one can produce most of the symptoms of Graves's disease.

Malignant Goitre.

In this condition complete and early operation offers the only chance for the patient. Unfortunately, a sufficiently early diagnosis is not usually made, the neighboring glands being already involved. Even in such advanced cases the patient may be made fairly comfortable by partial removal, thus relieving pressure and making possible a future tracheotomy.

I have done a thyroidectomy in only three cases of malignant goitre, all females. One who was also suffering from Bright's disease died a week later from uremia. It was at her own earnest solicitation that I operated in this case. The second case, an old lady of 70, died two weeks after operation of exhaustion following a long journey to her home. The third died of recurrence six months after operation.

Simple Goitre.

In a series of 66 cases of simple parenchymatous goitre operated on, I have had three deaths. The causes of these deaths are of interest:

Case 1. A huge goitre in a girl, aged 17, which was causing very severe pressure symptoms, was easily removed. Twenty-four hours later, when I visited her, I found her extremely lively and clamoring for food. The nurse reported that the patient had been feeling so well all morning, that it had been difficult to keep her in bed and impossible to keep her quiet. Six hours after my visit she suddenly sat up in bed, screamed once and fell back dead. No autopsy was allowed. The cause of death was probably pulmonary embolus. This result impressed me with the wisdom of insisting in all cases and, especially where the operation field has been very large,

that the patient shall remain perfectly quiet so far as the head and neck are concerned during the first 48 hours after operation.

Case 2. Was an aged woman, with the largest goitre I ever saw, weighing 6¾ pounds when removed. The anatomical relations behind the gland were much disturbed and the adhesions were dense. In breaking down some adhesions, the much-displaced and attenuated esophagus was unfortunately torn across and she died three weeks later of inanition. Here, again, the lesson was learned that in all such extreme cases, a stomach tube should be passed and the esophagus carefully outlined before the final steps of the operation are undertaken. Had this been done in Case 2, the accident would not have happened.

Case 3. Was a man aged 45, from whom the right lobe and isthmus had been removed two and a half years ago for Graves's disease. The remaining lobe had been injured some months ago and increased in size quite rapidly, so that he now returned to have it removed owing to severe pressure symptoms. The operation was difficult, owing to the cicatricial contractions and adhesions, and the extremely vascular nature of the tumor. He did fairly well for 30 hours, with the exception of some difficulty in breathing. At that time he suddenly became cyanosed, respiration quickly failed and he died shortly afterwards. It looked like failure of the respiratory centre, but no autopsy was allowed.

I am aware that this mortality of 4.54 per cent. is too large, but I feel sure that at least two of such deaths would never occur in one's practice a second time.

I should like to detail a few points in the history of the last named case, illustrating the effects of operation on a typical case of Graves's disease. Mr. W., aged 42, presented himself in September, 1904, with a very large goitre, both lobes being involved, the right being the larger. The vessels of the gland were enormous, the thrill and bruit being marked. Exophthalmos and tachycardia were extreme, the pulse rate being 130 to 140. Tremor was very marked. Although a tall man, he weighed about 100 pounds. This man's history dated back for about a year, since when he has lost flesh rapidly and all the symptoms of Graves's disease have developed. His mental condition was bad. There has been a complete change of temperament. He has threatened his wife's life and his own, and was noisy, flighty and at times vicious in temper. I removed the right lobe and isthmus and he returned home within two

weeks of operation. He returned to me in April, 1907. His weight was 160 pounds, and he had worked steadily since his recovery from the operation. Instead of the wild, excited picture which he had formerly presented, he was now quiet, self-controlled and mentally quite normal. The pulse rate was 82, the exophthalmos and tremor were gone and he declared that he was in excellent health. Unfortunately, during the previous winter, the left lobe, which had become much reduced in size, had been injured in an accident, since which it had grown rather rapidly, and he returned to have it removed because it was kinking the trachea and thus interfering with his breathing.

Illustrating the class of cases described by Kocher, as thyroidea gravesiana colloides, is the following: Miss B., aged 44, has had a goitre for fifteen years, but paid no attention to it until one and a half years ago, when tachycardia and tremor began to trouble her. Steady loss of flesh ensued and now exophthalmos is quite marked. All the symptoms are more moderate than in the case of Mr. W. just quoted. Left lobe and isthmus were removed. She went home in three weeks and a steady improvement has resulted. Though she had been unable to work for a year previous to operation, she is now, three months after operation, doing light house-work and enjoying life.

The next case quoted clearly belongs to the class of vascular goitres. W. J., aged 27, an Englishman, has been troubled with goitre for eight months. It interferes with his breathing, especially when he stoops. As he is a farmer, this prevents him from working. Thrill and bruit present and pulse rate 102 to 110. Slight tremor and muscular twitching. Exophthalmos is absent, but Kocher's sign is distinct, viz., sudden retraction of the upper eyelid when the patient is made to look steadily at his examiner. Right lobe and isthmus removed. Patient left hospital on ninth day. Four months after operation his physician writes to say that the man is quite well and working every day.

The Anesthetic.

I still use a general anesthetic, preferably chloroform, or a mixture of chloroform and ether, *administered by an expert.* We have always followed the rules mentioned in my former report[7] and in none of my cases have we had any serious difficulty.

The Technique.

The distinguished gentleman who is to open the discussion on Surgery to-day (Dr. Crile, of Cleveland), has done much to aid the surgeon in the carrying out of this operation by his teaching as to blood pressure and the use of adrenalin, while the elevation of the head and shoulders of the patient, especially in operations for Graves's disease, materially reduces the amount of blood in the field and the resulting hemorrhage.

The transverse incision is the one chosen in most cases, and the technique has changed but little during the last four years. There is one change which, perhaps, should be noted. Instead of transfixing and tying off the pedicle (which is usually the junction of the isthmus and the lobe to be left behind), I now tear through this pedicle with a blunt dissector and seize and tie any small vessels which may bleed. This is practically the only operation in which I use silk in ligating the vessels. The possibility of cat-gut ligatures slipping or untieing in a very restless patient and resulting secondary hemorrhage has so far deterred me from using it.

I am thoroughly impressed with the importance of another feature in the technique of thyroidectomy, viz., the avoidance of excessive manipulation of the gland during the removal. In some of the earlier cases where this rule was not carefully observed the convalescence was quite stormy. I am now convinced that this was largely due to hyper-secretion, caused by unnecessary manipulation; this, of course, being followed by undue absorption and the production of a toxic tetany. The manipulations must be gentle and the various steps of the operation carried out in a precise and clean-cut manner.

In cases of cystic goitre affecting both lobes, my experience has shown me that it is not enough to remove one lobe and the isthmus, as cystic degeneration will continue in the remaining lobe. It would seem to be safer, after having removed the lobe most affected with the isthmus, to incise the capsule of the remaining lobe and enucleate every cyst to be found.

References.

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3. McCallum, *British Medical Journal*, November 10, 1906.
4. *Medical Review of Reviews*, July, August, 1906.
5. *British Medical Journal*, May 26, 1906.
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SYMPOSIUM ON PUBLIC HEALTH MATTERS.—THE MEDICO-LEGAL ASPECTS.

By G. Silverthorn, M.D., Toronto.

In all civilized countries there is some form of preliminary investigation when there is reason to believe that a deceased person came to his death from violent or unfair means, or by culpable or negligent conduct of himself or others, and not through mere accident or mischance. The necessity of such an investigation is recognized by all and should be held without delay and by competent officers and, if necessary, without anybody being accused and, in fact, it is to afford evidence of the necessity or otherwise of anybody being accused that the investigation is of greatest use.

The mode of conducting such an investigation varies in different countries.

Among English-speaking nations, as a rule, the office of Coroner is charged with such. The Coroner investigates by interviewing the persons concerned, examining the circumstances and surroundings, etc., and if he then considers an inquest necessary, he makes a declaration in writing as to that necessity, before a justice of the peace, summons a jury of not less than twelve men, swears them, then together they view the body. The Coroner then examines witnesses under oath and the jury renders a verdict. There may or may not be a prisoner under arrest. The accused may be indicted on the inquisition without any presentation before the Grand Jury, but practically an independent inquiry is always held before a justice in the ordinary way.

Other Modes of Inquiry.

Neither the coroner nor his jury exists among the continental nations of Europe, and the modes of procedure in the case of bodies found dead by violence or unknown causes, in all continental countries, and in Scotland, agree in the absence of these officials.

In France, the investigation is conducted by two officers, whose functions are entirely distinct, a legal and a medical officer. The former, the procureur de la republique, an officer somewhat analogous to the district attorney, takes the initiative in each case, proceeds to view the dead body, summons

witnesses, and takes the evidence. Liberal power is granted to him, and he can seize articles, or papers,, connected with any crime, restrain persons from leaving the premises, and employ experts and detectives, as the case may require. In the latter direction the French system is, beyond question, an unusually efficient mode of procedure.

The other officer, the medical, is selected for his superior training and knowledge, and has charge of the medical examiation of the body. Sometimes two medical officers are employed. The medical officer is also still further associated with the subsequent prosecution of suspected parties when the legal officer has decided that a crime has been committed. His report must be signed by a police official and submitted to a magistrate. If the evidence presented to the magistrate is deemed sufficient, an indictment is prepared for the cour d'appel, and a trial may then take place before a jury.

