

The Nova Scotia Medical Bulletin

AUGUST 1928



Leading Features This Issue:

THE TREATMENT OF DIABETES MELLITUS

OCCIPITO—POSTERIOR POSITIONS

EDITORIAL

OBITUARIES

PERSONALS

PRINTED BY
IMPERIAL PUBLISHING Co., LIMITED
HALIFAX, CANADA

Ephedrine Hydrochloride "Frosst"

Is the salt of the true alkaloid, isolated from the Chinese plant Ma Huang.

It may be obtained in the following forms

TABLETS—MOULDED

For oral or hypodermic use.

No. 277—Ephedrine Hydrochloride.....	¼ gr.
No. 278—Ephedrine Hydrochloride.....	⅜ gr.
No. 279—Ephedrine Hydrochloride.....	½ gr.
No. 280—Ephedrine Hydrochloride.....	¾ gr.

SOLUTION

Ephedrine Hydrochloride 3% in distilled water.

CRYSTALS—¼ oz. and ½ oz. vials.

INHALENT—NASAL SPRAY

Ephedrine (Alkaloid) 1% in neutral oil, colored and pleasantly perfumed.

Indicated in Asthma and Hay Fever.

Advantages over Epinephrine:—

May be administered orally. Action is more prolonged. Solutions are more stable and may be sterilized.

Charles E. Frosst & Co.
Manufacturing Pharmacists since 1899

MONTREAL, Canada
U. S. Branch, Richmond, Virginia



The following is from a leading French syphili-graph:

"The Arsenobenzenes should be administered intravenously....."

Intramuscular injections give a false impression of security towards lesions and are notoriously insufficient."

Laboratories Poulenc Freres of Canada offer in the usual dosages, **Novarsenobenzol—Billon**, recognized throughout the world as the foremost arsenobenzene to be used in the early, intensive treatment of syphilis.

Literature and revised price list
on request.

LABORATORY POULENC FRERES (Canada) Ltd.

SUPPLIED THROUGH YOUR DEALER OR FROM

ROUGIER FRERES, Distributors - 210 Lemoine Street, MONTREAL

THE WORK OF A LIFETIME

Have you Safeguarded it?

Have you provided enough protection to secure it for your family after your own administration has ceased?

Prudent men of all times have left behind them carefully drawn Wills. The need for such protection was never greater than it is to-day.

It is your duty to your family to have your Will drawn and drawn correctly. A slip in phrasing or punctuation may change the whole meaning of a clause in your Will.

Do not have a homemade Will—it may prove fatal to your family.

Our officials are experienced in matters of this kind and will be pleased to discuss your Will with you and have it drawn by a solicitor.

The Nova Scotia Trust Company

EXECUTOR

TRUSTEE

GUARDIAN

162 Hollis Street

Halifax, N. S.

OPPORTUNITY

for a high class investment, well protected by values and earnings as to principal and interest payment is offered in the

5%

First Mortgage Bonds

of the

Nova Scotia Light & Power Co., Ltd.

(Formerly N. S. Tramways & Power Co.)

PRICE: $99\frac{1}{2}\%$ and Int.

*Ask for Particulars of our
Partial Payment Plan.*

J. C. Mackintosh & Co., Ltd.

Investment Securities

Established 1878

-

171-173 Hollis St., Halifax

With Our Advertisers

We picked up an interesting little booklet at the Charlottetown Convention which reflects credit on the authors, Ayerst, McKenna and Harrison, of Montreal.

The foreword arrests the attention with these significant lines—"Ayerst products are an achievement of Canadian scientific industry."

"This booklet is a product of Canadian workmanship."

The opening pages carry a beautifully worded sketch entitled "The Dawn of Health," which was specially written by Charles S. Gulston, followed by several well written articles on various subjects, such as Digitalis, Iodine, Calcium, with Vitamins, etc., which evidently have been prepared with painstaking care, "Gleaned from a wide range of scientific literature," as the foreword states.

Members of the Profession who visited this firm's exhibit and saw the demonstrations of experiments on the Albino rat must have been impressed with the excellent character of their work and the practical value of the several products which they feature.

This type of pharmaceutical attainment by one of our own Canadian companies is a source of gratification to the Medical Profession and should be encouraged.

Prophylactic Pollen Extracts.

The specific antigenic principle in plant pollens is best preserved by glycerin, or by a medium containing glycerin in appreciable quantity. For this reason pollen extracts for both diagnostic and prophylactic use are put up by some manufacturers in glycerinated form—the diagnostic extracts as a paste in small collapsible tubes, and the prophylactic extracts in liquid form, the diluent being glycerin and boric acid in one case, and 50 per cent. glycerin in the other.

The diagnostic extracts are put up singly and in groups, enough in each tube for fifty tests.

The prophylactic extracts are available in dilute form, ready for use; there is no necessity for the physician to make up his dilutions as required. By withdrawing 1/10 cc. from the vial containing 20 pollen units in each cubic centimeter, he has a dose of 2 units for beginning the prophylactic course. It is an easy matter then to increase the dose, passing in due time from the 20-unit concentration to the 200-unit and thence to the 2000-unit strength.

