

The Management of Rheumatic Heart Disease*

ADRIAN ANGLIN, M. D.

DURING the past few years there has been a gradual awakening of the medical profession to the urgency of the problem presented by rheumatic fever and its tragic sequelae. It is now recognized that, at least in the countries of temperate climate, it is the major cause of death between the ages of 5 and 20. It is surpassed in deadliness by tuberculosis only in the third decade. An American author has described it as the "major unsolved paediatric problem" and Sir John Parkinson, in the 1945 Harveian oration, aptly labels it "The most deadly enemy of youth."

In the clinical aspects of rheumatic fever there is little that is new. The understanding of disease, however, is founded on clinical understanding, and a review of the known facts and acceptable theories will be the basis of this brief paper.

Because, up to the present time, rheumatic fever has not been a universally notifiable disease, there can be no exact knowledge of its incidence. It is estimated that in Great Britain there are 300,000 persons whose lives are affected already or will be affected by the disease.

The first attack of rheumatic fever most commonly occurs between the ages of 4 and 15. Generally speaking, the younger the victim, the greater is the risk of serious cardiac damage. No immunity is conferred by any attack. On the contrary, it is characteristic and important to remember that recurrence or recrudescence of the acute process occurs in the majority of cases.

Concerning etiology, it has been the predominant opinion of most workers for some years that the prime responsible agent is the streptococcus *B. haemolyticus* alone or in association with a virus. This agent has been implicated largely by inference, from the close association of demonstrable streptococcal infection of the upper respiratory tract with the onset of rheumatic fever. Rather strong confirmation of this presumption has been obtained in the last few years as a result of the strikingly successful clinical experiments in the prevention of recurrent attacks of rheumatic fever by the use of sulfonamides.

Rheumatic fever is an infectious disease which may produce lesions in many organs, particularly in all the structures of the heart, in the blood vessels, serous membranes, lungs, skin, brain, joints and periarticular tissues. The characteristic lesion is the Aschoff body which is similar to the miliary nodule of tuberculosis. This produces a proliferative type of lesion and results in the heart in damage to the myocardium and thickening and deformity of the valves. The valve defects are first regurgitant and later stenotic. The valves of the left side of the heart, i.e., the mitral and aortic, are much more frequently involved than the tricuspid and pulmonary. The cardiac lesions overshadow in importance all other lesions in rheumatic fever, although certain extra cardiac phenomena must be recognized as of importance in certain cases. The peripheral blood vessels are widely involved, the lesion being a pan-arteritis. Involvement of the coronary vessels may produce signs of coronary insufficiency. The acute arthritic process which occurs in a proportion of cases is of value in making the diagnosis. Less commonly rheumatic subcutaneous nodules, similar in construction to Aschoff nodules, may make their appearance, and are characteristic of the disease. They are painless as a rule and are most com-

*Presented at the annual meeting of The Medical Society of Nova Scotia, Keltic Lodge, September 15, 1948.

monly found around the malleoli, the elbows, knees or vertebral spines. Involvement of the serous membranes results in an exudative type of lesion and may produce gross effusion. The lung may be grossly affected with the production of so called rheumatic pneumonia.

In the brain, rheumatic disease predominantly involves the basal ganglia and is manifested by the occurrence of Sydenhams chorea.

Discussion of the management of rheumatic heart disease must begin with, at least, a brief account of the treatment of acute rheumatic fever. In those patients with evident cardiac damage as a result of rheumatic fever, once the acute phase has subsided, the management of the condition can be considered under two heads:

(1) Rheumatic heart disease with full compensation.

(2) Rheumatic heart disease uncompensated. In each of these groups, again, the management can be considered in two divisions. (1) Regulation of the patient's life. (2) Treatment of complications.

Acute Rheumatic Fever

It need not be stressed here that rheumatic heart disease can occur, and does, in 20-30% of cases, without any antecedent history even remotely suggestive of acute rheumatic infection. In the remainder, the onset is variable. It may be insidious, with vague ill health over a period of days or weeks, often beginning with a sore throat. Tiredness and too ready fatigue may be the chief complaint. Pallor and loss of weight, or failure to gain weight, may occur. Pains in the joints, aggravated by movement may occur. It is now considered that muscular aches and pains not situated in the joints, so called "growing pains", are not manifestations of the rheumatic state. Between this insidious onset and the full blown acute attack all grades of severity may be observed and any combination of the known rheumatic phenomena may occur. It should perhaps be noted that chorea occurs very infrequently in association with joint manifestations and there may be no fever. Nonetheless, its appearance in children is definite evidence of the rheumatic state. It is probably true that the heart is less often involved where chorea is the chief manifestation, but it will by no means necessarily escape.

Briefly stated the general signs of rheumatic fever are these.

(1) *Pyrexia*—This is of varying degree, the height of the fever bearing fairly close relationship to the severity of the other general signs. Recrudescences of high fever usually suggest an increase in rheumatic activity in the joints or in the heart. Normal temperature does not necessarily indicate complete inactivity of the rheumatic process.

(2) *Arthritis*—This involves the larger joints one after the other with tenderness, heat, swelling and pain on movement. Occasionally only one joint will be involved.

(3) *Rheumatic Nodules*—When present, these are considered a most certain sign and it is said that, with them, carditis must be presumed.

(4) *Loss of weight*—is an important sign, in that evident gain in weight is an important sign of cessation of an active process.

(5) *Weakness*.

(6) *Blood Changes*—Anaemia.

W.B.C. 10-15,000

Increased sedimentation rate.

Repeated sedimentation rate estimations may be of considerable value in estimating activity, particularly in the presence of normal temperature.

Signs suggestive of Active Carditis.

- (1) *Tachycardia* 100-150—The pulse taken during sleep, because of removal of nervous factors may be a more reliable indication of the presence or absence of active carditis.
- (2) *Murmurs*—A systolic murmur at the apex may suggest the presence of active carditis, but is not diagnostic. A diastolic murmur at the apex may be present due to cardiac dilatation alone and does not necessarily indicate the presence of mitral stenosis.

The diagnosis of valve lesions should be left until the active process has subsided but if there is a persistent presystolic murmur at the apex or an aortic diastolic murmur heard to the left of the sternum, it is safe to conclude that mitral stenosis or aortic regurgitation has already occurred, not from the acute attack but from previous involvement.

- (3) *Pericarditis*—A friction rub, indicating the presence of pericarditis may be a very transient sign. For this reason frequent examination of the heart is important. When present, pericarditis is indicative of very serious myocardial damage. Pericardial effusion, if it occurs, is usually of small size.
- (4) *Cardiac Enlargement*—This usually occurs during prolonged carditis. If definite enlargement is observed with rapid regression, this may be due to pericardial effusion.
- (5) *Electrocardiographic Changes*—The most important single sign is prolongation of the P-R interval. This indicates involvement of the conducting system between the auricle and the ventricle producing a variable degree of "heart block."

Associated Clinical Features

- (1) *Tonsillitis*—Sore throat frequently precedes and sometimes accompanies the attack of rheumatic fever. It frequently ushers in recurrent attacks. Routine tonsillectomy as a preventive measure is not justifiable in the absence of evident chronic or recurrent tonsillitis.
- (2) *Skin Manifestations*—Erythemas of various kinds occur in association with rheumatic fever but are not per se of any importance. Erythema nodosum in children and adolescents is far more commonly tuberculous than rheumatic.

Chorea—This is a fairly common manifestation of rheumatic infection in children over 5 years of age. It consists in haphazard purposeless and uncontrollable movements of the face and limbs associated with exaggerated emotional response. Recurrences are common and the child who has had chorea is prone to later occurrence of arthritis and carditis.

Heart Failure—In the acute phase this usually occurs in those cases with pericarditis.