In Scotland the process employed is similar to that of France. The procurator fiscal, who has the investigation in charge, has for his guidance a code of instructions drawn up by the lord advocate. This code also gives detailed directions to the medical men who have the charge of the medical examinations, two medical officers being employed in each case. The reports of these officials are sent to the office of the crown agent at Edinburgh, and by him are transmitted to the advocate deputé. If he decides that there is suspicion of crime, he refers the report back to the procurator fiscal for further investigation. If he is in doubt, he may bring the case before the crown officers. Beyond this, a criminal trial is much the same as in England.

In Germany, there is neither coroner nor any analogous officer, nor a jury, on the preliminary investigation. A judicial officer has charge of the proceedings (Staatsanwalt). His powers are like those of a district attorney. The police are under his control in all matters relating to the investigation of crime. They are also bound on their own part to investigate suspected crimes, cases of sudden or violent death, and no interment is allowed in such cases till after the consent of the district attorney or a competent court is obtained. Medical officers are regularly appointed to make autopsies and medical examinations and report upon them. The German code of regulations as to the modes of procedure in examinations of bodies, both judicial and medical, is very explicit. If the district attorney believes that a crime has been committed he institutes a trial, and if the court believes that sufficient reasons

are presented, it orders a preliminary inquiry (gerichtliche Voruntersuchung), before a justice, the result of which is usually decisive. (Law of October 1st, 1879).

In Russia the law is similar in its provisions to that of France.

In Denmark the system is also very efficient, a judicial officer being appointed who has charge of all cases, which he decides without the intervention of a jury. He refers all medical questions to a medical officer, who is appointed for the purpose and reports to the judge the result of his examination, and autopsy, if one is made. He also makes a similar report to the Royal Bureau of Health. The trial which follows, in case of indictment, is first before the county judge, from whom appeals may be made to higher courts.

United States. The laws relating to inquests in the United States all bear the marks of English origin, and were evidently introduced by the early settlers, with most of the peculiarities of the English law, though stripped of some of the singular customs of early times. The coroner, the coroner's jury, and the inquest, exist in nearly all of the United States, at the present time, practically in the English form. Massachusetts made a radical change, abolishing the office of coroner, and also the jury, in 1877, since which time inquests have been conducted with greater care and economy, and to the entire satisfaction of the people and of the State (see *Examiner Medical*).

Connecticut and Rhode Island have also recently enacted similar laws, of a less radical nature.

In the other States there are certain points of difference, chiefly of minor importance, relating to the functions of the office of coroner, the mode of his election or appointment, his fees, the number of the jury and the employment of medical officers.

In a few States an inquest may be held in the case of a person who is seriously wounded, and in imminent danger of death. In Indiana, the jury was abolished by an act of 1879. In Texas, the inquest is also held without a jury.

After consideration of these various ways, it seems to me that a preliminary investigation by a properly trained medical man, such as a coroner should be, if necessary, followed by a subsequent investigation by him, with power to summon and examine witnesses under oath, together with an intelligent jury, is the best method of procedure. The usual objection to such is that of the inherent incongruity of an office requiring an ex-

pert knowledge of law and medicine. To my mind this objection is more than offset by the advantage of having the presiding officer of the court, one accustomed to the character of the evidence, as to the third part of the object of the inquiry, namely,—"by what means" the person came to his death. "When" and "where" are not usually such intricate questions as to need great legal acumen. In Ontario we have the coroner's investigation and the Coroner's court.

To my mind there is no just or sufficient reason for changing the system, no cases of corrupt practice, injustice or outstanding incompetence having shown themselves. The results are, as a rule, reliable and trustworthy.

The main facts of the system here in Ontario, to my mind, are, first: The manner of appointment of coroners. Secondly, their inadequate fees. Thirdly, lack of discrimination in the appointment of medical witnesses to perform the post-mortem examination. Fourthly, their inadequate fees. Fifthly, the lack of any central authority who should be entrusted with the compilation, classification, and publication of the returns.

Appointment of Coroners in England.

The name of the office was derived *a corona,* since the coroner was at first a royal officer. For many centuries county coroners have been elective officers. The right of the counties to elect their own coroners is confirmed by the Statute 3, Edward I., 10. Municipal boroughs also elect their own coroners. Certain franchises also have coroners of their own, within whose precincts the county coroner cannot act. In such places the coroner is appointed by the lord of the manor, and in one English franchise the coroner holds office by hereditary right. There are fifty-five franchise coroners, and one hundred and seventy-five coroners acting for counties, or parts of counties. These are very unequally distributed. Middlesex, with about four million inhabitants, including the populous part of London, has five coroners, while the small county of Huntingdon, with less than sixty thousand inhabitants, has also five, and Dorset, also a small county, has eleven.

Every freeholder is entitled to vote in the election of coroner. No professional qualification is required for the office, the only requisite being that the candidate should possess a freehold interest in the county.

For more than fifty years, complaints with reference to ignorance, and culpable neglect in the management of the office have been so common as to direct popular attention to the

necessity of reform; and while no comprehensive statute has been enacted with reference to such reform in England, the persistent efforts of prominent medical men have been so far successful that professional men are now usually elected to vacant offices.

A coroner usually holds office for life, but may be removed by the Lord Chancellor for misconduct or incompetence.

The county coroner receives a salary. He may appoint a deputy to act during his absence or illness. This deputy must be either a barrister, a solicitor, or a physician. The coroner is *ex-officio* a justice of the peace, and may therefore cause any one suspected of murder to be arrested, even before the jury has found its verdict.

The modes of election in the different States are quite diverse. In Alabama, Arkansas, Colorado, Georgia, Idaho, Iowa, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Nebraska, Nevada, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Washington, Wisconsin, and Wyoming, the coroner is elected by the inhabitants of the county. In Tennessee he is appointed by the county court. In Virginia a county court appoints a coroner for two years, and can appoint more if necessary. In Illinois, Indiana, Maine, and New Hampshire, the governor appoints the coroner. In Texas, Vermont, and Utah, the office of coroner is unknown, a justice of the peace acting in all cases in which the presence of such an official is required.

In several cities of the United States, the coroner is a salaried officer, such being the case in New York, Philadelphia, Detroit, St. Louis, Cincinnati, Cleveland, Washington, Charleston, Wilmington (Del.), and other cities, a plan which has obvious advantages.

In Ontario coroners must be specially appointed by the Lieut.-Governor by commission under the Great Seal, unless, indeed, the Chief Justice and the other judges of the Supreme and High Courts in Canada are sovereign coroners *virtute officii,* in a similar manner to the judges of the corresponding courts in England. One or more coroners are first appointed for each county, city and town and for any provisional judicial, temporary judicial, or territorial district, or provisional county, or for any portions of the territory of Ontario not attached to a county for ordinary municipal and judicial purposes. The appointments are generally made upon the recommendation of a member of parliament, or other person possessing influence with the executive.

When one county separates from another the municipal law of Ontario requires the Lieut.-Governor to appoint one or more coroners for the junior county, whose appointments take effect on the day the counties become disunited.

With regard to the number of coroners for any county, city or town in Ontario, there is no regulation. The number not being limited, the appointments are in part governed by the requirements of the locality, and possibly in part by the energy shown by those seeking the office.

In Ontario, "provincial coroners," for purposes of holding fire investigations, are appointed by the Lieut.-Governor-in-Council under the Great Seal. As to these coroners, see further at p. 29 (Boys on Coroners).

Qualifications and Disqualifications.

Formerly, the office of coroner was of such high repute that no one under the degree of knighthood could aspire to its attainment, and in the reign of Edward the Third a coroner was actually removed from the office because he was a merchant! It has, however, now fallen from such pristine dignity; and though still of great respectability, no qualifications are required beyond being a male of the full age of twenty-one years, of sound mind, and a subject of His Majesty, and possessing the amount of education and mental ability necessary for the proper discharge of the duties.

These qualifications are no more than what all public officers by the common law are supposed, and ought, to possess. The coroner has often a very delicate and very important duty to perform, and it need hardly be said that the proper discharge of that duty depends almost entirely on his personal character and ability. Where these are deficient, scenes sometimes occur at inquests which throw discredit upon the office of coroner.

Coroners in Ontario are not competent or qualified to be justices of the peace during the time they exercise their office. But an exception is made in territorial and temporary judicial districts, where stipendiary magistrates may be appointed coroners for such districts. And provincial coroners appointed in Ontario for holding fire investigations are justices of the peace for every county and part of Ontario by virtue of their office. And a stipendiary magistrate for any territorial or temporary judicial district in Ontario may be a coroner for the district.

Before acting as coroner, the oath of allegiance and the oath of office should be taken, since holding an inquest without

taking these oaths would subject the coroner to a penalty, although his acts would probably be legal.

From the above it would appear that in Ontario we must congratulate ourselves that the powers that be have recognized that only medical men should be appointed to the office of coroner. I would, however, suggest that the number should be limited and only those of a legal turn of mind be appointed. This would make for efficiency and be an encouragement for good and thorough work. In Toronto the experiment of appointing a chief coroner is at present being tried. To him are reported all cases, and he determines whether an investigation is to be held, and if so, appoints in rotation a coroner to undertake it. In certain class of cases he is debarred from acting, and then the County Crown Attorney appoints the acting coroner.

Fees of Coroners.

It would appear that the fees of a coroner in Ontario are not adequate for the time consumed and the services rendered. I am informed that an association of coroners is in process of formation, and it is hoped that such representation will be made to the Government as will result in a modification of the existing law in regard to fees.