Some physicians advise a continuance of the treatment beyond the usual 15-dose schedule, claiming better and more lasting results; and it is also claimed that, in case of complete protection following, it may not be necessary to repeat the treatment the following season; or, if there is any question on this score, a skin test may show that further prophylactic treatment is not required. The immunity continues for varying periods, according to the antigenic response of the patient.

Parke, Davis & Co. have a new booklet on Pollen Extracts in Hay Fever.

The Treatment of Diabetes Mellitus*

ELLIOTT P. JOSLIN, M.D., Boston, Massachusetts.

UPON inauguration of the treatment of a case of diabetes the doctor should remember that the patient is destined to live a decade or more and, unless thoroughly instructed in the nature and management of his disease, he will heed the advice of friends and fellow patients and wander from physician to physician until he finds that one who will take the time to teach him, and answer his questions, and lay out a future course of treatment which appeals to his common sense. If the physician has not the time, inclination or knowledge to do this himself, his own reputation with that particular patient and all his relatives will stand higher in the end by referring him at once to some doctor who knows more about the disease and is willing to take the entire or joint responsibility for his care, than to have him go to some one who may know less or to an irregular practitioner.

Already the introduction of insulin has allowed my patients to live about twice as long as formerly and experience with these cases of prolonged duration convinces me that on the whole the disease grows milder as its duration lengthens, that the overwhelming majority of the deaths which have hitherto shortened the lives of diabetics are preventable and that arteriosclerosis, which is the cause of half the present diabetic mortality, at least can be deferred and that diabetic coma can be completely eliminated.

Diabetic coma disappeared as a cause of death among 245 diabetic children during the 12 months ending July 1, 1927, notwithstanding that prior to insulin all such children died of it on the average within 3 years of the onset of their disease. This result was obtained through the use of insulin and instructions to these patients, scattered throughout the United States and Canada, (1) to call their doctor if they felt "sick" and until he arrived (2) to go to bed (3) drink a cupful of

*From the N. E. Deaconess Hospital, Boston.

hot liquids every hour (4) secure someone to wait upon them and thus save their strength (5) take an enema and (6) keep warm.

Diabetic gangrene and infections of the lower extremity are to be blamed for about one fourth of all Boston diabetic deaths. Our trained Deaconess Hospital Diabetics seldom develop gangrene, because they are taught to keep their feet as clean as their face—a quaint idea, but worthy of promulgation.

Demonstrate to the diabetic at the beginning of treatment the Benedict test for sugar, so that he can see for himself whether your advice is good or bad. Show him his positive test and later let him experience the thrill of proving himself sugar free. If he disregards his diet and sugar shows in his urine, he will know he has done wrong; if he disregards your diet and sugar does not show in the urine, he will probably tell you, and you must listen and explain why it does not appear, and then utilize your patients' dietetic experiment for his own good and let him see you are open-minded and willing to study his disease along with him. A doctor must be alert to discover the improvement of his diabetic case, if he wishes him to gain in tolerance for carbohydrate.

At the outset it is desirable not only to teach the value of the examination of the 24 hour urine, but also the advantage of testing the urine during the four periods of the day, morning, afternoon, evening and night. This is unnecessary daily, but is indicated whenever treatment gives unsatisfactory results. In this way it will be possible to adjust diet and insulin between the three meals according to the outcome of the Benedict tests. Even if a diabetic patient cannot read or write, he can do the Benedict test.

Diet Card.—There is no such thing as a standard diabetic diet. Each patient needs his own individual diet which he should understand is always for temporary use and requires alteration every day, week, month or year. The disease does not remain stationary and the patient should understand why he should return for your advice. Give him a diet card with specific directions. Unless you give him a list of food values with which you are familiar, he will secure one of his own and it will be necessary for you to become familiar with that. Be careful! Select a diet card which is simple, compact, can be carried in the pocketbook and don't betray your ignorance or indifference by tearing a diabetic-diet-list-leaf from the book of a drug supply house which has not revised its diabetic diet for a generation. Until you see a better or have devised your own diet card, I recommend the

following which contains about all the food values my patients need to know, because from this list they can make shrewd guesses about the values of other foods.

TABLE 1.
Carbohydrate, Protein and Fat and Calories in Common Foods.

Food 30 Grams=1 ounce	Carbohydrate Grams	Protein Grams	Fat Grams	Calories in Common Foods
Vegetables 5%.....	1	0.5	0	6
Vegetables 10%.....	2	0.5	0	10
Shredded Wheat (3 biscuits).....	23	3	0	104
Unedas, two (6 to 1 oz.).....	10	1	1	53
Potato.....	6	1	0	28
Bread.....	18	3	0	84
Oatmeal, dry wgt.....	20	5	2	118
Oysters, six.....	4	6	1	49
Milk.....	1.5	1	1	19
Meat (cooked, lean).....	0	8	5	77
Fish.....	0	6	0	24
Chicken (cooked lean).....	0	8	3	59
Egg (one).....	0	6	6	78
Cheese.....	0	8	11	131
Bacon.....	0	5	15	155
Cream, 20%.....	1	1	6	62
Cream, 40%.....	1	1	12	116
Brazil Nuts.....	2	5	20	208
Butter.....	0	0	25	225
Oil.....	0	0	30	270

TABLE 2.
Foods Arranged Approximately according to Content of Carbohydrate.