Differential Diagnosis

- (1) *Congenital Heart Disease*. Rheumatic heart disease is very uncommon in the first four years of life. Congenital heart disease is not accompanied by joint changes. Fever and acceleration of the sedimentation rate does not occur in the uncomplicated case. The differentiation may often be made by the situation and character of the murmurs.
- (2) *Osteomyelitis*: In osteomyelitis the lesion is epiphyseal rather than arthritic. It is rare to have more than one joint involved at a time. Leucocytis occurs, and evidence of pus formation. Distinctive x-ray changes occur.
- (3) *Septic Arthritis*—Except that, in this condition, involvement of the joint is evident, the features distinguishing it from rheumatic fever are as outlined for osteomyelitis.
- (4) *Rheumatoid Arthritis*:—Rheumatoid arthritis, unlike acute rheumatic fever, is most prevalent in the 30-40 age group. It almost invariably involves the small joints. It seldom has an acute onset and high fever is uncommon.
- (3) *Acute anterior poliomyelitis*:—This condition, in its early stages, may simulate rheumatic fever. The pain, however, is localized in the muscles rather than in the joints. Examination of the spinal fluid will establish the diagnosis.
- (4) *Subacute bacterial Endocarditis*—This disease does not select joints. It differs from rheumatic fever in the frequent occurrence of embolic phenomena, splenic enlargement, and the finding of organisms in the blood stream by culture.

The treatment of Acute Rheumatic Fever.

- (1) *Rest in Bed*—Complete bed rest should be instituted as soon as the presence of acute rheumatic fever is suspected and should be continued for four weeks after the disappearance of all signs of activity. The estimation of inactivity should not be based on any single sign but should depend on a return to normal of the pulse, temperature, sedimentation rate, haemoglobin level, leucocyte count and beginning gain in weight. If heart damage is evidently severe, bed rest may be wisely prolonged up to three months or more after all signs of activity have gone.
- (2) *Salicylates*—As soon as the diagnosis is definitely established, the administration of aspirin or sodium salicylate should begin. While maintenance of salicylate blood levels as high as 35 mgms. per cent has been advocated in recent years by some workers, certain more critical clinical observation would suggest that levels as low as 20 mgms. per cent are just as effective. Where salicylate estimation cannot be done, the rule suggested in the report of the Royal College of Physicians of England may well be followed, i.e., 9 grains per day for each

year of the child's age in 4 hourly doses. An equal amount of sodium bicarbonate or an equivalent amount of some other alkali such as citrocarbonate should be given to combat the acidosis produced by large doses of salicylate. When salicylates are not well tolerated, an enteric coated preparation may be valuable.

Salicylates have no specific effect on the carditis of rheumatic fever but are given simply to allay the pain and discomfort of the arthritis. In a diagnostic way salicylates are valuable. If there is no improvement in the arthritis within 48 hours of commencing treatment, the diagnosis should be re-considered.

Diet in the early days will usually necessarily be light since the patient will be reluctant to eat. As soon as possible, he should be provided with a good mixed diet in whatever quantity he may wish.

When there is sufficient evidence that all activity has ceased, and a sufficient period of rest had been obtained, gradual, but not slow, return to normal activity should be allowed. During this period a close watch should be kept for any evidence of recurrence of activity, particularly by observation of the pulse and temperature. These observations can easily be done by the parents or other members of the household. From this point onward the primary attention should be directed towards the prevention of relapses. Foci of infection should be dealt with. Chronically infected, but not healthy, tonsils should be removed. Diseased teeth should be extracted; when tonsillectomy or dental extraction is carried out, penicillin, in the amount of at least 300,000 units, should be administered in the 24 hours preceding operation, and for twenty-four hours following it. This is to combat the bacteremia which is undoubtedly a frequent accompaniment of such procedures.

It is at this stage, likewise, that consideration should be given to the use of one of the sulfonamide drugs, preferably sulfadiazine, over a period of years, to prevent further attacks and further damage to the myocardium. Much evidence has accumulated in favour of the procedure and it has been endorsed by the Surgeon General of the U. S. Army. In 1946, Rosenberger and Hinch, (*Med. Clinics of N. America*, 1946) reviewed the subject and came to the following conclusions:

- (1) Sulfonamide prophylaxis cannot be considered to be excessively risky.
- (2) The drug of choice is sulfadiazine in doses of .5 to 1 gram daily.
- (3) Although the exact value of sulfonamide prophylaxis for rheumatic fever appears to be still a matter for some debate, for the present the arguments in favour of this procedure appear to be much stronger than those so far advanced against it."

Very striking results have been obtained in the armed services in the U.S.A. With regard to rheumatic fever, Carter, Coburn and Hollbrook reported reductions paralleling those in the incidence of respiratory infections caused by the haemolytic streptococcus. Carter reported that, at a certain point, "the rate of admission for scarlet fever varied from 63.5 to 171.6 per 1,000 during the observation period before sulfadiazine. Following the institution of prophylaxis the rate fell to zero within 2 weeks." The incidence of tonsillitis fell from 426 per 1,000 to 46 per 1,000 and the incidence of rheumatic fever was "reduced from 87 per 1,000 to zero within 4 weeks."

Toxic reactions in these huge series were rare, fatalities nil.

Rosenberger and Hinch conclude this section of their review with the following words: "These reports should engage the early attention of institutional physicians in attendance, at schools, colleges and camps."

They state further, "When a truly potent, relatively inexpensive oral preparation of penicillin becomes available for wide use, the chemoprophylaxis of rheumatic fever by such a preparation can be expected to do much to reduce the incidence of acute rheumatic exacerbation by controlling the provocative hemolytic streptococcal infections."

When one is confronted with the individual with established rheumatic heart disease well compensated the problem is one in which ordinary common sense dictates the management. It resolves itself into three principle considerations and a number of lesser ones. The three principle considerations are:

- (1) Full and frank discussion with the patient of his condition.
- (2) Instructions regarding physical activity.
- (3) Diet and personal habits.

No patient should ever be simply told that he has a heart murmur, or heart trouble or heart disease and that he should "take it easy for awhile." His condition should be explained to him. He should be assured that, with some restrictions and some care, he may live a long and fairly normal life and that the matter very largely lies in his own hands.

If the patient is a child similar and even fuller discussions should be carried out with the parents. It is important to stress with them, however, and for obvious reasons, that after the imposition of reasonable restrictions, the child should be treated as much as possible like any other child and not be allowed to grow up with the feeling that he is essentially different from others.

Regarding physical activity it should be stressed that physical exercise is as important to cardiaes as it is to non-cardiaes. Instructions should be detailed and specific and must be based on a carefully obtained knowledge of the patient's established habits, occupation and personal preferences. Speaking generally, all competitive sports should be banned. Such recreations as walking, cycling, skating and golf are eminently suitable when reasonably carried out. The prime guiding rule of the life of the cardiac patient is that he should do nothing which produces shortness of breath, of any significant degree, nothing which produces marked fatigue, and nothing which produces cardiac pain.

Recreational physical exercise must be considered in association with the individual's occupation. Heavy manual labour, is, of course, unsuitable for any patient with an abnormal heart. Certain lighter forms of manual labour such as bricklaying and carpentry may be quite suitable. In these cases, however, it may be felt desirable to lay more emphasis on extra physical rest than on extra-occupational exercise.

In the child, similarly, competitive sports should be banned, because the stresses and strains involved in such sports are unpredictable and often uncontrollable. Supervised physical training and gymnastic exercises should not necessarily be ruled out, especially exercises for the correction of faulty posture, which may itself add unnecessary burden to the heart. Concerning these and other school functions, wherever it is feasible, discussion with the school

authorities should be of invaluable assistance. The child with rheumatic heart disease, however well compensated, must always be assured of adequate rest. Early to bed must be a strict and constant rule. A half hour rest on returning from school, is an important adjunct to this program and an hour of rest after the mid-day meal at weekends should be insisted on.

William G. Leaman, in his book, "The Management of the Cardiac Patient," heads the chapter on diet in heart disease with this quotation from Benjamin Franklin—"I saw a few die of hunger; of eating a hundred thousand."

The objective of dietary regulation in chronic heart disease (as it should be in every person) is the maintenance of good nutrition with the avoidance of overweight. To accomplish this the total caloric intake must be regulated according to the patient's daily physical activity, e.g., a man doing normal light physical work requires 3,000 calories. A woman 2,500 calories. Proteins should be moderately restricted, i.e., to not more than 50 grams daily, carbohydrates may be taken freely and fats reduced to the minimum compatible with palatability.

All patients with cardiac disease should be warned against smoking and advised to give it up if possible. Sir Thomas Lewis says, "We may not know definitely that long continued smoking is injurious to the blood vessels, but we have reason strongly to suspect it."

The use of alcohol by the cardiac patient need not necessarily be discouraged providing it is used moderately in the right amount, at the right time and in the right place. Alcohol, in fact, may be a useful medicine in that it encourages relaxation and promotes appetite.