Appointment of Medical Witness to Perform Post-Mortem Examination.

In Ontario, if the coroner finds that the deceased was attended during his last illness or at his death by any legally qualified medical practitioner, he may issue his order for the attendance of such practitioner as a witness at such inquest. Or, if the coroner finds that the deceased was not so attended, he may issue his order for the attendance of any legally qualified medical practitioner, being at the time in actual practice, in or near the place where the death happened; and the coroner may, at any time before the termination of the inquest, direct a post-mortem examination by the medical witness summoned to attend at the inquest. (Boys, 249.)

The practitioner chosen to make a post-mortem examination should be the best qualified the neighborhood affords. (Boys, 252.)

A second medical practitioner cannot properly be called by the coroner alone. The majority of the jury must ask for him, and name him to the coroner in writing. (Boys, 251.)

From the above it appears that the coroner has the greatest latitude in choosing who shall perform the post-mortem ex-

amination. Prof. Tidy states that if the medical attendant of the deceased is in any way inculpated, or his treatment called in question, or if any accusation regarding the death or treatment of the deceased has been made by a medical man, he should not perform the post-mortem, and that it is not advisable that he should be present at it, but he should be represented and name him to the coroner in writing. (Boys, 251.)

In some of the States in the United States, physicians are regularly appointed to perform the necessary examinations for coroners. If, then, the coroner always exercised his best judgment in the protection of the medical practitioner to perform the post-mortem, it would do much to improve the condition of affairs. The fees allowed the medical witness who performs the post-mortem differs from that of the medical witness without a post-mortem in that the former is allowed five dollars more for the first day at the inquest. In other words, the post-mortem is rated at five dollars. This sum is, in most cases, very inadequate, and when one considers the case of exhumation or a badly decomposed body, the absurdity is striking. Such a fee is not enough to attract the most capable men, and so the coroner often hesitates to summon the most capable, feeling that he is, to some extent, imposing a duty without adequate remuneration. No provision is made for a microscopical examination which, in many cases, is to be deplored.

While advocating an increase in the fees allowed the coroner and the medical witness who performs the post-mortem examination, we must not lose sight of the fact that the cost of investigations of this character should not be excessive. In many places this cost is easily ascertained, but in Ontario this is at present almost impossible, owing to the fact that there is no central authority to whom full reports are sent. Here in Ontario the depositions or evidence must be certified and subscribed by the coroner and caused to be delivered without delay, together with the written information, if any, and the inquisition, to the crown attorney for the county. In cases of manslaughter or murder, to a magistrate who will ultimately send them to the crown attorney. The crown attorneys then, all over the Province of Ontario, have in their possession the records and are no doubt made use of only for legal purposes in each case where further action is taken.

In addition to this coroners in Ontario are required to return lists of the inquests *super visum corporis* held by them during the preceding year, together with the findings of the juries, to the provincial treasurer, on or before the first day

of January in every year. In regard to expenses in Ontario the coroner is supposed to pay them and he can then present his account to the county treasurer for payment. In practice, however, each person makes out his own account, and after getting it certified as correct by the coroner, leaves it with the clerk of the peace. For an analysis, the coroner must apply to the Attorney-General for his sanction in order to have the amount paid by the Government. The coroner should give the medical witness an order for the payment of his fees on the treasurer of the city or county. In regard to the final payment of these accounts I understand that the coroner's account is repaid to the municipality by the Government, but the fees for the medical witness is not so repaid. I am informed that in the city of Toronto, the number of cases investigated were, 1904, 3; in 1905, 71; County of York, 1905, 14; in 1906, 12; but whether these were only preliminary investigations or inquests is not stated. From this it is seen that it is not an easy matter to come to any conclusion as to the cost of the necessary work in this regard in Ontario.

To conclude, then, it seems to me that before we are in a position to properly discuss this question further and outline a scheme for the improvement of the conditions prevailing, it is necessary for us to be in a position to ascertain the number of inquests held, the number of preliminary investigations held, fees paid to coroners, fees paid to medical witnesses, and in addition to have some system whereby the records may be accessible for study and comparison.

Discussion.

W. Arrell (Cayuga).—The present method of paying coroners is very unfair. If a coroner is asked to make an investigation in a case of death by a crown attorney he ought to be paid for this investigation, and if an inquest is held as a result of this investigation he ought to be paid for the inquest held. As the law now is, if a coroner makes an investigation and an inquest is held after, he is paid nothing for the investigation although he may have spent days and driven many miles.

H. S. Bingham (Cannington).—Dr. Bingham opposed the election system in the appointment of coroners, and further supported the idea of the office of a coroner being filled by a medical man, rather than a lawyer, etc., etc.

John Hunter (Toronto).—Would it not be advisable to somewhat widen the scope of the coroner. For instance, a patient may be apparently at least making favorable progress

when suddenly a change takes place and death follows. The physician may be very desirous to ascertain the exact cause of death, but the relatives object. Could not some scheme be devised whereby the attending physician in sending out the certificate of death, might make some suggestion that could be acted upon by the coroner, and an autopsy held by a competent physician. The report of these autopsies should be filed, so as to be made use of by medical men. Some such scheme would furnish very much valuable information.

N. A. POWELL.—The coroner's office in many States of the American Union is a reward for political services, and the result is what might have been expected. Massachusetts, disgusted with what had been seen, turned to the medical examination system, and it has been such a success that other States are now introducing plans for the investigation of violent deaths. Ontario, by the appointment of medical men only as coroners, and by requiring an oath as to the necessity for an inquest before a warrant is issued, has raised the status of these investigations and given us a system of which we do not need to feel ashamed. Still we could, with the greatest advantage, change to a system, in the main similar to that of Massachusetts, in which a legal expert, such as a junior county judge, investigates each case of suspicious death along lines in which he is capable of doing his best work, while an expert in pathology investigates its strictly medical aspects, and so the ends of justice are swiftly and inexpensively furthered without undue publicity.

D. D. MACTAGGART.—The Coroner's Court is essentially a Court of Record, according to the authorities on Criminal Law, and coroners should legally keep a record of all investigations held either with or without jurors.

The judicial acts and proceedings should be enrolled as a perpetual memorial and testimony. A complete record should be made in every case, and these records deposited in the vault of the nearest Court House, and at time of making deposit the coroner should obtain a receipt from the Clerk of the Peace and Crown or other official in charge. These returns should be made every month, so that contents of records may be of use to those requiring them.

I am of the opinion that the position of coroner should be filled by a legal man, who should have associated with him a medical examiner. In cases of violent death or sudden death without medical attendance, the medical examiner would be called and make the necessary examination. If he is satisfied

that there is absolutely no evidence of crime, he makes such report to the coroner, who may then dispose of the case. But if, on the other hand, there is the slightest evidence of crime, then the coroner will exercise his judicial functions by calling a jury and witnesses and investigating the case. By this means the legal side is left entirely to lawyers, as it should be, and the medical examiner has only to deal with things medical. If medical men are appointed as coroners, they are often called on to act as judge and witness, and no man can fill the two positions.

My suggestion would be to divide the province into districts and have one coroner for each district, who should have a deputy to assist him and act as the clerk of the court. A chief medical examiner and assistants should be appointed for each district. The appointment of coroners should be made by the Lieut.-Governor-in-Council. Medical examiners should be appointed in the same way and should be selected from men who have had a large experience in autopsy and pathological work in order that correct results may be obtained.

The question of fees should be a secondary one. The first object is to establish a proper system with good appointments, and this having been done, the question of fees could then be taken up. In large centres, like the City of Toronto, a salary might be given, but in other places, where the work is not arduous, a magistrate could fill the position and be paid by fees.

Coroners' Association.—Following the suggestion I have made of separating entirely the legal and medical sides of the question, I cannot see that a coroners' association would be of any benefit to the medical profession, but would suggest rather the formation of a Medico-Legal Society, the nucleus of such a society to be the Medical Examiners, and that this society either hold a meeting yearly or form a section of the Ontario Medical Association, and not take up homicide only, which is the only investigation that one has to deal with at a coroner's inquest, but take up also insanity, disability following injury and other matters of a medico-legal nature, which are continually coming before the civil courts.

Analytical reports of the medical examiners could be compiled and submitted at the annual meeting. By this means a broad view of medico-legal matters is taken, and the results would be of benefit to the profession in general. As medical men, our duty is to find the cause of death—let the lawyers, acting on the side of justice, find out who is responsible for the death.

HOSPITALS FOR THE INSANE IN ONTARIO—IDEALS.

By C. K. Clarke. M.D. LL.D., Toronto.

On the whole Ontario has done well for the insane of the Province, and while the highest ideals have not always been striven for, it must be remembered that in developing countries, a process of evolution through crudity to a better condition of affairs is inevitable. Ontario has at least initiated some things worthy of imitation, and along practical lines has been well to the front: non-restraint; the proper employment of patients; training of nurses; isolated hospitals, etc., were developed here early in the day, and in some of these things, at least, the United States had to follow, rather than lead.

The greatest failure has been in the way of developing the scientific side of the work, and while in this respect we have been no worse than many states, there is no reason why, in this particular, we should wish to longer remain in a subordinate position in America.

We cannot afford to lag in the race to achieve a solution of the problem of psychiatry. The demands of modern medicine are inexorable, and we must meet these as fully as possible.