5%	5%	10%	15%	20%
Lettuce	Tomatoes	String Beans	Green Peas	Potatoes
Cucumbers	Brussels Sprouts	Pumpkins	Jerusalem	Shell Beans
Spinach	Water Cress	Turnip	Artichokes	Baked Beans
Asparagus	Sea Kale	Kohl-Rabi	Parsnips	Green Corn
Rhubarb	Okra	Squash	Lima Beans	Boiled Rice
Endive	Cauliflower	Beets		Boiled Macaroni
Marow	Egg Plant	Carrots		
Sorrel	Cabbage	Onions		
Sauerkraut	Radishes	Green Peas		
Beet Greens	Leeks			
Dandelions	String Beans			
Swiss Chard	Broccoli			
Celery	French			
Mushrooms	Artichokes			

TABLE 2—Continued.

5%	10%	15%	20%
Ripe Olives Grape Fruit	Strawberries Lemons Cranberries Peaches Pineapple Blackberries Oranges	Raspberries Currants Apricots Pears Apples Blueberries Cherries	Plums Bananas Prunes

Diabetic Records.—Unless a doctor has before him upon a single line of a single sheet the result of the analysis of the urine for sugar (preferably also of the blood though at less frequent intervals), the composition of the diet, either accurate or approximate, and a record of insulin used, he can never make satisfactory progress in the treatment of his patient. In this way comparisons can be instituted from day to day or year to year. The more intelligent patients always use and bring their charts which they often design for themselves. An example of such is shown in Table 3.

TABLE 3.

No. Name Hospital

Date	Vol. c.c.	Sp. Gr.	Alb.	Di- acetic acid	Sugar in Urine		Diet in Grams C. P. F.	Naked Wgt. Lbs.	Non Protein Nitrogen	Blood Sugar %	Insulin Units time given
					Reduc- tion	Total G.					

The Diabetic Treatment of Diabetes.—Complete diabetes I do not see and consequently I seek to discover the tolerance of the patient for carbohydrate. In the process of doing so I try to develop this tolerance to the utmost by gradually relieving the load thrust upon the pancreas by nature's crude attempt and failure through polyphagia to secure enough food for bodily needs in addition to that lost in the urine. Overeating brings on diabetes in the adult just as overgrowth favors it in the child. Everyone agrees that the diabetic must never be over-fed and particularly so at the beginning of treatment. It is advantageous temporarily and at the start to make use of mild undernutrition, which experience before insulin taught us all

worked so well in rendering the urine sugar free. Within one week the diet can be raised to a maintenance value and in the meantime the gastro-intestinal tract of the patient is not suddenly shocked by the increase of fat calories to make up for the inevitable reduction in carbohydrate calories. When the patient first arrives for treatment it may seem as if he had no tolerance for carbohydrate, but if protein is kept at a reasonable amount—about 1 gram per kilogram body weight for adults, 2 to 3 grams for children—carbohydrate reduced to 100 grams and with fat the total calories brought up to 20 calories per kilogram, successive days will show decreasing sugar in the urine and improvement in tolerance, which, it is true, can be hastened by the use of insulin. One can promptly determine whether the carbohydrate should be lowered toward 50 grams, a level below which I no longer go, or raised to 150, 200 or very rarely to 250 grams, the latter figure being not much below what the average man or woman eats whose weight is 60 kilograms—132 pounds, naked.

A higher carbohydrate diet at the beginning of treatment does not appeal to me, because in diabetes one is dealing primarily with a disease of disturbed carbohydrate metabolism and it is rational to spare the overworked carbohydrate function of the islands of Langerhans and allow these to recuperate. A lower carbohydrate diet likewise is obnoxious, because upon it in the first instance, the diabetic cannot disclose his true tolerance, in the second he is deprived of the opportunity to show an improvement in the same and thirdly a disused function retrogrades rather than improves.

The Preliminary Diet.—Plain foods, universally obtainable, which will form the basis of the diabetic's diet for life, should compose the preliminary diet. These should furnish bulk, such as 5 per cent. vegetables, first for satisfaction and second because carbohydrate administered in low concentration is better utilized than when given in highly concentrated form. Fruit is indicated, because it relieves the monotony, replaces desserts, and partly because its carbohydrate content is so easily learned by the patient. Thus grape fruit contains 5 per cent., orange 10 per cent., a banana 20 per cent. carbohydrate. A half grape fruit contains about 10 grams carbohydrate, a really small orange 10 grams and the average banana 20 grams. Uneda biscuits are desirable, because each happens to contain 5 grams carbohydrate which for demonstration purposes every patient should know is the exact weight of a Buffalo nickel. Oatmeal is two-thirds carbohydrate and a liberal saucerful, cooked, amounts to 20 grams, slightly less than in a shredded wheat biscuit, which contains 23 grams. Cream contains one gram carbohydrate per 30 grams or ounce. The values for protein and fat in these foods and in eggs, meat, butter, cheese, are all shown in Table 1.