The treatment of the patient with chronic rheumatic heart disease, uncompensated, is the treatment of any heart disease, with failure. The objective of treatment is the restoration and maintenance, for as long as possible, of adequate cardiac function by means of bed rest, dietary regulation, diuretics and digitalis.

The recognition and treatment of complications constitutes an important part of the management of rheumatic heart disease. The most important complications are these:—

(1) *Cardiac Arrhythmias*—The most important and by far the commonest of these is auricular fibrillation.

(2) Susperadded infections.

1. Acute Endocarditis

2. Subacute Bacterial Endocarditis.

(3) Haemoptysis

Auricular Fibrillation

Auricular fibrillation may be paroxysmal or chronic. Paroxysmal fibrillation occurs in attacks lasting a few hours or a few days, rarely longer than 10 days. This type of fibrillation is usually due to rheumatic disease. It may occur in hyperthyroidism. Occasionally no underlying abnormality may ever be discovered. It may occur during a variety of acute infections, particularly in elderly patients. In paroxysmal fibrillation, digitalis should be avoided since it tends to prolong the attack. Quinidine is the drug of choice. A preliminary test dose of 3 grams should be given to rule out the abnormal

reactors. If no untoward symptoms occur it should be administered in a dose of 6 grams 6 times daily. This dose may be gradually increased to double this amount if normal rhythm does not occur. Quinidine should not be given in this dosage for more than 3 weeks. In recurrent paroxysmal fibrillation, quinidine may be administered indefinitely as a preventive. In this case a dose of 3 to 5 grams each morning and evening is recommended.

Quinidine should never be used in the aged, in the presence of venous engorgement or other signs of failure or with gross cardiac enlargement.

In chronic auricular fibrillation, digitalis is, of course, the standard remedy, and should be used whenever the heart rate is higher than 80 per minute. Patients under digitalis treatment for the first time should be in bed. The usual routine we have used is 9 grains of the powdered leaf (digifoline) on the first and second days. Subsequent dosage is based on the heart rate. A rate of 70 is arbitrarily chosen as the target. It has been our experience that with rates below 60 patients with fibrillation are apt to feel very miserable indeed. Signs of digitalis intoxication, i.e., nausea, vomiting and diarrhoea are rarely encountered before satisfactory slowing of the heart rate has occurred. For very rapid digitalization in urgent cases of severe failure, digoxin intravenously is an effective and relatively safe drug. It is given in dosage of .5 mgm, which may be repeated in 6 hours and after which the digitalis leaf may be used for continuation of therapy.

Haemoptysis

There is no specific treatment for haemoptysis occurring as a complication of mitral stenosis. Strict bed rest, adequate sedation and digitalis, if fibrillation or failure are present, are the only important steps.

It is important, however, to remember that mitral stenosis is one of the common causes of haemoptyses even of gross degree. In one case, in fact, who came under my observation, massive haemoptysis was the first indication to the patient that he suffered any heart disease. His death occurred as a result of repeated massive haemorrhages.

Acute Bacterial Endocarditis

This usually fatal condition occurs as a result of an acute septicaemia originating in an extra-cardiac focus and produced by a variety of organisms, most commonly, the streptococcus haemolyticus, staphylococcus, pneumococcus, gonococcus meningococcus, H. influenza, etcetera. Valves previously damaged by rheumatic fever are particularly susceptible. The treatment is massive doses of penicillin, i.e., 800,000 or more units daily, except in the case of acute endocarditis caused by the H. influenza in which it might be anticipated that streptomycin would be an effective agent.

Subacute Bacterial Endocarditis

It is a febrile disease occurring in a patient with rheumatic heart disease or congenital heart disease in 95% of cases. It is caused by the streptococcus viridans. The disease is characterized by continued fever, leucocytosis, anaemia, multiple and changing heart murmurs and embolic and haemorrhagic phenomena such as splenomegaly, hematuria, purpuric spots, subconjunctival and retinal haemorrhages, splinter haemorrhages under the nails and Osler's nodes, the latter being tender spots on the balls of the fingers and toes.

Embolism in the intestine may produce diarrhoea, in the brain and spinal cord may produce paralysis. Clubbing of the fingers may occur. The diagnosis is definitely established by culturing a green growing streptococcus from the blood. It may be necessary to culture many specimens before obtaining a positive one. The H. influenza is a rare cause of S. A. B.

In those cases produced by the streptococcus viridans, the only effective treatment is penicillin, in massive doses, i.e. 800,000 units per day or more over long periods of time. No shorter period than 21 days should be considered on adequate trial. Even with this treatment the prognosis, although no longer hopeless, is not good. As in acute bacterial endocarditis, if the H. influenza is identified as the causative agent, then streptomycin is worthy of a trial.

In conclusion I would like to say, with regret, that I have been unable to include in this paper a discussion of certain important special problems in rheumatic heart disease, as, for instance, the problem of rheumatic heart disease and pregnancy. That could easily constitute a much longer paper than this by itself.

In the preparation of this paper I have, in certain sections, borrowed rather freely from the report of the Committee of the Royal College of Physicians of England, published in the *Lancet* in May, 1947. I recommend this to anyone who wishes a good working account of the problem of rheumatic fever.

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Letters To The Editors

DOCTOR MACPHERSON'S MODESTY

Dear Sirs:

Amid the compliments which I am told you have received on the March number of the Bulletin may I be permitted to present a word of slightly different note in the interest of truth and justice?

The writer of your feature article, Doctor Cluny Macpherson of St. John's, Newfoundland, omitted an important detail in connection with the discovery of the gas-helmet in the first Great War. In justice to his country he showed that the invention was that of an officer of the Newfoundland Regiment, and there he stopped.

Some of the details of that event I had remembered, and I have now been reminded of others in a personal communication just received from Doctor N. S. Fraser, one of Newfoundland's most highly respected senior physicians.

The officer referred to by Doctor Macpherson was Doctor Macpherson himself, and the basic idea for the gas-helmet was a style of cap favored by Newfoundlanders who found necessity for protecting their faces from the "biting blast."

Doctor Fraser reminds me that Doctor Macpherson was given charge of the development of this first mask and that for his work he was given the C.M.G. This, with becoming modesty, Doctor Macpherson had omitted.

And now that truth and justice have been served, I should like to add, that I trust none of your readers will get the idea that because I have here mentioned a couple of Scottish names, Newfoundland is another Scottish province. Heaven forefend! I shall, however, have to stop there, for if I were to continue, I should have to admit that in the current, as well as in the earlier, medical history of the country, Scottish names stand out in very clear distinction.

NORMAN H. GOSSE, M. D.

Dear Editor:

In reading the March number of the Nova Scotia Medical Bulletin I was interested in the article "Medical History in Newfoundland" by my old friend Doctor Cluny Macpherson of St. John's.

One short reference to Doctor Herbert Smith of Burin especially attracted my attention, bringing back memories of other days and events when following my graduation I went to Burin as locum tenens for Doctor Smith.

He had been out of Burin but once in the preceding thirty-five years when he was called to St. John's to perform a Caesarean Section—but ere he arrived the patient died so he returned home immediately.

Doctor Smith had lost two fingers from one hand and one from the other hand; also had a Dupuytren's contracture in both hands. The latter disability he wished to have treated and needed a locum ere he could leave and consult Doctor John Stewart of Halifax.

My duties involved the charge of the very extensive practice of an unusually brilliant and able medical man, one who not only knew his medical lore—for he kept up his medical reading from current journals, but was steeped in the Humanities, reading Greek and Latin as readily as English. He came honestly by

it, as he had been nurtured in such an atmosphere. His brother who was Professor of Classics at Mt. Allison University was considered the foremost Latin scholar of his time on this continent. We corresponded for some years after my departure, and his letters were replete with classical quotations and references, many of which I regretfully admit were beyond my ken.