The failure in the past has been the result of misapprehension on the part of Governments—too much attention to the requirements of political exigency, and an impression that what Ontario did was of necessity a pattern for the world to follow. The belief that the duty of the State ended when the chronic insane were comfortably housed and cared for was very prevalant; that they were provided for more cheaply than anywhere in the world was glory enough for some minds. This would be admirable, if it included everything that should have been done; unfortunately it did not. Preventive medicine had little or no place in the scheme, and too often appointments were made to the service without the slightest recognition of its requirements. Fortunately some of the men appoiuted have proved superior to the hamperings of want of special training and knowledge, but all will, I think, admit that the system is a bad one and has not been calculated to inspire assistants with enthusiasm and industry.

Psychiatry is, after all, very much like any other of the departments of general medicine, and it is scarcely possible to achieve a knowledge of it without a long and intelligent apprenticeship in the Hospital. At best it is a most difficult study, and in the wards of an institution for the insane, as ordinarily administered, opportunities for an acquirement of a thorough training have not been what

they should be. Now it has been a popular method of the general practitioner to decry Governments because they appointed Superintendents without experience, over the heads of Assistants.

The medical profession, as a whole has not been without sin in this matter, and active crusades on the part of general practitioners in behalf of certain favored candidates have not been unknown. Certainly the cause of the trained assistant has not been taken very deeply to heart by the profession as a whole; however, the solution of the difficulty is at hand, and an unpleasant subject may safely be left in the hope that a new order of things is to be initiated. I merely wish to point out that Governments have not been the sole offenders in the development of an abuse so roundly condemned by the profession at large. The profession itself has had something to answer for.

The assistants have really had the greatest grievance of all, and even they have not been beyond criticism, because they went into the work fully aware of what was before them, and it was always their privilege to leave the service, if they were not satisfied with the condition of affairs.

They soon learned that their duties were largely clerical and when they had finished their routine of books, general medicine, etc., there was little time for research. Fortunately some of the assistants have proved superior to their difficulties and have struggled manfully to keep up with the modern trend, although well aware that there was little hope for advancement.

Now all of this was wrong; and yet the day of emancipation is at hand, if the signs of the times mean anything. Just as might have been expected, the Government has awakened up to its responsibility in the matter and has practically said, "We are willing to be guided by competent advice. What must we do—not to follow, but to lead along the lines which seem to be marked out as desirable by modern medicine?"

Fortunate indeed is it that the present Provincial Secretary is a man who takes the broadest view possible of the requirements of the situation, and the cause of psychiatry is not likely to suffer in his hands. Already the spirit of advance is being developed, and if the institutions do not go ahead the fault will rest with those in charge. Assistants have, where desired, been emancipated from clerical work, and encouraged to go on with clinical investigation, and while staffs are yet too small to accomplish all that is wished to do, still a beginning has been made.

Now what are the ideals we should strive for?

My impression is that in Ontario, the policy adopted by the Government is the very best possible to lead to the solution of the problems we could not solve in the past. Let me then for a few moments leave the faults of byegone days and deal with ideals which are to be attempted, I trust, in the near future.

For some years I have felt and contended that psychiatry has had a tendency to dissociate itself too much from general medicine, and our methods have exaggerated the evil. It has not been possible to make plain to the general profession the importance of the subject, and at college the student has had little or no opportunity to come in touch with it practically.

Then again, the treatment of acute cases in Hospitals for the Insane has been attended by many difficulties, although good work has been done in some of the institutions. Incipient cases have generally been allowed to develop at home on account of the dread of the Asylum. Now it is not for me to argue regarding the importance of the Psychiatric Hospital, as its place has long ago been put beyond controversy, even if America has not yet accepted this policy. It has been left for Ontario to take the important step. What I advocate is this: the establishment, as population makes necessity for them, of Psychiatric Hospitals at the University centres: Toronto, Kingston, London. The moment for the development of such a Hospital in Toronto has arrived, and the Government policy seems to be all that can be desired or expected. The establishment of such an institution does not mean that development of scientific work in the large hospitals must cease, but on the contrary it should enable such work to be done far more efficiently than ever before. There should be a most intimate relationship between the Psychiatric Hospital and the other institutions, and they should work in complete harmony in carrying on investigations of the greatest importance.

The Psychiatric Hospital should be equipped in the most thorough manner to treat recent cases energetically and scientifically.

At Munich the theory of the organization of such a clinic is something as follows:

Small size, to enable a complete study of each patient.

A large staff of physicians and nurses.

Well equipped laboratories for the teaching of students and for research work in clinical psychiatry; psycho-pathology and neuro-pathology, etc.

A dispensary and out door department.

Provision for the study of criminals in whom mental disease is suspected.

While the proposed institution will, if developed, have all these requirements, it will also have several additional functions, if the greatest good is to result. There should be facilities for the training of all of the assistants in the Hospitals for Insane in psychiatry, neuro-pathology, and clinical methods, and these assistants should then be required to give evidence of further development in research work when they are attached to the different Hospitals.

The nursing staff should establish reciprocal relations with the

General Hospital, and the nurses in training in each institution receive in this way mutual benefit. The asylum nurse would get what is lacking her course and the General Hospital nurse becomes proficient in mental nursing, a branch in which she has failed to a great extent in the past.

The University would benefit by having a Department of Psychiatry in which a practical study of the abnormal in the Hospital laboratories would give results not at present attainable.

The problems of psychiatry are so clearly allied to those of general medicine that they can best be studied in a clinic not too far removed from the General Hospital. While it is true that only those who are conversant with mental disease can direct its treatment to the best advantage, it is also true that even they would be benefited by consultation with men eminent in general medicine, as a different point of view is not always without its advantages.

The treatment of acute alcoholics should be undertaken in the Psychiatric Hospital, as these toxic mental cases properly belong to its wards.

The stigma attached to detention in a Hospital for the Insane would no longer prevent the acute and incipient cases coming under immediate treatment; however, the advantages of the Psychiatric Hospital are so well established that it is a waste of time to further dilate upon them. What Germany has done to revolutionize psychiatry is well known.

Now, taking it for granted that in time central clinics in University centres are established and large colonies for the chronic insane developed, it will not be difficult to attain ideals that are at present impossible.

It has been said that with the establishment of clinics the interest in scientific work in large institutions will die out, and they will become nothing more than alms-houses on a large scale. Nothing more erroneous could be promulgated, as the clinical work to be done among the chronics is of just as great importance as that in the Psychiatric Hospitals. Take the scientific work to be developed in connection with general paresis and dementia praecox and paranoia alone, and see what fields for investigation open up. Post mortem research; blood examination; in fact every field in the domain of medicine is within reach. The convalescing insane will frequently make their complete recovery at the hospitals for the insane, where ideal out door conditions are available.

My whole plea then is to have the service put on a scientific basis, every physician in this service a well educated psychiatrist, whose idea must be that he is to do something to advance the knowledge of a difficult branch of medicine. I think that this will best be accomplished by the development of Psychiatric Hospitals, as before detailed, having an intimate relationship with large institutions of the chronic insane and progressive universities.

DISCUSSION.

W. C. HERRIMAN (Kingston).—I am very glad to hear what has been said in this discussion, especially what was said by Hon. Dr. Reaume and Dr. Burgess. Being one of those who have been several years in this department of the public service I appreciate the promise of better things which can be anticipated from what has been said in Dr. Clarke's paper and this discussion. It has been hinted, however, that the Asylums of Ontario are away behind the times. Hon. Dr. Reaume very properly resents this idea. It has been publicly said very recently that nothing is being done in the Asylums of Ontario looking to the treatment and cure of the insane. That there remains much to be done we all admit and great things are about to be accomplished as foreshadowed by Dr. Clarke, but I want to say that if any person makes the assertion that nothing has been done or is being done he simply does not know. To any who have been led to think that such is the case I want to extend an invitation to visit us at Rockwood Hospital, or I am sure he would be treated well in any of the Provincial Hospitals.

T. J. W. BURGESS (Montreal).—Mr. president and gentlemen, I thank you most sincerely for the privilege of taking part in the discussions of Dr. Clarke's able and interesting paper. In an address, "The Insane in Canada," delivered at San Antonio, Texas, two years ago as president of the American Medico-Psychological Association, I summed up my remarks by saying, that while with respect to custodial care and ordinary treatment, moral and medical, Canada, generally speaking, was well up to the times, she was doing little toward the solution of the many problems connected with the scientific aspect of insanity, and, in this respect, she presented a sorry picture when compared with the good work being done in many hospitals elsewhere.