The patient's full diet is usually attained by the end of the first week, but at the beginning the quantity of cream is one quarter of a pint, 4 ounces, 120 c.c., instead of one half a pint.

TABLE 4.

Diabetic Diet Susceptible of Easy Modification.

		Carb.*	Prot.	Fat
5% Vegetables	{ 4 saucerfuls 20 ounces 600 grams }	20	10	0
Oranges	3 small 300 grams	30	0	0
Oatmeal	{ 1 saucerful cooked 30 grams dry (240 grams cooked) }	20	5	2
Uneeda biscuit	2 biscuits 12 grams	10	2	0
Cream (20% butter fat)	{ one half pint 8 ounces 240 grams }	8	8	48
Eggs, 2		0	12	12
Meat (cooked)	60 grams	0	16	10
Bacon (cooked)	30 grams	0	5	15
Butter	30 grams	0	0	25
		88	53	102
		4	4	9
		352	212	918

Total cal. 1482

The division of the diet between the three meals is such that less than a third of the carbohydrate is given for breakfast and the remainder allotted to noon and night.

The above diet would furnish nearly 30 calories per kilogram for the individual weighing 50 kilograms,—110 pounds naked,—or 25 calories per kilogram for the one whose weight is 60 kilograms (132 pounds). Without changing the carbohydrate at all an addition of meat 60 grams would add 150 calories, butter 30 grams—225 calories, and changing the cream to that of 40 per cent butter fat strength—432 calories. Combine all these and they would represent a total increase of protein of 16 grams and of fat 83 grams, 811 calories.

The total glucose value of the original and modified diets would be as shown in Table 5. Personally I am not impressed with the utility of estimating the total glucose in the diet.

TABLE 5.

Total Glucose.

Carb.,	88 grams x 1.00 =	88	88 x 1.00 =	88
Protein,	53 " x 0.58 =	31	69 x 0.58 =	40
Fat,	102 " x 0.10 =	10	185 x 0.10 =	19
		129		147

*5% vegetables vary in content of carbohydrate from 2 to 5%; arbitrarily a mixture of 4 portions is estimated to be on the basis of about 3% or 1 gram carbohydrate per ounce..

So high a proportion of fat to carbohydrate as 2 to 1 or, in fact, so high a quantity of fat as the 185 grams of this modified diet in the diabetic diet I do not advocate. It is seldom necessary to raise the fat above 150 grams even with individuals whose net weight is 80 kilograms (176 pounds), because with such patients the tolerance for carbohydrate is relatively high or can be kept so with small doses of insulin. Furthermore because of the high blood pressure of these individuals and their overweight, their body weight should be reduced. Third the basal metabolism of such individuals for age, height and sex is low and at work is usually less than 30 calories per kilogram body weight. The basal metabolism of a male, 50 years of age, net weight 80 kilograms, height 5 ft. 7 inches without shoes is 1685 and that of a woman of similar age, net weight 70 kilograms (154 pounds, height without shoes 5 ft. 4 inches is 1393 calories.

By keeping the total calories low and the total calories derived from fat relatively low, and by this is meant not allowing more than 1.0 to 1.5 grams of fat for each 1 gram of carbohydrate, my patients have done the best. The Ann Arbor Clinic, at which low carbohydrate and high fat diets have been employed, has done all diabetics a service in recording the absence of any gain in tolerance for carbohydrate by their methods in 5 reliable patients studied over periods of 32 to 45 months.

In contrast to their experiences with the low carbohydrate, low protein and high fat diets can be placed my own more favorable experience with a more liberal carbohydrate and protein, but smaller fat diets, and specifically with 5 also reliable patients.

If the weight of the patient is above normal and he is over 35 years of age, it is as desirable to reduce it as in any non-diabetic individual. But rapid loss of weight is contraindicated, because that would mean the substitution of body fat for food fat and then the patient would be living upon a high fat diet. An excess of body fat in the diet is almost as bad as an excess of extraneous food fat.

One of the harmful effects of a high fat diet, particularly if associated with a diet containing less than 100 grams of carbohydrate, appears to be its production of premature arteriosclerosis. I believe this, but I await the reports of the incidence of arteriosclerosis in those clinics where large quantities of fat have been fed as in Lund, Sweden, and Ann Arbor in this country.

Insulin.—With the help of insulin my diabetic children have already lived twice as long as formerly and give every indication of living for years to come. Is not this an unanswerable argument for insulin? At some crisis during his diabetes most every diabetic requires insulin. There are therefore excellent reasons for his education in its use when he first comes under observation. Usually I begin at the first day I see the patient and if, as many do, he can omit it later, so much the better. In this way I try to insure my diabetics against emergencies.

The fundamental reason for the use of insulin is its power to store glycogen. With glycogen in the liver a diabetic is safe, without glycogen in the liver he is in danger from the accumulation of an excess of fat in the liver and accompanying acidosis. The aim of insulin administration, therefore, is to promote the utilization of carbohydrate and to store some of it as glycogen in the liver and muscles. When glycogen is stored the metabolism runs more economically than when it is lacking. Krogh found extremely high as well as extremely low respiratory quotients disadvantageous.