Up till 1901, he had never seen a preparation for an abdominal operation—nor had he seen an operation except from such a distance as an undergraduate student of his day would observe one. The course then was of two years duration, and very few abdominal operations were performed. None the less he had not let this act as a deterrent to performing many operations himself. He had done many amputations, and those I saw had remarkably good stumps. Some twenty odd cases of hernia, the scars of which on examination, were either hard to discover or in excellent condition. One had been a large strangulated hernia with a perfect result after many years. Having a locum fresh from hospital seemed to him a suitable opportunity to have a demonstration in modern technique of abdominal preparation and so an operation (removal of an ovarian cyst about the size of a grape-fruit) was to be performed by yours truly. You can imagine my amazement and consternation, having had no actual training or experience in such work and being fully conscious of my deficiencies; but he insisted, stating he would assist and assume all responsibility. The operation was performed—the diagnosis correct and convalescence uneventful.

Next day I administered chloroform to an old lady whilst he removed a cataract from one of her eyes. He gave me the necessary instructions for treatment and left for four months. Providence was good, is all I have to say, as both cases turned out favourably.

This introduction to the main objective of this letter has been rather long—but was necessary to introduce Doctor Smith—who, to my mind, was one of the most remarkable men it has been my privilege to know. His income was mainly derived from fish in payment for professional services and medicine. For the collection of these quintals of fish he employed a man by the name of Joe Cesar, who asked "How many in family?"—then so many quintals,

Joe married a young woman who had a Kypho-scoliotic-rickety pelvis and was very badly deformed. She became pregnant, how? only God knows—but she did and the end result was for Doctor Smith to empty that uterus piece-meal. In spite of warning, a second pregnancy occurred with a similar ending. Then a third time when Doctor Smith thought it time to stop this once and for all—so he said to the woman, "Sis, this has got to stop; it must not occur again and when you come to term I'm going to open your belly and take the baby that way."

He made plans and in due course with the aid of his "team"—the Custom House officer to administer chloroform, and the blacksmith to assist, he proceeded to do a Caesarean Section. The operation took four hours, and he not only delivered a healthy living female infant, but proceeded to do a "Porro" as had been first done and reported by Porro in 1876, though he actually followed the improved procedure as described by Sanger in 1882. The operation was most successful from every standpoint—the mother made a complete and uneventful recovery. This operation was in 1892, and in honour of the occasion he had the girl christened "Julia Porro Cesar," though he hesitated leaving out the Sanger, but the former was more euphonious. He could not resist the temptation of the name though he well knew that Julius Caesar had not been delivered by the abdominal route.

Minutes of Meetings of the Executive of The Medical Society of Nova Scotia, 1949

A SPECIAL meeting of the Executive of The Medical Society of Nova Scotia was held at the Dalhousie Public Health Clinic, Halifax, N. S., on Monday May 16, 1949, at 2.35 p.m., for the purpose of considering a request from the Provincial Government that The Medical Society of Nova Scotia provide medical care for the pensioners in Nova Scotia.

Doctor H. A. Fraser of Bridgewater presided. The following representatives of the Executive and members of Council of the Canadian Medical Association attended: Doctors H. G. Grant, R. O. Jones, P. S. Cochrane, S. Marcus, W. A. Hewat, John R. Macneil, F. J. Barton, J. R. Ryan, H. B. Havey, W. J. MacDonald, G. A. Dunn, A. E. Blackett, H. D. O'Brien, V. O. Mader, J. F. L. Woodbury, J. S. Brean, P. E. Belliveau, J. G. B. Lynch, J. S. Robertson, R. A. MacLellan, Margaret E. B. Gosse, A. L. Murphy, N. H. Gosse, R. A. Moreash, Eric W. Macdonald, H. W. Schwartz, E. I. Glenister and S. R. Johnston.

President H. A. Fraser stated that the special meeting had been called to discuss prepaid medical care for old age pensioners, widows and the blind. He stated that The Medical Society of Nova Scotia had been requested by the Provincial Government to take on the care of this group of about 26,000 people. The Government will turn over a certain amount of money per capita, and the Society provide limited medical care. A meeting had been held that morning at the Minister of Health's office, at which were present Mr. F. R. MacKinnon, and Mr. H. S. Farquhar of the Department of Welfare, Doctor J. S. Robertson, Assistant Deputy Minister of Health, Doctor H. A. Fraser, President of The Medical Society of Nova Scotia, Doctor N. H. Gosse and Doctor H. G. Grant. Hon. L. D. Currie, Minister of Health, was unable to be present. The Provincial Government had suggested a figure of 75c per month per person. First we have to decide whether the Society wants to handle it, and if so work out a scheme. Doctor Eric Macdonald asked whether the figure of 26,000 could be broken down.

The following letter was then read:

P. O. Box 696,
Halifax, N. S.
May 11, 1949.

Dr. H. G. Grant,
Secretary, Nova Scotia Medical Society,
Halifax, N. S.

Dear Dr. Grant:

I am advised by your office that the statement I sent to you early in March has been mislaid. I am now enclosing a copy of the last annual report of the Old Age Pensions Board, and would draw your attention to the information on Page 7 as to the number of pensioners at November 30, 1949, and their location by Counties. The total number of pensioners has increased since November 30th to 19,414 on April 30th, made up of 18,536 Old Age and 878 Blind Pensioners.

The number of mothers in receipt of Mothers' Allowance at the present time is 1,747. To that number must be added approximately 4,900 children under sixteen years of age, and 775 disabled husbands, making a total of 7,422 individuals.

To sum up, the total number of potential beneficiaries under the proposed medical scheme as at April 30, 1949, would be 26,837.

Yours faithfully,

(Sgd.) H. S. Farquhar,
Director of Old Age Pensions.

Doctor N. H. Gosse advised that Ontario in 1935 had provided medical care for those on relief, and at first gave the profession 25c per head per month; later they received 56c from the Government, and last May they were given 83c, which would very nearly pay the doctors' bills. The suggestion has been made by representatives of the Government that this Society accept 75c; the Ontario scheme included drugs; the Nova Scotia scheme is only medical service. This morning it was shown that the very limited drugs of the Ontario scheme cost about 6c per capita, this subtracted from the 83c would leave 77c. It would cost more per capita to operate the scheme here than it does in Ontario because of the smaller total sum involved. He thought the Society would have to consider whether or not they would accept it in principle; and that beside the question of drugs the Society would also have to consider something additional for the cost of administration. Doctor Lynch thought that if Ontario had started off with 25c, eventually landing at 83c, that 75c in Nova Scotia would be very good.

Doctor N. H. Gosse stated that his understanding was that the suggestion of 75c had come from the Government, and that it was on the basis of our scale of fees being lower than Ontario's, which actually is not true. If their suggestion is payment at the Ontario rate then that is 77c.

Doctor H. A. Fraser asked whether the Maritime Medical Care Incorporated could handle it.

Doctor N. H. Gosse advised that the Maritime Medical Care Incorporated could well handle it, but had no experience yet in the matter of administrative costs. It has been shown that the cost of operating these schemes is from nine to eighteen per cent across Canada. When we discussed "Blue Cross" operation of our scheme 12 per cent was mentioned. Some of the schemes are operating around nine or ten per cent.

Doctor Eric Macdonald asked what the cost of administration in Ontario was. Doctor H. G. Grant advised that the cost of administration was 38%. He thought that with the Maritime Medical Care Incorporated set up it would cost them about 10% to administer this plan.

Doctor Eric Macdonald thought that with Maritime Medical Care Incorporated having an organization now it should cost less to operate.

Doctor N. H. Gosse did not see how it would make very much difference as extra help would have to be put in to take care of it.

The following summary of medical care for pensioners was then given by Doctor H. G. Grant.

Alberta: In 1948 the College received \$10.00 per year per person. No restriction as to service. The doctors collected 56% of their accounts. In the second year the grant was increased to \$12.50. The doctors will collect about 60%. Administration consisted in one book-keeper and three clerks. There are 24,000 eligible for service. The doctor renders his account monthly. He is immediately paid 50% and the balance at the end of the year. Hospitalization paid by the Department of Health. The doctors only supply the usual drugs at the office or house—other drugs, adhesive, etc., are charged to the pensioner. Surgery is included.

Saskatchewan: Began in 1945—at the rate of \$9.50. The new agreement 1949-50 has a rate of \$12.00, not including administration charges. Drugs, bandages, adhesive, etc. are not included. The accounts are all arranged by a department of government (administration). A committee of the College (The Central Medical Assessment Board) is paid by the government to administer.

Ontario: Began in 1935—with the agreement to provide home and office care to people receiving relief from the municipalities. In 1942 pensioners, blind pensioners, and mothers allowance cases were added. In the beginning the drugs, etc. were supplied through the Ontario Retail Druggists Association, but this was discontinued on account of cost. The Ontario Medical Association now provides drugs from an agreed list.