With the erection of a Psychiatric Hospital, as outlined by Dr. Clarke, such a reproach can no longer be made, and as a native of this province, I am proud to think that Ontario should be the first to take a step that will place her not only foremost as regards this Canada of ours, but foremost as regards the whole vast continent of America. In praise of the wisdom of the Government for taking such an advanced view too much cannot be said; and here let me tell you that such an establishment will be not only a boon to the most unfortunate of all God's afflicted ones, the insane, but a true economy. Most of you, I have no doubt, know how very prone mental disorders are to become chronic and incurable; and some of you are probably aware that, once the acute stage is passed, lunatics are even more likely than the sane to live to a ripe old age, because protected within hospital walls from so many malign influences But have any of you thought what each thirty or forty

years of lunatic life costs, not only in actual outlay for hospital care but in the loss to the state of the wage-earning power of each insane person. It is simply an enormous sum and if the establishment of a Psychiatric clinic increases the rates of cures by even five per cent., as I feel sure it will do, the institution will more than pay for its cost, no matter how large that may be. For their choice of a superintendent for the new clinic the Government deserves no less praise. To Dr. Clarke we are indebted for our first training school for nurses for the insane, our first isolated hospital for the treatment of the sick insane, and, I think, for our first building for the segregration of the tubucular insane. In the length and breadth of the land no better or more experienced man could have been chosen. I wish I could say the same for the rest of their appointments. To get the best results in our hospitals for the insane all medical appointments thereto should be of men thoroughly trained and experienced in every branch of the specialty, and yet how rarely we see this rule observed. The appointment of outside practitioners to superintendentships for political purposes is a flagrant injustice to the patients, to the taxpayers, and to deserving juniors, of whom there are many in the service. No man should be given charge of an institution for the insane unless possessed of experience in the treatment of the insane, and no junior should be appointed unless he has had special training in psychiatry and has shown a penchant for the work.

I speak freely on this subject, gentlemen, because I myself have gone through the mill. Sixteen of the best years of my life were spent in the asylum service of Ontario, and when time and again I saw myself passed over in favor of some outside man, though the senior for promotion, I thought it was time to quit, which I did. This was of course, under the regime of the late Government. Whether the present one would have treated me any better I cannot say, but I think it extremely doubtful.

Do not think I blame the Government entirely for the wrong done by the appointment of outside practitioners. The men who accept such positions without previous experience are equally blameworthy. As bearing on this point I would like to quote you a few words by one of the ablest writers, himself a physician, in the city of Montreal. They appeared in an editorial, "Insanity and Politics," published in the *Montreal Medical Journal*. In this the author says:—"We yield to none in our admiration of the general practitioner. We are aware of his energy, his resource and his fidelity, but not even the general practitioner will lay claim to a capacity for treating off-hand and to the best advantage grave lesions of the eye and ear, or of the more secret parts of the body. He should adopt the same attitude toward the brain. In time it will come to be a shameful thing for a general practitioner to accept

a position for which he is not qualified, since thereby he is committing a wrong towards his colleagues and towards his patients."

To my mind the ideal asylum service is that which exists in New York State. There, all the superintendents are appointed by the Boards of Management of the various institutions, and must be selected from men who have served at least five years in an institution for the insane, and have proved their capacity by passing an examination for a superintendency. The assistants are appointed by the superintendents, their selection being restricted to the three names first on the list of those eligible for the vacancy. No step in advance can be won unless the candidate has had previous experience in a lower grade of the specialty, and proven his fitness by passing an examination before promotion. In conclusion, gentlemen, I would urge upon the profession that they should combine to right this wrong in the matter of asylum appointments. If only the medical men of this province, as a whole, would say, "We wish the system of the promotion of deserving juniors to be established," no Government dare gainsay them. It is for this Association, representing as it does the very pick of the profession, to set the ball rolling, and I sincerely trust that ere the close of your sessions some steps towards that end will be taken. In this way, better than any other I know of, you will put yourselves in a position to attain the ideals for Asylum work in Ontario, a height to which I feel sure you all aspire to see the service reach.

A DANGER IN ALCOHOLIC MEDICINES.

By W. C. Abbott, M.D.

One of the most difficult cases of alcohol habit the writer ever treated was a man in whom a hereditary taste for alcohol was aroused by a little wine employed to flavor the sauce of a pudding Seven years' drunkenness followed.

In former years when we employed habitually in practice the elegant wines and elixirs of the pharmacy, we found that some patients would too greatly relish these preparations, and that they were taken as beverages rather than medicines. Many times the patient who was prescribed a bitter elixir to improve the appetite would really partake of less food than formerly, preferring to take a swallow of the medicine instead of eating. Others showed so decided a fondness for the medicine and disinclination to have it changed, that we took alarm and gradually discontinued the use of these seductive preparations.

In view of the popular movement against the making of drug fiends and inebriates surreptitiously, by the taking of alcoholic, opiate and coca nostrums, it seems that we might with advantage look to the clearing of our own skirts. If we believe that alcohol is needed for a case, let us give it as alcohol, and while we utilize the perilous drug in the manner best suited to the case, we need not make it unnecessarily attractive to the unsuspecting patient. Indeed, it would be no more than one's duty to warn them beforehand, and ascertain if there were any hereditary tendency that might be thus aroused. But if the effect desired is merely a tonic one, why employ so dangerous an aid when there are so many better ones that may be administered without this peril?

There is, we believe, not a solitary use to which alcohol may be put in medical practice for which there is not a better remedy to be selected. The value of alcohol lies in its adaptability to so many uses. But we do not have to use one remedy for twenty purposes, when we have one other for each of the twenty that is for that one purpose better than the universal remedy.

It is the indolent doctor who uses opium for all pains, alcohol for almost everything else, who diagnoses nearly all his cases as "malaria," or "uric acid," and shuns the task of accuracy in diagnosis and therapeutics. It is this same indolence that make a drunkard now and then, by careless prescribing. Nevertheless, we admit that a man will sometimes be so busy, and have so many matters of life and death occupying his mind, that he may not recollect to ascertain the possibility of alcoholic tendencies in every new case. It is here that the practice of active principle therapeutics saves us from the awful burden of making inebriates. The little granules are devoid of this danger, and if they should be given in solution it is simply dissolving them in a little water, and not a trace of alcohol is employed.

This may seem to some to be a small thing, not deserving of time and space. To us it is a very grave matter. As we seek to shun even the appearance of evil, so we seek to guide our steps into paths that lead to safety, even in the gloom of night.

Chicago, Ill.

Physician's Library.

Wellcome's Photographic Exposure Record and Diary, 1907. Burroughes Wellcome & Co., London and Montreal, is a neat, chaste, unique production.

The Cure of Consumption with Subcutaneous Injection of Oils is a neat brochure, reprinted from *The Antiseptic*, Madras, India, and written by THOMAS BASSETT KEYES, M.D., of Chicago. Dr. Keyes claims he is offering the greatest therapeutic advance in the treatment of tuberculosis that has ever been made, by the subcutaneous injection of oils which are digested by the white globules of the blood. By such he claims tuberculosis is absolutely curable in every climate and in every country.

The Doctor's Recreation Series. Vol. VII. The Inn of Rest. Divers Episodes in Hospital Life, Relative to the Doctor, the Nurse, the Patient. By SHELDON E. AMES. The series edited by Charles Wells, Moulton. Akron, Ohio, U.S.A.: The Saalfield Publishing Co.

One is quite safe in saying that the editor of this volume has succeeded in compiling a worthy companion volume to the other very excellent volumes which have preceded this. While some selections can be recognized as old friends, there are here set forth several new ones, original in this compilation. The illustrations are five in number. The first is probably the best known—Before the Operation; the second shows Lannec, the Inventor of the Stethoscope, at the Necker Hospital, Paris; the third, Penel at the Salpétriére; the fourth, Ambrose Paré.

Surgical Diagnosis. By DANIEL U. EISENDRATH, M.D., Adjunct Professor of Surgery in the Medical Department of the University of Illinois (College of Physicians and Surgeons). Octavo, 775 pages, with 482 original illustrations, 15 in colors. Philadelphia and London: W. B. Saunders & Company, 1907. Cloth, $6.50 net; half morocco, $8.00 net. Canadian agents: J. A. Carveth & Co., Toronto.

It is difficult, in the limited space at our command, to do full justice to this magnificent work. The view point of the clinician and that of the didactic lecturer are of necessity radically different in many ways; and while we are not prepared to decry the work of the later, in many cases we can't help thinking that the intrinsic value of the former method of teaching is much greater to the

student of surgery. It is "all very well" to describe in detail the etiology, symptoms, treatment, etc., of any particular surgical affection, but it seems to us *all very much better* to describe the conditions as they are usually associated in real life, and from this grouping of associated conditions to differentiate the more important—in other words, to take up the study of Diagnosis as one must in active practice, rather than in an academic manner.

Professor Eisendrath has, to our way of thinking, evolved the most complete and most satisfactory work on the subject we have yet seen. In the preface he says: "An attempt has been made to group injuries and diseases in the manner in which the surgeon or general practitioner must consider them when he examines a patient for the purpose of making a diagnosis. Thus in the chapter upon injuries of the head, the various traumatic lesions of the scalp, skull, and brain are considered together. In the chapter upon the abdomen the injuries of all of the abdominal viscera are taken up in a similar manner."

Again he says: "Being a strong advocate of the teaching of surgery by the education of the eye, I have introduced a large number of original illustrations of clinical cases and specimens." And here we can express nothing but the highest admiration for the profuse number, and excellent character of the illustrations—so thoroughly helpful in explaining the text. Here is a work which is bound to be of great help to the clinical teacher. Those of us who are engaged in clinical work know how hard it is at times to obtain a case which will exactly illustrate some particular phase of a given lesion or its complications. Take a case at random from the large number portrayed in this work: figure 251 shows very clearly a case of Hernia and Hydrocele in the same patient—a condition not met with over frequently, and consequently difficult to demonstrate to the student.

At the end of the work are two splendid chapters, viz., one on Post-operative Complications (Hemorrhage, Shock and Collapse, Pulmonary, Cardiac, Hepatic and Gastric Complications, etc.), and the other on Methods of Examinations (including examination of blood in surgical cases, Opsonins and the Opsonic Index, Newer Methods of Diagnosis of Renal Lesions, etc.).