The effect of insulin lasts about 8 hours and theoretically one should give it at 8 hour intervals three times a day. Practically however, this is not necessary, because most cases of diabetes manufacture enough insulin of their own to provide for the periods at which they are not taking food. It is true, however, that the severer type of patient goes to bed at night relatively mild, because he has glycogen stored in his liver as a result of his day's treatment, but he wakes up severe, because his glycogen store has become exhausted. Such a diabetic, often this is a child, requires a few units, 2 to 5, in the late evening to protect him, and in this way he begins the next day as a mild case. No better proof of the advantage of storing carbohydrate in the body by means of insulin is afforded than to observe the course of such a patient in the following 24 hours. These few units at night often obviate the necessity for three times as many units the next day. In reality in this manner the severe diabetic starts the day as a mild diabetic. In every conceivable way I try to keep my patients mild and this is one of them.

Small doses of insulin are safer than large doses. Usually I begin with 2-5 units before each meal and increase the quantity as necessary with each successive meal until the urine saved in 4 period portions becomes sugar free upon the diet above described. This entails frequent urinary examinations for sugar, but they can be done qualitatively adjoining the ward by the nurse or at home by the patient. Thereby much time and expense can be saved the patient and the efficiency of the hospital beds increased. Within 36 hours one can determine whether a fourth dose of insulin should be injected at night or the three doses reduced to 2 by the omission of that at noon. Likewise one can decide whether dosage should be raised to 10, 15 or 20, rarely 25 units before breakfast. Automatically before the evening meal it is less, still less at noon if used at all, and least of all upon retiring.

The interval between the injection of insulin and the meal is greatest before breakfast, because at that time of the day the blood tends to be highest. Occasionally to attain best results this period must be an hour. Before the other meals 20 minutes, more or less, suffice to afford an opportunity for insulin to act and reduce the blood sugar to a normal level at the beginning of a meal and to counteract the rise in blood sugar which is caused by the ingestion of the meal.

The site of injection is not of especial moment, provided it is varied and no two injections are given in the same spot in the course of the month. Therefore I recommend for systematic use the right leg in the morning, the left at night, 4 parallel lines down the leg for each week of the month and a spot on each of these lines for each day of the week; if other doses are given utilize the arms or buttocks. Insulin given constantly in one place leads to atrophy of the tissues, is unabsorbed and hence wasted.

Whereas it is legitimate to begin the treatment of a youthful case of diabetes rapidly, that of a patient above the age of 50 should be commenced gradually and for three reasons. First, his tissues do not accommodate themselves so quickly to the fall in sugar and the changed diatetic regime, second, he is apt to be milder and a little dietetic coaxing will disclose the benign character of the disease, and third, I am afraid of the consequences of a sudden lowering of the blood sugar in the coronary vessels of the heart, because the heart muscle especially is dependent upon sugar for its proper action.

Exercise.—Exercise is of paramount importance for the diabetic. Just as diabetes is prone to develop when exercise is given up, so carbohydrate tolerance fails when it is restricted. Glycogen is oxidized in the muscles and their tone must be kept up and their demand for glycogen made urgent. The value of exercise in utilizing and lowering the blood sugar is easily demonstrable. A child is on a constant diet and insulin dosage, but an unusual romp with his father at night brings on an insulin reaction. A game of golf is equal to 5 units of insulin. A Marathon run will bring on the equivalent of an insulin reaction. It is more fun to take exercise, healthier to take exercise, makes one's disposition better to take exercise and one is better looking for taking exercise than to take insulin alone. Therefore I tell my patients to exercise, stand erect, be proud of their posture and show off, if they will, because physically all these things will do them good. Of course I am proud of my diabetic children and intend to make them proud of themselves. They average above other children in height and in mental capacity and I rather think in good looks and it is right that they should take advantage of these traits to offset their glycosuric handicap.

All my surgical cases have exercise while in bed under the supervision of a physical therapist. The value of the exercises with the Buerger board may be partially explained by the exercise it involves. The patient raises his leg with deficient circulation for 3 minutes until the blood runs out of it, lowers it for two minutes until the blood runs into it, keeps it horizontal 5 minutes and repeats the cycle 6 times an hour and 3 hours a day.

All diabetics must work physically if they wish to work mentally. Patients do better in the summer time, better in warm climates, better on farms, better on mountain hikes—all because they exercise. We must make our diabetics perfect physically.

Insulin Reactions.—The diabetic must be familiar with the symptoms of an insulin reaction. If he realizes the same symptoms of hunger, tremor, sweating and unconsciousness, even convulsions, can be brought on by extreme undernutrition and over-exercise it simplifies the problem. Weakness, anxiety, nervousness, diplopia, disorientation, monoplegia, may occur. Convulsions are rare. More essential is it for the patient to know how to stop a reaction. He must carry a few lumps of sugar in his pocket. In the case of a child the mother must be ready to give an enema of glucose, using karo syrup if she will or something similar and it is helpful to know how to use adrenalin, a quarter c.c. or more of a 1:1000 solution.