At first the Ontario Medical Association received 25c per month per beneficiary. In 1947-48 this was increased to 57c, in 1948 was further increased to 83c. Before 1948 the average payment was from 50% to 60%. The last payment was 95%. Drugs are included in the 83c per individual per month (from the list in the agreement). The administration costs in Ontario are 3.8%.

British Columbia: Scheme going into effect 1949. Cost of \$14.50 per individual per year including administration. Administered under a Board of Trustees. Drugs are provided by an agreement between Government and the Pharmaceutical Association.

Doctor Grant said that we would have to decide whether The Medical Society of Nova Scotia would provide limited medical care, then to decide what we think should be paid for providing this service.

President H. A. Fraser advised that the bulk of the pensioners lived in the rural areas; the City of Halifax has 1,200, and the County 2,600.

It was moved by Doctor J. G. B. Lynch and seconded by Doctor P. S. Cochrane that the Executive agree with this scheme in principle.

Doctor W. A. Hewat asked how the principle would be enforced; if a group of men were taken within a given radius for a group of pensioners living fifteen miles away, how would you see that these pensioners got the care they required.

Dr. J. S. Robertson stated that mileage would be paid to the nearest doctor.

Doctor W. A. Hewat asked how the doctors would carry out their agreement with the Government.

Doctor H. A. Fraser stated that the Government had announced that they would do it.

Doctor N. H. Gosse stated that the Government has asked that we give these people medical care, and he thought that principle should be settled.

Doctor A. E. Blackett asked whether there was an element of supervision over the administration being carried out by The Medical Society.

President H. A. Fraser stated that there would not be any supervision.

Doctor J. S. Robertson: "This thing is from the Department of Welfare not from the Department of Health. A list is made out of all the people who are eligible and that list is given to The Medical Society of Nova Scotia and they assume responsibility."

Doctor J. R. Ryan stated that at Springhill, a mining town, they received about fifty cents, or a little less, per capita per month, and that in his opinion seventy-five cents was rather a generous offer.

Doctor H. W. Schwartz asked what the principle included.

President H. A. Fraser advised that it included old age pensioners, about 18,000, widows and their dependents and their children, six or seven hundred blind, and mothers' allowances.

The motion that the plan be approved in principle was carried.

The next matter to be decided was the financial end of it.

Doctor Eric Macdonald: "We have an organization now that is set up to administer medical care. I would suggest that we make the best possible bargain with the Maritime Medical Care Incorporated to administer this pension scheme. I would say to Doctor Gosse that the cost of administration of "Blue Cross" includes cost of selling insurance and travel expenses, that in the administration of this fund these would not be a feature."

Doctor N. H. Gosse stated that the Provincial Government had reckoned upon the figures of Ontario, 83c, 6c taken off for drugs, bringing it down to 77c, and as they considered our scale of fees lower than Ontario, it was made 75c. If The Medical Society of Nova Scotia were able to have a staff working as the Ontario Medical staff they could use that staff to reduce operation costs, but as we have not he submitted that the cost of administration will be higher in Nova Scotia, and that there should be some extra cost for administration. Therefore he thought that our figure should be somewhere in the vicinity of 80c.

To Doctor H. W. Schwartz's question, "How much do the doctors in Ontario get?" the answer was 95%.

Doctor V. O. Mader asked if there were any suggestions made as to what time this scheme would begin.

President H. A. Fraser advised that they wanted it in effect as soon as possible.

Doctor P. S. Cochrane: "I do not see why this could not be taken on by the Maritime Medical Care Incorporated. It would mean approximately \$13,000 a year. It would mean accounts coming in from 400 doctors. I think they could operate on a 5% basis: it would be about \$13,000."

Doctor J. S. Robertson: "Would you set up an assessment committee? Would they have to be reimbursed?"

Doctor H. G. Grant: "I think there are a few things to be thought of. There would have to be a central assessment committee. There would have to be local referees. I would think the central assessment committee would have to meet once a month to assess the bills; they would have to have their expenses paid."

Doctor J. S. Robertson: "In Ontario they had regional assessors at first but now they have one central assessment committee which is working out better than ever."

Doctor Eric Macdonald: "The assessment committee could be made up from doctors all over the province."

Doctor J. G. B. Lynch asked if the matter could be talked over with the Maritime Medical Care Incorporated.

Doctor N. H. Gosse stated that they had had a meeting yesterday and had talked it over.

Doctor J. G. B. Lynch moved that the Chairman appoint a committee to study this scheme and also to talk it over with the Maritime Medical Care Incorporated.

Doctor A. E. Blackett said that the Maritime Medical Care Incorporated was the only legal body to handle it.

Doctor H. G. Grant moved that the matter be continued by the Executive rather than left to a committee at this stage of the discussion. This was seconded by Doctor V. O. Mader.

Doctor Eric Macdonald asked whether this matter could be settled now, whether this fund is going to be turned over to the Maritime Medical Care Incorporated or not, and if so, arrange details as to how the money would be expended.

Doctor A. E. Blackett: "It would be very desirable when the annual meeting comes up if a complete scheme were laid before them."

Doctor J. G. B. Lynch: "To finalize things I would move that the committee to be appointed by the chairman be given power to go ahead and finalize things with the Maritime Medical Care Incorporated and report back to this Executive."

There followed considerable discussion on the matter of procedure, during which it was shown that it would require the adoption of a formal resolution by the Society to make an agreement with the Government to cover this matter; that the Government in the circumstances should deal only with the Society, and that it in turn could properly use its own body, Maritime Medical Care Incorporated to administer the plan, and that legally Maritime Medical Care Incorporated is qualified to do so since "to assist the Government in extension of its health services" is written into its letters of incorporation as one of its purposes.

Doctor H. G. Grant, with permission of Doctor V. O. Mader, withdrew his motion, and Doctor J. G. B. Lynch's motion was re-stated: That the Chairman appoint a committee of four or five to meet representatives from Maritime Medical Care Incorporated, and to go into the whole matter and report to a special meeting of The Medical Society of Nova Scotia within two or three weeks, if the Committee can report in that time. This was duly seconded and carried.

Meeting adjourned at 3.50 p.m.

A meeting of the Executive of The Medical Society of Nova Scotia was called to order at 4.00 p.m. by President H. A. Fraser.

The following letter was read by the Secretary.

City of Sydney Hospital
May 9th, 1949.

Dr. H. G. Grant,
Secretary, Nova Scotia Medical Association,
Dalhousie Public Health Centre,
Halifax, N. S.

Dear Dr. Grant:

With reference to your letter of May 2nd concerning the status of our recently formed Radiological Association, I herewith make application for formal acknowledgment as a Branch of the Nova Scotia Medical Association.

The Nova Scotia Association of Radiologists was formed at a meeting of Provincial Radiologists on October 12th, 1947, during the session Annual Meeting Nova Scotia Medical Society. A request for articles of incorporation was made through the Provincial Legislature at their session in 1948 and this was granted, making our Association duly incorporated in Nova Scotia.

Would you be good enough to bring this matter before the Executive of The Medical Society of Nova Scotia at an early date in order that we may be formally acknowledged as a Branch of the above named Society.

We wish to also advise you that our Vice-President, Dr. D. R. Johnstone has been named to the Executive and he will act as our representative at the next Executive meeting.

Yours very sincerely,

(Sgd.) H. R. Corbett, M. D.,
Secretary-Treasurer.

It was moved by Doctor S. R. Johnstone that this application be received which was seconded by Doctor P. S. Cochrane, and carried.

After showing of the two new drawings submitted by Henry Birks and Sons Limited for emblems for doctors' cars it was moved by Doctor R. O. Jones, seconded and carried, that the Society purchase 200 emblems like sample "A".

Doctor H. G. Grant then read the following resolution:

At a special meeting of the Colchester-East Hants Medical Society held on December 2, 1948, the following resolution was unanimously passed.

"Resolved that appointments to the House of Delegates of the Maritime Medical Care Incorporated be made by the various Branch Societies of The Medical Society of Nova Scotia, according to their membership and not from the floor of an open meeting of The Medical Society of Nova Scotia, or by the executive of The Medical Society of Nova Scotia."