In conclusion, realizing that our criticism is, at best, only fragmentary, we beg to proffer our heartiest congratulations to Professor Eisendrath on his magnificent work—a work, par excellence, for *the student of surgery*, whether graduate or undergraduate.

Annals of Surgery for June (one dollar).

Never was greater enthusiasm or more strenuous effort displayed by any profession, never were more arduous labors performed, never was more efficiency advocated and never were more

glorious results achieved than in the surgery of to-day. The magnificent advance of this art, so well depicted in the *Annals of Surgery* during the last twenty years, has blazed the way, and made possible the solution of innumerable problems of our associates in other departments of the profession. Truly if the sum total of human happiness is to be measured by the saving of life, then, indeed, should modern surgery be honored and its masters revered.

So well does the June number of the *Annals of Surgery* portray this fact, that the reader is amazed, and ponders over future possibilities.

The June number of the *Annals* will be a remarkable collection of the choicest literature on modern surgery. Each article will be a practical, comprehensive treatise by an eminent specialist who has actually performed the operations described. No expense will be spared to make this the best issue, completing the forty-fifth volume.

The colored illustrations, of which there will be an abundance, have been placed in the hands of the leading medical artists of the country, and will be reproduced to the minutest detail.

Reviews of Books, List of Contributors and a Volume Index complete the book, a work alike creditable to the surgical profession, the editors and the publishers.

The Care of the Baby. New (4th) edition. By J. P. CROZIER GRIFFITH, M.D., Professor of Diseases of Children in the Hospital of the University of Pennsylvania. 12mo, 445 pages, illustrated. Philadelphia and London: W. B. Saunders Company. Cloth, $1.50 net. Canadian agents: J. A. Carveth & Co., Toronto.

"The fourth edition of this excellent work has been revised throughout, and such additions and corrections made as the passing of time and the advancement of knowledge have made advisable." The work is fully up-to-date, and among other new features presents a second appendix on page 425, which is intended to appeal to the lay reader as well as the physician.

A Manual of Personal Hygiene. New (3rd) edition. Proper living upon a physiologic basis. By Eminent Specialists. Edited by WALTER L. PYLE, M.D., Assistant Surgeon to the Wills Eye Hospital, Philadelphia. 12mo, 451 pages, illustrated. Philadelphia and London: W. B. Saunders Company. 1907 Cloth, $1.50 net. Canadian agents: J. A. Carveth & Co. Toronto.

If it be true that "The proper study of mankind is man," and that the study of personal hygiene is but indifferently taken up at

school, and still more neglected by the mass of mankind at large, the *raïson d'être* of this volume is amply justified. What an infinitely better investment it would be for the average young person —a work of this kind, rather than some mediocre work of fiction! But youth is youth, and recks little of such an important matter as personal hygiene, until the years are sped, and impaired health forces the serious consideration of the science and art of living properly. The work under consideration is admirably conceived and well carried out.

The American Pocket Medical Dictionary. Edited by W. A. NEWMAN DORLAND, M.D., editor "The American Illustrated Medical Dictionary." Fifth revised edition. 32mo, 574 pages. Philadelphia and London: W. B. Saunders Company, 1906. Canadian agents: J. A. Carveth & Co., Toronto, Ont. Flexible morocco, gold edges. $1.00 net; thumb indexed, $1.25 net.

On former occasions it has been our pleasure to speak quite highly of this exceedingly handy book. That it has met with universal acceptation is quite evidenced now that the fifth edition has appeared. The author tells us he has carefully revised the text for this edition, thus keeping pace with the continuous advances in medical literature. The vocabularly is strictly up-to-date. There is a great deal of matter in tabular form which will be appreciated.

Diagnostics of Diseases of Children. By LEGRAND KERR, M.D., Professor of Diseases of Children at the Brooklyn Postgraduate Medical School. Octavo, 542 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1907. Canadian Agents: J. A. Carventh & Co., Toronto, Ontario. Cloth, $5.00 net; half morocco, $6.50 net.

This work is fully illustrated and is the best on the subject we have seen. As the diseases of children are large y, in fact mostly, treated by the practitioner of general medicine we conceive there will be a large demand for this book. It is quite apparent in the perusal of the volume, that one particlar aim of the author has been to keep the book practical. In this he has succeeded admirably. It will prove a great help to those engaged in the practice of general medicine, and greatly enable us all to further qualify and equip ourselves in successfully handling that section of medicine, which, at times abstruse, may now become wonderfully enlightened. That the book is comprehensive and covers the field well is shown in the fact that over 500 pages are consumed, and these pages are not unnecessarily given over to unessential details. We bespeak for this work a warm welcome from the profession.

The Elements of the Science of Nutrition. By GRAHAM LUSK, PHD., M.A., F.R.S. (Edin.), Professor of Physiology at the University and Bellevue Hospital Medical College, New York City. Illustrated. Philadelphia and London: W. B. Saunders Company, 1906. Canadian Agents: J. A. Carveth & Co., Toronto.

The widespread interest in the subject of nutrition at the present time is ample reason for the publication of this work. The author's aim is to review the scientific substratum upon which our knowledge of nutrition rests. Metabolism in health as well as in disease is considered, and special attention is given to the metabolic disturbances that occur in gout, diabetes, myxedema, exophthalmic goitre, phosphorus poisoning, and anemia.

The prominent position which Dr. Lusk holds as an investigator in nutritional processes makes the book all the more valuable.

Manual of Clinical Chemistry. By A. E. AUSTIN, A.B., M.D., Professor of Medical Chemistry and Toxicology in the Medical Department of Tuft's College, Boston. D. C. Heath & Co., Publishers. 1907.

The aim of the author is to write a book on chemistry applied to the study of clinical medicine in a form suitable for the ordinary student of medicine. He does not burden the minds of the readers with matters which are not of direct value in studying disease; but at the same time he takes the student through the study of the elements and constituents of the body.

The first part of the work is devoted to the study of the chemical processes of the body, and of constituents of foods. Then follow chapters on the chemistry of blood, milk, enzymes, and digestive fluids. The concluding portion is principally taken up in describing the clinical methods of examination of gastric contents, urine and feces. Students and physicians will find this work an excellent guide in chemical methods in clinical medicine.

The Canadian Medical Protective Association

ORGANIZED AT WINNIPEG, 1901

Under the Auspices of the Canadian Medical Association

THE objects of this Association are to unite the profession of the Dominion for mutual help and protection against unjust, improper or harassing cases of malpractice brought against a member who is not guilty of wrong-doing, and who frequently suffers owing to want of assistance at the right time; and rather than submit to exposure in the courts, and thus gain unenviable notoriety, he is forced to endure black-mailing.

The Association affords a ready channel where even those who feel that they are perfectly safe (which no one is) can for a small fee enroll themselves and so assist a professional brother in distress.

Experience has abundantly shown how useful the Association has been since its organization.

The Association has not lost a single case that it has agreed to defend.

The annual fee is only $3.00 at present, payable in January of each year.

The Association expects and hopes for the united support of the profession.

We have a bright and useful future if the profession will unite and join our ranks.

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Dominion Medical Monthly

And Ontario Medical Journal

EDITORS:

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ASSOCIATE EDITOR:

T. B. RICHARDSON, M.D.

MANAGING EDITOR:

GEORGE ELLIOTT, M.D.

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COMMENT FROM MONTH TO MONTH.

The 27th Annual Meeting of the Ontario Medical Association has been, its influence still is, its results are to be. Writing after the enthusiasm of immediate attendance upon the meeting has somewhat cooled, one cannot but look upon it as one of the best, if not the best, of recent years. In point of attendance it has been surpassed by but one since the inception of the Association, that of 1889. This was due to the earnest work of those whose responsibility it was to work up an interest in the meeting, and undoubtedly to the personal magnetism of the President.

There were many interesting features about the meeting aside from the papers which were presented. One cannot but consider with favor the manner in which the various papers dealing with the relation of medical men to matters of public interest were received. It indicates a broad and generous citizenship which augurs well for the products of medical education. The moulding of public and professional opinion which comes from the discussion of these matters secures a more harmonious understanding of the basis upon which questions involving these relationships shall be settled. The committee did well in asking Mr. Justice Riddell to discuss the paper dealing with the matter of providing means for the institutional care of the confirmed inebriate. Similar

discussion of the paper upon the care of the degenerate might also have been undertaken with an endeavor to estimate the force of public opinion upon such a matter. The public has a right to concern itself with the question and to aid in solving so difficult a problem.

The papers considering questions of professional interest were many and some exceedingly well presented. We were glad to see the determined effort upon the part of the committee to provide for an intelligent and careful discussion of the papers. Many of the discussions had been written only after thoughtful consideration of the papers with which they were associated and were consequently of as much value as the paper itself.

The address in Surgery by Dr. Crile dealt with a specific subject, an endeavor to establish the position of direct transfusion of blood in the relief of surgical shock, hemorrhage, and other conditions. The talented lecturer, as a result of repeated experiment both in the laboratory and clinically, has demonstrated the fact that with these two conditions, and possibly with others, it offers the most certain relief of any means at our disposal at the present time. His citation of various cases which have been restored after extreme and apparently hopeless conditions, the result of shock and hemmorhage, created the conviction in the minds of his hearers that this almost neglected procedure may be reviewed to the advantage of many patients who would otherwise be lost.