The Differential Diagnosis between Hypoglycemia and Diabetic Acidosis. A wrong conclusion as to the cause of the unconsciousness of a diabetic patient might lead to death. Eleanor's mother believed her commencing unconsciousness after a hard set of tennis was due to acidosis, because the urine contained sugar and acid, and she gave her 20 units of insulin when she was in hypoglycemic collapse. A strange doctor was keen enough to catheterize the bladder, in this second specimen of urine found sugar and acid absent, made the correct diagnosis and saved Eleanor for the frontispiece of my book as an example of a diabetic child with diabetes of 10 years' duration. Never fail to realize the first specimen of urine you obtain may have been manufactured hours ago. Steers sometimes urinate but once in 24 hours.

The history of the case almost always allows a telephone diagnosis between hypoglycemia or coma. The patient with hypoglycemia has eaten too little, the one with acidosis has eaten too much. But analyze the correctness of the data and not be led astray by deficient absorption of food. Hypoglycemia is rare in acute infections, but acidosis is common, because of increased metabolism of body protein and fat. The patient with hypoglycemia has taken too much insulin, the one with acidosis too little, but remember the insulin injected may have gone into scar tissue and not been absorbed. The hypoglycemia patient is more mentally upset, disorientated and even violent as he becomes stuporous, in contrast to the acidotic case, who becomes sicker and sicker as he glides into coma before you hardly realize it has claimed him. Hypoglycemia comes on in minutes even if they do sometimes reach 60 or more, acidosis culminates in coma only after hours and days. The one is sudden, the other gradual. No suffering precedes hypoglycemia, but vomiting and pain in the epigastrium and abdomen generally, even in fully 80 per cent of the cases, usher in acidosis. In hypoglycemia one is never confused by the possibility of appendicitis, gall stones, pancreatitis, or the perforation of a duodenal ulcer, but in coma you are puzzled and not infrequently must operate. In fact it is always safer to do so if in doubt, although hourly observation for 3 or 4 successive hours may save surgical interference. The quiet respiration in hypoglycemia and the labored Kussmaul respiration

in acidosis are the outstanding physical features. Analyses of blood and urine furnish precise information. With appropriate treatment of hypoglycemia, recovery is swift, but is slow in acidosis. Yet its progress is easily registered. With either condition temporary improvement must be followed by continued observation, at least for a day, or serious relapses may occur.

Treatment of Coma.—First the diagnosis. Be sure it is not uremia, opium poisoning, meningitis, apoplexy, hypoglycemia. 2. When satisfied it is coma, give insulin 20 to 40 units every half hour or hour until improvement is shown by falling sugar in blood or urine, obtained by catheter if need be, or by the state of the patient. 3. Wash out the stomach, because one must be sure liquids can be absorbed as consciousness returns. 4. Give salt solution by enema, subpectorally and more rarely intravenously. 5. Caffeine in $7\frac{1}{2}$ grain doses has been our best circulatory stimulant. We have not used glucose or sodium bicarbonate. Glucose may put an end to an anuria and possibly might be given for that reason. As a rule in the second 24 hours, perhaps in the second 12 hours, the patient begins to take carbohydrate by mouth at the rate of 50 grams daily and rapidly returns to his standard diet. Sodium chloride acts as an alkali. As yet no series of cases treated with sodium bicarbonate has shown results comparable with those published by Petrén and others without sodium bicarbonate.

Petren: Munch, Med. Wchnsshr, 1927, 74, 1123.

Joslin, Root, and White, Med. Clin. N. Amer., 1927, 10, 1281.

Brace: Annals of Int. Med., 1927, 1, 203.

Campaign for the Blind. An endowment fund of \$300,000.00 is requested to put the work for the Blind in the Maritime Provinces on a practical basis. The object must appeal to all, and none, more than the medical profession, realize how much it means that a blind person shall have occupation. We note among those who, have assumed charge of Committees to carry out this work that doctors have taken their share of the rather uninteresting work of collecting the funds. We note that Dr. J. S. Brean is Chairman of the local committee in Mulgrave, and Dr. J. A. Proudfoot in Inverness. Dr. H. I. Taylor heads the Committee in St. George, N. B.

Judge: "The jury having acquitted you of the charge of bigamy, you are free to leave the court and go home."

Prisoner: "Thank you, my lord, but I want to be on the safe side—which home?"

The Maritime Medical News

PART VII. 1903.

THE first article in the January 1903 issue of the *Maritime Medical News* is one by "M. A. B. Smith, M.D., Professor of applied Therapeutics and Class Instructor in Practical Medicine, Halifax Medical College." and the title is "Gall-stone Disease." We conclude that at that time surgeons and internists were not quite in accord, as he stated,—“There are surgeons that write, ‘the presence of gall-stones is always an indication for their removal’ while on the other hand, internists said,—‘scarcely one out of thirty of those who suffer from gall-stones will ever need to undergo an operation.’” From a casual reading of medical journals the last two years there does not appear to be this difference of opinion. Perhaps Dr. Smith, who still wields a facile pen, might let the readers of the *Bulletin* have his ideas on the subject to-day, after a lapse of twenty-six years, from the viewpoint of the internist!