((Sgd.) D. S. McCurdy,
Secretary-Treasurer.

Doctor N. H. Gosse asked to speak to this stated that it was written into the Constitution of Maritime Medical Care Incorporated that the House of Delegates be named by the Executive of The Medical Society of Nova Scotia, and that had been duly adopted by the medical profession of Nova Scotia. As to whether or not The Medical Society of Nova Scotia would consider re-

commending a revision he did not know. Maritime Medical Care Incorporated is a product of The Medical Society of Nova Scotia, and not of its branches, but representation of branches is effected through the Executive and nominations to the House of Delegates are made by such representatives who may be instructed by their branches. The President stated that it was difficult to see how we could take any action at this time. Agreed.

President H. A. Fraser stated in drawing up a programme for the annual meeting no local papers had been included, and asked if that would be subject to the approval of the Executive.

Doctor Eric Macdonald: "After all this is our Society. While I recognize that multiplicity of papers is a great error, I think we would make a mistake not to ask our own people to give papers. I think we should encourage the younger members of our Society to prepare and deliver papers. It is much more important than bringing down men from medical centres. I would strongly advise that we do not over-load our meeting with scientific papers, no matter what calibre they are."

President H. A. Fraser then asked the opinion of the Executive on having the first business session on Tuesday evening.

Doctor J. G. B. Lynch moved that the first business session be held on Tuesday evening.

Several letters were next read from Doctors Fraser, Mader and Gosse regarding the fact that the Cancer Committee of The Medical Society of Nova Scotia had not been included in the Advisory Committee on Cancer to the Government and after some discussion it was moved by Doctor N. H. Gosse that this Executive confirm the position of the Cancer Committee of The Medical Society of Nova Scotia, and that it request the Advisory Committee on Cancer to advise and consult on matters affecting the Advisory Committee to the Government. This was seconded by Doctor J. G. B. Lynch and carried.

Doctor J. G. B. Lynch stated that as the Halifax meeting is to take place in 1950 he would like to have a progress report so that he could present it to the Executive Committee of the Canadian Medical Association in June. He also mentioned the fact that there was some talk of having a combined meeting of the Canadian Medical Association, the British Medical Association and the American Medical Association in Canada. He also stated that the Newfoundland Medical Association would join the Canadian Medical Association meeting in 1950.

Doctor R. O. Jones stated that the Society had some bonds which are held by the Cogswell Fund, and advised that two of the bonds had matured, and that we are now in the position of requiring two more bonds. The bonds were Sisters of Charity Hospital Bonds. It was moved by Doctor P. S. Cochrane that the Treasurer reinvest the money in trust funds. This was seconded by Doctor J. G. B. Lynch and carried.

The meeting adjourned at 5.05 p.m.

Society Meetings

PICTOU COUNTY MEDICAL SOCIETY

A MEETING of the Pictou County Medical Society was held on April 8th, 1949, at the Nurses' Residence, Aberdeen Hospital, New Glasgow. Those present were—Doctors J. C. Ballem, R. M. Benvie, A. E. Blackett, J. B. MacDonald, F. J. Granville, C. G. Harries, H. F. MacKay, I. E. Mackay, T. W. MacLean, V. H. T. Parker, L. M. Sproull, C. E. Stuart, H. J. Townsend, H. B. Whitman, W. A. MacQuarrie, G. F. Day, G. R. Douglas, S. D. Dunn, G. A. Dunn, J. A. F. Young, C. B. Smith, A. M. Arbuckle and D. S. Clark.

The minutes of the last meeting were read and approved.

As there was a deficit in the treasury of Thirty Dollars (\$30.00) with several outstanding bills owing, it was moved by Doctor Ballem and seconded by Doctor Benvie that the annual dues be raised from Two Dollars (\$2.00) to Three Dollars (\$3.00).

There was a general discussion of the Maritime Prepaid Medical Plan. The discussion was prefaced by a few explanatory remarks from Doctor Blackett and in answer to a request from Doctor N. H. Gosse in the Nova Scotia Medical Bulletin of March 1949, the following resolution was proposed by Doctor Blackett:

"We re-endorse our adherence to the principles regarding Health Insurance as printed on pages 78 and 79 of the March issue of the Nova Scotia Medical Bulletin and further noting that the Nova Scotia Government is preparing to provide medical treatment of certain groups, (viz. old age pensioners, the blind, and others) we urge that The Medical Society of Nova Scotia, through the appropriate committee, request the government to institute this treatment through The Medical Society as is done in British Columbia." The reference to the British Columbia plan is explained in the Bulletin of the Vancouver Medical Association, February 1949.

The election of officers for the coming year was as follows:

President, Doctor H. B. Whitman, Westville.

Vice-President, Doctor C. B. Smith, Pictou.

Secretary-Treasurer, Doctor S. D. Dunn, Pictou.

Representatives to The Medical Society of Nova Scotia, Doctor A. E. Blackett, New Glasgow, Doctor G. A. Dunn, Pictou.

Doctor J. Arnold Noble of Halifax then gave an interesting and informative address on "Painful Conditions of the Shoulder Joint," illustrating his talk with lantern slides and finishing up with a motion picture showing the actual surgery as performed.

Doctor D. S. Clark of River John was admitted as a new member of the Society.

The meeting then adjourned to the sitting room of the Nurses' Residence, where a delightful lunch was served.

STUART D. DUNN, Secretary

CAPE BRETON MEDICAL SOCIETY

The Annual Meeting of the Cape Breton Medical Society was held in the Royal Cape Breton Yacht Club on May 12th.

Doctor B. F. Miller of Halifax was the guest speaker, taking as his subject "The Value of Manipulation in Orthopaedic Practice."

The following officers were elected for 1949-50:

President, Doctor A. C. Guthro, Little Bras d'Or Bridge

Vice-President, Doctor C. P. Miller, New Waterford

Secretary-Treasurer, Doctor H. R. Corbett, Sydney.

Representatives to the Executive of The Medical Society of Nova Scotia,
 Doctor H. J. Martin, Sydney Mines, Doctor John R. Macneil, Glace Bay, Doctor M. J. Macaulay, Sydney, Doctor H. J. Davidson, North Sydney.

Representatives to the Executive of the Cape Breton Medical Society,
 Doctor Gordon C. Macdonald, Sydney, Doctor H. J. Devereux, Sydney, Doctor Joseph A. MacDonald, Glace Bay.

H. R. CORBETT, Secretary-Treasurer.

The Nova Scotia Society of Ophthalmology and Otolaryngology

A spring meeting of the Nova Scotia Society of Ophthalmology and Otolaryngology was held at Halifax, Nova Scotia on Wednesday, May eleventh with Dr. B. E. Goodwin of Amherst, the President, in the chair.

There was an excellent attendance of our active members and we were pleased to have with us and to welcome to our meeting two of the honorary members, Dr. L. DeV. Chipman of Wolfville and Dr. A. E. Doull, Sr. of Halifax, also as guests four members from the New Brunswick Society of Specialists, three from Moncton and one from Saint John.

The programme consisted of a two hour clinical presentation of cases at the Victoria General Hospital. Cases were shown by Dr. H. W. Schwartz, Dr. A. E. Doull, Jr, Dr. E. I. Glenister, Dr. L. G. Holland, Dr. D. M. MacRae and Dr. R. H. Stoddard.

A short business session was held following the clinical meeting and the feeling of the members was that a joint meeting with the New Brunswick Specialists Society should be arranged at a time and place to be decided by the executives of the two societies.

Luncheon was served at the Lord Nelson Hotel and the afternoon session was held in the Auditorium of the Victoria General Hospital where the following papers were presented.

Dr. J. Land, Glace Bay presented a paper on "Modern Cataract Extraction." The paper discussed fully the pre-operative care, the best techniques and the post-operative care in the light of modern teaching at the larger centres. There was considerable discussion by various members.

Dr. J. P. McGrath, of Kentville presented a paper "Pathology of the Fundus Oculi." The paper was accompanied by slides illustrating the following conditions—Embolism of the Central Retinal Artery—Thrombosis of the Central Retinal Vein—Arterio Sclerosis of the Retina (Retinitis)—Renal or Nephritic Retinitis—Diabetic Retinitis—Retro-Bulbar Neuritis and Papill-aedema. Considerable discussion by various members followed this paper.