Dr. Ravenel's presence and address upon the etiology of Pulmonary Tuberculosis recalled the famous pronouncement made by the brilliant German investigator at London in 1901, as to the relation of Bovine and Human Tuberculosis. Ravenel, one of the most urgent opponents of Koch's theory at that time, in his paper of May 30th, after a prolonged and cogent argument substantiated by experiment, again claims the truth of his position that a large proportion (very much larger than has hitherto been claimed) of patients with Pulmonary Tuberculosis owe their infection to milk and meat, and that in the absence of intestinal lesion in the recipient or of tubercular processes in the udders of the cows from which the milk was obtained.

Each of the addresses was given scrupulous attention, as their importance warranted.

The Committee on Arrangements outdid themselves in entertaining their guests. Future committees undoubtedly have a standard of excellence set for them which will be hard to surpass. The concert on Tuesday evening was a very enjoyable affair, while the plaudits awarded the members of the committee for the success of the dinner were very general. It is seldom in Toronto that so many able, witty speeches have been made as followed the toasts of Wednesday evening. There was no exception, from the time that his Honor the Lieutenant-Governor opened his lips until the

President declared the list closed, the flow of brilliant wit sparkled and ran to the delight of every one present. May we live to see many another dinner as good.

The Association did itself honor when it so gracefully added to its list of honorary members, for life, the names of Drs. Thomas Tipton Harrison, of Selkirk, and James Henry Richardson, of Toronto. These names have for years stood for rugged, upright, loyal Canadianism, they have been worn honorably before their fellows, both in professional and in the wider field of public life, and none more worthy grace the roll of the Association—

Hail! O Harrison! and unto thee, O Richardson, Hail!

As to the business of the meeting a number of important matters came up for attention, perhaps the most significant of which was the appointment of a committee to report to the Association at its next meeting as to needful changes in the Constitution and By-Laws to make possible affiliation with the Canadian Association and with the County and City Societies, it being a *sine qua non* that the Provincial Association shall be the connecting link between the intra-provincial societies and the Federal Association. The Committee is authorized to discuss the question with the Canadian Association at its next meeting.

Now, the duty to a considerable degree for the success of next year's meeting falls upon Hamilton. Dr. Olmsted, the new President, has been an energetic member of the Association for years. He is held in honor by the profession at large as well as by his fellow members. Every member should undertake missionary work for the year, so that the meeting at Hamilton in 1908 will be to the advantage of all, both in the quality of the work done and in actual attendance. There ought to be at least 500 attending meetings where so many useful papers are presented and so many questions of public weal are discussed. C. P. L.

The American Medical Association engages the whole of the editorial mind of *American Medicine* for May. One did not need to read these editorial paragraphs to know that within the last few years the American Medical Association had attained a mighty influence and standing in the United States, and that it puts forth a journal of which any country's physicians should be proud. Whilst we could not endorse fully its policy, especially as regards proprietary articles, believing as we do, that an association journal should be wholly without advertisements of any description and not in any way advancing the interests of commercial houses of any description, we do believe that it is an ably conducted journal, and could yet far better do its work without a single advertisment. Say that its weekly issue is now 50,000, and its subscription price $5.00 a year, there should be margin enough out of $250,000, if its

members were all truly loyal, to provide for the work of its publication.

"Is Cancer Contagious?" is the title of a reprint kindly handed us by Dr. A. Laptham Smith. The subject of cancer is a broad and liberal one. It is a disease widespread in its destruction of human life. It causes untold suffering. That suffering is mental as well as physical. To make the diagnosis of cancer almost always sounds the death knell. Great numbers die from it annually. Its cause is unknown. Its ravages are known. Dr. Smith's pamphlet preaches contagiousness and scouts heredity. For over twenty years his observations have extended and confirm him in his belief that the disease is contagious. Not content with taking the experiences and observations of men of note, as Shrady, Behla, Thorna, Roswell Park and Gaylord, that the disease was contagious, Dr. Smith went after the rank and file of the profession, and in this way has been able to collect a large number of reports of cases where there was not an atom of heredity in them. Amongt the cases coming directly under his own observation, he found that nine out of ten had a family history absolutely free from cancer. The cases cited are interesting and instructive. One thing we are sure about in cancer: In the beginning it is absolutely a local disease and should promptly be removed by the surgeon's knife, which is better than dallying with pastes and X-rays.

The Calculi found in the human body are biliary, intestinal, pancreatic, prostatic, renal, salivary and urinary. From the standpoint of the X-ray, they are interesting, as not all are opaque nor yet all transparent. Biliary calculi are exceedingly transparent to the X-ray, and there is generally no inconsiderable difficulty in diagnosing their presence. Intestinal calculi are not by any means common. Their composition is such that they should offer some resistance to the passage of the X-ray, though there as yet seems to be few, if any, cases of their determination so recorded. Pancreatic calculi are exceedingly transparent and they are, too, exceedingly rare, the rarest of all glandular caluli. Prostatic calculi are, as a rule, exceedingly small, and as their composition is largely calcium phosphate, they should be shown. To diagnose renal calculi by means of the X-ray is probably the most important part of the surgeon-radiographer's art.

It may be pointed out that in several instances renal calculi have been diagnosed by means of the X-ray, when all clinical symptons have failed, or were absent, except pain. Salivary calculi can readily be radiographed, as they can usually readily be palpated, being generally situated near the orifice of the duct. Probably the X-rays would not often be required in their detection.

Urinary calculi can generally be readily detected by the sound or cystoscope. As there is an element of danger in this method, the X-ray might readily, with great benefit, be employed in determining stone in the bladder or urethra. Large stones can be detected easily; smaller ones, owing to the bones of the pelvis obscuring the field, not so readily.

Were a General Practitioner appointed chief oculist to the Toronto General Hospital, or some other general hospital, one can imagine the meek manner such appointment would be received by the oculists, the specialists already on the staff, men who by special study and training had qualified themselves to treat people with diseases of the eye. We question whether any general practitioner would have either the gall or self-conceit to accept such position, even though a salary of two thousand dollars and free light and fuel accompanied the appointment. Only into the realm of psychiatry can a general practitioner jump at a moment's notice and at once be a specialist, without any special training or education, except that received in the ranks of a political party, in a political caucus, or on the back township concession lines. What a great training ground the political field is for putting forth alienists simply by the falling of the politician's magical wand. Are the assisttants in the various provincial hospitals for the insane in Ontario, some of whom for fifteen or twenty years or more, have made a specialty of psychiatric practice, undeserving of promotion, or are they of such meagre calibre, that the government fails to fulfil its bounden duty to its unfortunate wards, and prefers to place at the heads of the several institutions in the province, general practitioners who lately, and in the past, have taken "a prominent part on the Conservative side of politics." What is the Ontario Medical Council doing, what is the Ontario Medical Association doing, what is the Hospital Association doing, what are the Psychiatrists themselves doing, that this nefarious and altogether ridiculous, if not inhuman practice, is allowed to continue to prevail? To place a general practitioner-politician over the heads of skilled, trained men in this department of medicine is downright scandalous, yes, silly. For a general practitioner-politician, or even a plain ordinary general practitioner, to accept such a position over the heads of specialists is proof positive that he has no clear conception of honor and common decency. The people of Ontario should demand of the government, competent and trained men at the heads of its provincial hospital service, certainly not men whose best and only qualification is that the appointee has taken a prominent part in Conservative or Liberal politics. It is not necessary to here state what special appointment this time we are driving at.

Editorial Notes.

British Columbia Medical Association.

The Eighth Annual Meeting will be held in the Parliament Buildings, August 1st and 2nd, 1907. Dr. R. L. Fraser, Victoria, is the President, and Dr. R. Eden Walker, New Westminster, the Secretary.

Meeting of Canadian Medical Association, at Montreal, Sept. 11th, 12th and 13th, 1907.

The committee on papers and business desire intimation of papers or other matters to be presented at the forthcoming meeting. Papers will be limited to fifteen minutes and are to be submitted to the Committee three weeks before the meeting.

RIDLEY MACKENZIE,
Local Secretary.

192 Peel Street, Montreal.

Toronto General Hospital—Department of Immunization and Medical Research.

Types of cases which will most likely benefit from treatment by inoculation.

CLASS I.

Containing those in which the bacterial focus is strictly localized and the disease is of a chronic nature.

1.—*Due to the Tubercule Bacillus* :—So-called surgical tuberculosis: Such as tuberculous dermatitis, certain cases of lupus, tuberculous glands, tuberculous epididymitis and orchitis, tuberculous cystitis, tuberculous peritonitis, tuberculous disease of bones and joints. Also tuberculous iritis, Bazin's disease, sinuses and fistula. Early pulmonary tuberculosis.

2.—*Due to Staphylococcus* :—Boils, acne, sycosis, felons, carbuncules and the majority of "sceptic" surgical processes, such as infected wounds, certain cases of chronic osteomyelitis, etc.

3.—*Due to Streptococcus* :—Certain cases of chronic osteomyelitis; infected wounds, chronic urethritis, certain cases of cystitis, certain chronic septic processes,—puerperal sepsis.

4.—*Due to Pneumococcus* :—Certain cases of cystitis, chronic empyemata, antrum disease, chronic septic processes.

5.—*Due to Gonococcus:*—Acute gonorrhea, chronic gonorrhea, gonorrheal rheumatism.