While looking over some papers written at this time by men who are still in active practice we feel an urge to inquire if they ever look back from the glare of scientific light to-day, to see how *near right* they were in the early days. We feel like asking Dr. H. H. McKay of New Glasgow if he can write any more authoritative paper on Insomnia than he did for the Medical Society of Nova Scotia in 1902?

In these notes we have several times referred to medical practitioners who actually sacrificed their lives on the altar of duty to their profession. The January 1903 *Maritime Medical News*, in noting the death in December 1902 of Dr. W. S. Harding of Saint John, N. B., recalls the terrible scourge of ship fever, cholera and small-pox in 1847 at Saint John. In this work, associated with Dr. Harding, was Dr. J. Patrick Collins who gave his life in serving these stricken *thousands*. The *News* reference is brief, the scourge was so great and it happened so long ago, that we cannot refrain from quoting this tribute to a member of our profession.

“The following article taken from the *St. John Globe* will be found of considerable historic interest:—

In reference to Dr. W. S. Harding a few days ago mention was made of the fact that he had a great deal of hard work at the time ship fever came here with the immigrant vessels. The late Mr. W. Reynolds, in an article in the *New Brunswick Magazine*, in 1898, told in detail the sad tale of the sufferings of the people coming to this country over fifty years ago. The main points in Mr. Reynold's article are as follows:

The first of the immigrant ships to arrive in St. John was the brig *Midas*, on the 5th of May, 1847. It was from Galway and had made the passage in thirty-eight days. During the voyage two adults and eight children had died and many of the passengers were sick when landed on Partridge Island. Following this came other vessels, and on the 16th the barque *Aldebaran* arrived. It had left Sligo with 418 passengers and of these thirty-four, chiefly children, had died during the forty-eight days' voyage. Over one hundred were sick when they reached here, eighty of whom subsequently died, being buried on the island. Many of the vessels were overcrowded, and food and water were scarce on almost every ship.

During the month of May twelve vessels arrived and were placed in quarantine, the passengers being removed to the Island Hospital. Among these craft were some veritable death ships, one of them the *Mary Dunbar* from Cork, having smallpox on board.

Dr. George J. Harding was the quarantine physician and was assisted by Dr. George L. Murphy, but the cases multiplied so rapidly that further medical aid was necessary. In the latter part of May two doctors from the city were sent to the hospital on the Island. One of these was Dr. W. S. Harding; the other Dr. J. Patrick Collins, who was destined to give his life in the effort to lessen the sufferings of the people of his race. Dr. Collins was then only twenty-three years of age and there was every promise of a most brilliant career for him. He had been married in the previous autumn to a sister of the Revs. Pas. and Edmond Quinn, who is still living. Drs. Harding and Collins were well aware of the terribly infectious character of the fever, but they went to the Island to do their duty whatever might be the result. During the month of June thirty-five vessels arrived, having on board 5,800 souls. Two hundred died in quarantine, and over 880 of them were sick in the hospital at the close of the month. Drs. Harding and Collins both contracted the fever and on July 2nd Dr. Collins died, a martyr to his duty and a hero in the truest sense of the word. The funeral took place on the following Sunday, and was the largest ever seen in Saint John.

In the meantime the infection was extending to the city and, by the last of July, 66 had been admitted to the Immigrant Hospital at the old poor house, at the corner of Great George's (now King) and Wentworth Streets. Of these, sixty-two had died and the death rate was increasing. When this refuge became too crowded, sheds along the back shore, near the Marine Hospital, were brought into requisition.

It transpired that Dr. Geo. Harding had by this time also contracted the fever, but recovered. Dr. Wetmore was sent to the Island with Dr. W. S. Harding at this time. In the city Drs. W. Bayard, Wetmore and Paddock were ill, one after the other, in their attendance at the poor house, but all recovered. Andres Barnes, steward of the Marine Hospital, died from it.

In July 4, 58 more immigrants arrived, making a total of 9,900 up to that time.

During the six months the fever raged on Patridge Island the scenes were beyond description. Oftentimes five hundred people had to be carried ashore, helpless from the terrible disease. Those were gruesome processions. In many instances a whole day was consumed in debarking. Many of those, not sick, camped about the various places over the Island, securing what shelter they could. A supply of tents was sent down from the city, but in the blustery days these were swept away by the score. Others used the rude boards sent down to convert into coffins, and erected huts.

As to the coffins, it soon grew so hard a task keeping up to the demand that even the board receptacles were finally abandoned and the dead were interred in their clothing only. There being little earth on the rocky isle, many graves showed evidences of the clothing of those buried, and the stench was something awful. Quicklime was generously used, and the thinly-earthed spots deepened. At one time, through the prostration of the hospital staff, forty-five bodies accumulated. These were placed in one large pit.

Long after the fever ceased St. John had many poor on its streets. Beggars from door to door were common, and some of them were pitiable sights, truly! Many who recovered went to the United States, their originally-intended destination. Fever ships arrived at other New Brunswick ports and in some cases the disease made great havoc.

By November the epidemic on the Island was under control, and the patients were removed to the city poor house. The number of Irish immigrants landed on the Island that year was 15,000. About 800 died on the voyage, 601 died in the hospital and on the Island, 595 died in the poor house hospital, making the total mortality in excess of two thousand."