There was a brief adjournment and the members were entertained at afternoon tea as the guests of the Superintendent of Nurses and her staff at the Nurses Residence of the hospital.

The meeting then continued with the presentation of a very interesting talk and description by Dr. R. S. Shlossberg, New Glasgow, of his attendance at the "Gill Post-Graduate Course at Roanoke, Virginia, 1949."

Two films were then shown. "The Stone-jardin Implant Operating Procedure and Fitting with the Monoplex Eye." Through the courtesy of the American Optical Company of Canada and through the courtesy of Davis and Geck Inc. a film on "Cataract Extraction."

The meeting then adjourned with the announcement that the next meeting would be the annual meeting and would be held at White Point Beach near Liverpool at the time of The Medical Society of Nova Scotia meeting September sixth to September eighth.

The members planning to attend are urged to make their reservations early with the Hotel Manager.

In the very near future members will be contacted with regard to presenting papers at this meeting and it is hoped that those who up to the present time have not presented papers will give it serious consideration and cooperate with your executive in arranging a suitable programme.

E. I. GLENISTER, M. D.
Secretary-Treasurer.

Obituary

The Bulletin extends sympathy to Doctor W. T. McKeough of Sydney Mines on the death of his son, William Francis McKeough, who passed away after a brief illness on April 19th, at the age of twenty-nine.

Doctor Charles Burton Popplestone was killed March 30th in Waterville, Maine, when his car and a train collided at a grade crossing. Doctor Popplestone was a native of Mahone Bay, and graduated from Dalhousie in 1924. He interned at Toronto General Hospital, and some time ago assumed his duties as Superintendent of the Central Maine Sanatorium at Fairfield in Maine. He was forty-eight years of age.

Book Reviews

CORRELATIVE NEUROANATOMY. By J. J. McDonald, J. G. Chusid and J. Lange. Pp. ii+156. Fig. 60. 10" x 7". Ed. 4, 1948. University Medical Publishers, Palo Alto, California. \$3.00 (U. S.)

This book gives, in condensed form, abundant information on the gross anatomy of the central nervous system and peripheral nerves, microscopic anatomy of the central nervous system, neurophysiology, neuropathology, the clinical features, diagnosis and treatment of neurological disorders. The presentation purports to be "correlation," but it is questionable if mere juxtaposition of information on the various topics is sufficient to justify the term. The text is typescript reduced in size and reproduced by multigraph. The illustrations are line drawings. The book creates the impression of a crowd of somewhat lifeless details, compiled from larger textbooks for the student to memorize. Some students, taking certain types of course, doubtless appreciate it. Others, attracted by its small size and low price, may find it useful as a handy reference book.

FOUR HAND BOOKS FOR INTERNES AND OTHERS

H. H. JACOBSON

Victoria General Hospital Interne Staff

A review of four publications designed for internes and others associated with the work of general hospitals and practice.

In the following reviews, no attempt is made to place these efforts on a comparative basis. Many teaching units publish their own manuals designed to conform to their individual likes and dislikes, and although all four considered here follow a similar pattern and purpose, the scope of each differs from its neighbour, so that comparison would be unfair and unjustified.

Because the American Medical Association Manual devotes a section to the responsibilities of training internes and because the writer is an interne and therefore full of the grievances peculiar to that social order, considerable space is devoted to the relationships of the interne to his hospital.

A.M.A. INTERNES MANUAL. W. B. Saunders Co. \$2.50.

This book is designed to provide suggestions for conduct proper to an interne on his service, basic useful data for reference, laboratory methods, emergencies and information about proven drugs.

It contains a very valuable section on General Information regarding internships and residencies, e.g. what the hospital expects of the internes and what internes *should* obtain from hospitals. The Association stresses the importance of well conducted bedside teaching and the value of staff and departmental meetings at which the interne is expected to take an active part, and the continual encouragement of the interne. Thus hospitals training both residents and internes should recognize their responsibility to both groups and not curtail too sharply the opportunities ordinarily given to

internes by an excess of solicitude for the residents or students. Too often the interne finds himself a whipping boy for the numerous hospital routines which give useful information but leave him little time for critical thought and study.

The A.M.A. believes it necessary for hospital regulations to be developed locally in keeping with various requirements, but each interne may properly expect to receive an explicit statement on his relation to the hospital as a whole and to administrative, nursing and other personnel; his relation to the Staff Interne Committee, especially the nature of disciplinary action for misconduct, and opportunity for a fair hearing on the part of such a committee.

A statement of his relationship to the House Staff and Visiting Staff, what are his responsibilities with regard to prescribing and written orders on both public and private services, his responsibilities during emergencies, and his relationship to the resident staff, should all be included.

Finally the interne should know what the hospital requires in his personal conduct, his attitude to and restrictions in examining patients, post mortem requests, admission and discharge routines, and nature and quality of records.

Since the press forms an important and sensitive part of the community, internes should know what the hospital-press attitude is with regard to information to newspapers and outside agencies such as Insurance Companies Compensation Boards and Welfare Agencies.

To avoid misunderstanding, it is desirable that each interne and resident at the time of his appointment should enter into a formal agreement with the hospital defining mutual obligations. Such agreement should be honourably fulfilled by both parties.

The Manual gives information of the choice of internes and includes a useful table containing the details of licensure by states and territories of the United States.

So that internes will not overemphasize special or unusual techniques a table is given of situations which general practitioners have reported that they are required to meet in list order of frequency both in home calls and office calls. Thus it is hoped that interns will concentrate on proficiency in these respects, rather than on the highly specialized investigative problems so frequently seen in public wards.

The requirements for specialty candidates are given and residents are acquainted with certain important relationships regarding teaching and conduct. Aside from daily contact with patients and attending staff, the manual stresses a point some hospitals are inclined to forget—the assumption of responsibility is a most valuable aspect of residency training.

The section on Clinical and Laboratory data deals with the common emergencies, techniques, interpretations of laboratory tests, and tables of normal values for blood, urine, gastric analysis and C.S.F. examination.

Drug Administration is a useful and interesting chapter. The sections on dosage and methods of administration are especially useful to the interne. Tables of weights, measures and equivalents are included as well as a long list of solubilities.

The Materia Medica contains 246 drugs of established effectiveness with uses and dosage, and the section on acute poisoning contains symptoms, antidotes and treatment of the common poisonings as well as a concise section on general principles in treatment of poisoning.

Diet and Nutrition form a valuable addition containing information to aid in prescribing foods for either normal or special diets.

The Course of Physical Medicine includes a section on Heat (including infra-red, paraffin baths, diathermy) massage, remedial exercises, radiant energy, hydrotherapy, fever therapy and low frequency and constant current.

PHARMACOPOEIA AND CLINICAL METHODS MCGILL UNIVERSITY
Publishers. McGill University Press. \$1.50.

This soft covered, extremely portable little book easily fits the back pocket, is brief, concise and beautifully organized. It contains an easily referred to table of doses, a Formulary with sections devoted to General Medicine, Paediatrics, Dermatology, Ophthalmology and Oto-Laryngology. The Prescriptions are written in entirely with Metric and Imperial systems, and a valuable table of standard capsules, tablets and ampules is included.

The clinical methods section follow a similar pattern, a chapter for methods in the Departments of Medicine, Paediatrics, Surgery, Gynecology and Obstetrics. Metabolism data and food tables, special diets and recipes are brief, adequate, quickly and easily read. Organ extracts, insulin and hormones are similarly treated, while the section on Infectious Diseases, prevention and treatment contains valuable paragraphs devoted to chemotherapy, incubation and isolation periods and disinfection in private practice.

Preparation of the patient before the operation discusses sedatives in relation to various anaesthetics, and skin and instrument preparation. There is a useful paragraph on post-operative care and intravenous solutions as well as formulae of special surgical preparations and dressings. Gynecological and Obstetrical routines are presented in the usual manner.

Special dental procedures offer a page of extremely useful information. There is a section on laboratory methods with complete simplified procedures for diagnostic tests, and on procedures related to the X-ray department plus treatment of radiation sickness and burns.

The organization, type setting and information contained in this manual make it one of the best of its kind.

MEDICAL MANUAL. W. A. Feasby, B.A., M.D. University of Toronto
Press. \$2.25.