6.—*Due to Bacillus Coli:*—Infected wounds, chronic cystitis, persistently discharging gall-bladder and abdominal wounds, sinuses and fistulae, pyelitis, etc.

7.—*Due to True and Pseudo-Diphtheria Bacillus:*—Certain cases of meningitis, infected abdominal wounds, etc.

8.—*Due to Typhoid Bacillus:*—Prophylactic and chronic periostitis, etc.

9.—*Due to Micrococcus Neoformans:*—Certain cases of malignant disease.

CLASS II.

Containing those in which the bacterial focus is not strictly localized.

1.—Pulmonary tuberculosis, certain of the more serious septic processes such as follow upon infected fingers, etc.

CLASS III.

Containing the blood infections, septicemias and pyemias: Such as puerperal septic processes, ulcerative endocarditis and pyemias of any variety.

The resources of the department are also available for the diagnosis of medical and surgical cases, especially where tuberculosis of any sort is suspected.

In so far as time will permit, observations will be undertaken upon the coagulability of the blood, upon the contents of the blood in the salts of calcium, upon the alkalinity of the blood, upon renal sufficiency by the method of hemolysis and upon cardiac affections by means of MacKenzie's polygraph.

News Items.

T. W. GREER, M.D., Peterboro, becomes an associate coroner.

DR. W. F. LEWIS, M.P.P., Orangeville, Ont., died suddenly in Toronto, May 25th.

DR. YOUNG, a well-known physician of Vancouver, B.C., was drowned on May 23rd.

DURING the week ending May 25th, Montreal had 75 births more than the ordinary weekly average. The total was 240.

MR. A. MCGILL succeeds Mr. Thomas MacFarlane as chief Dominion Analyst at Ottawa, Mr. MacFarlane having been superanuated (now deceased).

DR. STEWART, son of S. Stewart, of Ruthven, and a graduate of Toronto Medical College, is practicing with Dr. J. W. Brien, Essex, Ont.

DR. AND MRS. GUNN, of Clinton, left recently for a two months' European trip which will include Paris and different parts of Great Britian.

DR. W. T. CONNELL, professor of bacteriology and pathology at Queen's Medical College, has been appointed pathologist to Rockwood Hospital.

DR. H. S. BINGHAM, of Cannington, has disposed of his practice to Dr. Brown, late of Coboconk. Dr. Bingham may join his son in British Columbia.

DR. JOHN F. SNELL has been appointed Assistant Professor of Chemistry in the new Macdonald College of Agriculture, at Ste. Anne de Bellevue, Que.

DR. W. J. GREENWOOD, who has been associated with Dr. Anderson for over a year, has returned to St. Catharines to practice with his uncle, Dr. F. S. Greenwood.

DR. J. L. TURNBULL, formerly of Clinton, is winding up his timber, lumber and saw mill business near Listowel, which will be two or three weeks, when he will leave for Calgary, where he goes into practice with another medical man.

DR. J. J. TEETZEL, of St. Thomas, who has been spending the past six months in the West Indies, is back, and will remain some weeks prior to leaving for the west, where he will spend the summer, with Mr. and Mrs. Harvey, at Fort Steele, B.C.

THE St. Catharines, Ontario, medical men have formed a medical society with Dr. Sutherland, President, and Dr. Armour, Secretary-Treasurer. All have agreed that after the expiration of present contracts there will be no more lodge practice.

DR. EDDIE BRYANS, formerly of Jamestown locality, Huron county, who has been residing in Winnipeg for some time is now practicing physician and surgeon for one division of the Grand Trunk Pacific Railway, with headquarters at Killaly, Sask.

BRIGHT'S disease caused the death on May 29th of Dr. William Claxton, of Verona, aged 60 years. He was born in Frontenac County, and graduated at Queen's University. He was prominent in political and municipal circles, and was a leading temperance advocate, vigorously supporting local option.

A MONTREAL physician has been fined $20.00 or one month imprisonment for failing to register within twenty-four hours the death of a child who had died from typhoid fever. The doctor claimed he had only visited the child once and did not know of its death, which took place on a Sunday, and that he was not in the habit of paying visits on Sundays. The Judge held, however, that it was his duty to have visited the child on Sunday.

THE first meeting of the Academy of Medicine, Toronto, took place Saturday evening, the 1st of June, when the following officers were elected; President, Dr. J. F. W. Ross; Vice-president, Dr. McPhedran; Hon. Secretary, Dr. H. J. Hamilton; Hon. Treasurer, Dr. D. J. G. Wishart; council, the just mentioned officers and Mr. I. H. Cameron, Dr. R. A. Reeve, Dr. H. A. Bruce, Dr. J. T. Fotheringham, Dr. A. A. Macdonald, Dr. H. P. Anderson, Dr. W. P. Caven, Dr. E. E. King, Dr. John Amyot, Dr. F. N. G. Starr, Dr. R. D. Rudolf, Dr. R. J. Dwyer. Chairman of the three sections of surgery, medicine and pathology have yet to be elected. These will be added to the council.

Publishers' Department

THAT NEW ANESTHETIC.—REPORTS FROM THE FIELD.

FAR SUPERIOR TO CHLOROFORM.—The Hyoscine-Morphine-Cactin Anesthetic (Abbott) has been entirely satisfactory. In obstetrics it is far superior to chloroform. No nausea, shock or disagreeable symptoms with the mother. The child is born cyanotic but comes round all right. Our county medical society has taken up the matter; all reports have been very favorable. I think it will have a national bearing in the increase of population, as women will cease to dread the pangs of child-bearing and will increase the number of children born. The nation will owe you a debt of gratitude.—J. S. Dickenson, Trenton, Ky.

TWENTY CASES SUCCESSFULLY.—I have used the Hyoscine-Morphine-Cactin Anesthetic (Abbott) successfully in twenty cases, full reports of which I have kept, as they were all hospital cases.—J. B. Wright, Trenton, Mo.

JUST THE THING IN MISCARRIAGE.—I find Abbott's hypnotic anesthetic just what I have wanted for sometime, and will keep a supply always on hand. In miscarriage, where the placenta must be removed under anesthesia, they are the very thing and relieve the operator of the worry of chloroform or ether. I believe them superior to the morphine and atropine hypodermic, as more lasting and certain in effect.—A. D. Barnett, Guilford, Mo.

NOT WILLING TO BE WITHOUT THEM.—I have not used the H.M.C. tablets in cases enough to make a satisfactory report. But I will say, from the success I have had with them, I would not be willing to be without them.—John Boice, Denver, Colo.

SAVED THE PATIENT'S LIFE.—The H.M.C. tablets have given me great satisfaction and my patients great comfort. In one case of gangrenous appendix, I feel they saved the patient's life, as the patient slept all night, with no vomiting or nausea and practically no shock. In an operation for cystocele and repair of perineum in a very nervous patient, no nausea followed, and the patient was perfectly comfortable at all times. The same results in amputating the cervix and curetting. The patients seem to have no fear of operation when they take this anesthetic. In my medical practice I find it a very useful combination and use it to advantage in some case nearly every day—Marcus A. Newell, Albany, N.Y.

EVERY PHYSICIAN KNOWS.—Every physician knows full well the advantages to be derived from the use of antikamnia in very many diseases, but a number of them are still lacking a knowledge of the fact that antikamnia in combination with various remedies, has a peculiarly happy effect; particularly is this the case when combined with salol. Salol is a most valuable remedy in many affections; and its usefulness seems to be enhanced by combining it with antikamnia. The rheumatoid conditions so often seen in various manifestations are wonderfully relieved by the use of this combination. After fevers, inflammations, etc., there frequently remain various painful and annoying conditions which may continue, namely: the severe headaches which occur after meningitis, a "stitch in the side" following pleurisy, the precordial pain of pericarditis, and the painful stiffness of the joints which remain after a rheumatic attack—all these conditions are relieved by this combination called "Antikamnia and Salol Tablets," containing 2½ grs. each of antikamnia and of salol, and the dose of which is one or two every two or three hours. They are also recommended highly in the treatment of cases of both acute and chronic cystitis. The pain and burning is relieved to a marked degree. Salol neutralizes the uric acid and clears up the urine. This remedy is a reliable one in the treatment of diarrhea, entero colitis, dysentery, etc. In dysentery, where there are bloody, slimy discharges, with tormina and tenesmus, a good dose of sulphate of magnesia, followed by two antikamnia and salol tablets every three hours will give results that are gratifying.

"SUMMER COMPLAINT."—During the summer months gastroenteric diseases, in which diarrhea is a prominent symptom, are very prevalent, and most fatal in infants and children. After correcting all hygienic and dietetic errrors, an imperative indication is to empty the small intestine and overcome the fermentation and decomposition going on in the alimentary tract. Phillips' Milk of Magnesia, in doses of a tea to a tablespoonful is a safe and a pleasant laxative for infants and children, and after clearing out the intestinal canal, small doses, five to fifteen drops in a teaspoonful of sterile cold water, every two or three hours, will act as an antacid and gastric sedative, controlling nausea and vomiting, and checking any further gastric or intestinal fermentation. It may be combined with opiates, carminatives, astringents, or antiseptics. The mouths of infants and children suffering from "Summer Complaint" need prompt and careful attention, and this can be successfully carried out by swabbing the buccal cavity with Phillips' Milk of Magnesia and wiping the gums with absorbent cotton or a piece of soft linen moistened with it.