Prepared for use of senior students and internes in hospital practice, this pocket-fitting little reference book follows the usual effort to include information required for every day investigation and treatment of common cases. Its diet section is especially interesting, containing dietary instructions presented in a form suitable for patients, with lists of foods not allowed, and a very useful table of 100 caloric portions of commonly used foods.

The sections on clinical methods depart somewhat from the usual presentation in that it offers outlines of suggestions as a guide to special investigation required after routine physical and laboratory examinations. Treatment of common medical emergencies is more comprehensive than usual.

A most valuable contribution are the pages devoted to technique for procedures such as thora-centesis, sternal punctures, etc., and the set-ups for individual sterile trays.

The section on Obstetrics, Gynecology and care of new-born contains a treatise on pre-natal care and initial steps in serious ante natal emergencies as well as excellent pre-and post-operative gynecological case. Anaesthesia is presented in more detail than usual, and the suggested investigative outline is continued through Ophthalmology, and Oto-Laryngology.

There is a chapter on legal considerations in Canada and a chapter of common diagnosis according to the standard nomenclature.

This Book is a well conceived and well constructed little mine of information and deserves a wide acquaintance. Its suggestions for investigation of cases, though never intended to be all inclusive, are a welcome addition.

PHYSICIAN'S HANDBOOK. John Workentin, Ph.D., M.D. and Jack D. Large, M.S., M.D. University Medical Publishers. Palo Alta., California. \$2.00.

The purpose of this \$2.00 handbook has been to summarize tersely, clearly and comprehensively diagnostic procedures and factual data which a physician must have quickly available. At the same time the scope of the book has been extended so as to make it a serviceable pocket reference library for many types of medical practice. Included in it is a relatively complete laboratory manual, the common clinical tests and such other factual information hard to remember but often needed. Considerable space is devoted to the significance of abnormal laboratory findings.

A more complete work than this pocket-sized, loose-leaf, 270 pages effort would be difficult to imagine. The book is a popular one among senior students and internes at Dalhousie Medical School and is especially appreciated, because of the clear interpretations of laboratory results and the summaries of normal physiology and normal constituents and findings of different systems. Techniques are described and explained, comparative tables and diagnosis included.

Hardly a clinical procedure is omitted and the bonanza of clinical facts ranges from history outlines for different specialties, innervation and referred pain, fluid balance, tables of height and weight, autopsy procedures, stages of anaesthesia, to a score of other subjects.

The text is roughly divided in half, the first part devoted to an extensive coverage of laboratory diagnosis, the second half comprising a similarly detailed account of clinically important procedures and facts. No space is wasted, even the covers are devoted to tables of normal values and equivalents. No practitioner should be without this amazingly helpful and informative, inexpensive handbook.

Personal Interest Notes

DOCTOR Victor O. Mader of Halifax recently attended a meeting of the American Association for Thoracic Surgery in New Orleans. On his return he visited the John Hopkins University in Baltimore and hospitals in New York and Boston.

Doctor L. H. Burdett of Dundas, P. E. I., who graduated from Dalhousie last year, is now practising in Oxford.

The annual meeting of the Nova Scotia Association of Radiologists will be held at the Victoria General Hospital, Halifax, on June first.

Doctor C. J. W. Beckwith of Halifax recently attended a two-day session of the executive of the Canadian Tuberculosis Association, at which one of the main concerns was discussion of detailed arrangements for the annual convention to be held at the Nova Scotian Hotel in Halifax in June. Doctor Beckwith who is president-elect of the Association, reports that a hundred or more are expected to be in attendance. The executive will meet on June 22nd, and the scientific programme will run from the 23rd to 25th, inclusive.

Doctor H. D. Lavers of Truro was the guest speaker at a well attended meeting of the Home and School Association at Great Village early in May. Doctor Lavers, who is District Health Officer, outlined his work and urged the inoculation of the pre-school child against communicable diseases.

Doctor Robert O. Jones, Professor of Psychiatry at Dalhousie, gave an address before the Halifax Branch of the Engineering Institute of Canada at the end of April.

Doctor V. D. Schaffner of Kentville has been honoured by being made a founder member of the American Board of Thoracic Surgery, which is an affiliate of American Board of Surgery Incorporate. Doctor Schaffner received the invitation at the annual meeting of the American Association for Thoracic Surgery at New Orleans which he attended. He is the second surgeon in the Maritimes to receive the honour, the other being Doctor George F. Skinner of Saint John.

Doctor Alexander M. MacKay of New Glasgow, has been named head of the department of anaesthesiology at the University of Wisconsin Medical School. Doctor MacKay was born in New Glasgow forty years ago, a son of the late Doctor and Mrs. H. H. MacKay. After his graduation from Dalhousie in 1933 he was in general practice in New Glasgow. Later he served at the Radcliffe Infirmary at Oxford University, England, and received a diploma in anaesthesiology from the Royal College of Physicians and Surgeons of England. He also received certification as a specialist in anaesthesia from the Royal College of Surgeons of Canada. During World War II he served in England and in Europe with the 7th Canadian General Hospital. Doctor MacKay joined the faculty of Wisconsin University last Fall as assistant to Doctor Ralph Waters, a world famous anaesthetist and head of the department. Last Fall he was named acting sub-chairman of the department and on Doctor Waters' retirement in April was elevated to his post.

Surgeon Commander Marvin Wellman, R.C.N., has left Halifax for Ottawa.

Amongst those attending the Institute of Aviation Medicine at Toronto in April were Doctor Harry Wilson, formerly of Ship Harbour, who is now the Chief of Civil Aviation Medicine, and Doctor W. O. Coates of Amherst.

The Bulletin extends congratulations to Doctor and Mrs. W. J. Dyer of Halifax on the birth of a daughter, Mary Lois, on April 27th; to Doctor and Mrs. J. E. Donahoe, Montreal, on the birth of a son, Ian MacDonald, on May 13th; to Doctor and Mrs. F. C. Hazen of Guysborough on the birth of a daughter on May 16th; to Doctor and Mrs. T. H. Earle of Upper Stewiacke, on the birth of a daughter, on May 19th; and to Doctor and Mrs. Frank W. Morse of Lawrencetown on the birth of a son on May 20th.

The Board of Directors of the Leonard Wood Memorial (American Leprosy Foundation) have announced the appointment of James A. Doull as Medical Director. Doctor Doull, as many of his friends will remember, was a graduate of Dalhousie in 1914. He is a brother of Hon. Justice John Doull of Halifax.

We are glad to note that there is a slight improvement in the condition of Doctor M. E. McGarry, M. P., for Inverness-Richmond, who has been a patient at the Victoria General Hospital in Halifax for the past few weeks.

Recent Appointments to Dalhousie. Martin M. Hoffman, B.A. (Mt. A). M.Sc. (Dal.); Ph.D., M.D., C.M. (McGill) will assume the post of Research Professor of Medicine. A native of Saint John, Doctor Hoffman is at present assistant professor of medicine at McGill, assistant physician at the Royal Victoria General Hospital, and Montreal, and assistant director of the McGill University clinic. At Dalhousie he will be in charge of the biochemistry service and clinical research at the Victoria General Hospital.

Doctor Robert O. Jones has been named Professor and head of the Department of Psychiatry on a full-time basis. He is a graduate of Dalhousie in Science and in Medicine and has been associate professor of Psychiatry at the University for a number of years. Doctor Jones will provide courses in psychiatry for nurses, social welfare students, medical students and graduate physicians who propose to follow this work as a specialty, a project which is supported by Federal Health grants.

Recent Appointments to Victoria General Hospital Staff. Doctor James S. Hammerling will assume the post of Assistant in the Eye, Ear, Nose and Throat Department. He is a Bachelor of Science from City College New York, and an M. D. from New York University in 1933.

Dr. Hammerling was in the United States Army and served overseas in the medical branch. Following this he established practice in Halifax. His wife is the former Doctor Ann F. Linder, who graduated from Dalhousie in 1934.

Doctor F. A. Dunsworth of Halifax has been appointed Assistant Psychiatrist on the staff. He graduated from Dalhousie September 1, 1943, and during the war served with the medical corps of the Canadian Army. While in the Army he was posted to special work in psychiatry and has been attached to Camp Hill Hospital and to the Department of Psychiatry at Dalhousie, where he is now assistant professor. He took post-graduate work at the Menninger Clinic at Topeka, Kansas, and received the diploma of the American Board of Psychiatry.