Another leading article in the January number is one on "Medical Ethics" by Dr. W. R. Dunbar of Truro, then located at Shubenacadie. It had been presented at a meeting of the Colchester Medical Society the previous year. In its illustrative details it was just the paper to give at a small society where everyone was aware of the frequent occurrences described and could recognize how unethical they were.

The February Editorial was entitled "Care of the Feeble-Minded." In the June BULLETIN 1927 was published the "Findings of the Royal Commission" sitting just 25 years later. Just 25 years wasted, for all the "findings" had been made public that long ago, even to the extent of a "census," which seems to be the modern craze before any philanthropic work can be undertaken. "It may be a matter of surprise to some to know that for this element of our population we have absolutely no provision. In other countries and one province of the Dominion institutions, some supported by the state, others by private charity, exist, to which the feeble-minded are sent, and in which are provided such instruction as will develop any latent intellect,

and, as a result, a large percentage can be taught to take care of themselves to a certain extent. In fact under proper methods of teaching, all, except the hopelessly 'idiotic, receive distinct benefit."

Now, after twenty-five years, altho we have had a census, a Royal Commission (how we dote on Commission in N. S.) with its report, and even a money appropriation, we still cannot get up enough energy to even employ such occupational therapy as could be carried out in many of the County Homes where these unfortunates are still corralled. We venture the criticism that the medical profession in Nova Scotia has been entirely too lethargic in this matter.

Carlyle it was who said, "Biography is by nature the most universally profitable, universally pleasant of all things." We are then following good precedent in these notes when we make frequent reference to the men that have passed on, leaving the trail that we should endeavor to follow. Perhaps a few, who followed the remains of the late Dr. Philip McLarren to their last resting place, recalled the early passing in 1903 of Dr. Andrew Halliday. To one who clearly recalls those days there was a striking similarity in these two tragic events. We cannot do better than quote freely from the *News* editorial of this further illustration of the sacrificing of life to human service.

"A busy profession, keen in the struggle for individual advancement, too often looks upon large practice and financial success as the proper criterion of professional merit. It is only on such occasions as the present, that we tardily realize that there may have been one amongst us, neither a busy practitioner, nor a seeker after great emoluments, who filled a larger place, and leaves a vacancy more difficult to supply, than were possible for the most successful (from the ordinary standpoint) of his colleagues. Sadly too few have we of medical men in this province, willing to "scorn delights and live laborious days" in the laboratory and class-room, at the inadequate salary available, simply for the love of knowledge and for the good of the state.

As the late William Scott Muir, who died exactly a year earlier to the very day, will long be remembered as an example of the great and good physician, sacrificing comfort and even life, in devotion to his work as a busy general practitioner, so Andrew Halliday, devoted to the scientific side of medicine, was willing to sacrifice means and health to the arduous work entailed by his services to education and the province. In his more limited sphere he was like Kantback, of Cambridge, and Wyatt Johnston, of McGill, wrapped up in his work, indefatigable in his labour, and unsparing of himself. His career in Halifax was brief, in fact, after years of preparation he might be said to have just entered upon it, and with the limited means at his disposal, and the increasing public duties he was called upon to perform, he was unable to give much time to original work; but the cultivated mind of the student, the instinct of the investigator, and the capacity of the teacher, were so obvious that no one in frequent contact with him could doubt the future that lay before him.

It is good for us as a profession to occasionally pause for a moment in our struggle for existence, wealth or fame, and to inquire if, with all our success, we can hope to leave a record so clean and free from the stain of common human failings, as either William Muir, or Andrew Halliday. Muir was the busy, bustling practitioner, with grand physique, fine health, and full of boisterous life, withal kind and gentle as a woman, a loyal friend, and if perchance a foe, an honourable foe. Halliday, endowed with feebler frame, and less robust health, and an almost diffident manner, was gifted with great natural talent and indomitable industry—the type of the gentle student. Each in his sphere represented what is best in medical life.

His capabilities, as a bacteriologist and analyst, were so quickly recognized by medical men and municipal authorities throughout Nova Scotia, that shortly after his appointment he became overwhelmed with work—samples and specimens to be examined poured in on him from all directions. He was generally accepted as an authority, and his work was proportionately large and responsible. The strain of such severe work told on his—never robust—constitution and with lowered vitality he fell a victim to the great white plague, which has played havoc with so many young lives of great promise.

LETTER OF CONDOLENCE TO MRS. HALLIDAY.

Dear Mrs. Halliday:

At the last meeting of the Halifax, Nova Scotia Branch of the British Medical Association it was unanimously resolved that we should communicate to you the expression of our deep sympathy in your great sorrow. The sad bereavement which has deprived you of your life's companion has also taken from us one of our most active and useful members.

In the many interesting contributions which Dr. Halliday made to our Association, and which were almost always the result of original investigation, we felt the influence of an earnest and scientific mind, and we shall certainly miss the stimulus of his presence and help in our discussions. We consider that the work he accomplished as Director of the Government Laboratory of Hygiene has been of the greatest value. And those who knew him best feel that his early death is a loss to the profession and to the country.

Please accept for yourself and for your little son the assurance of our heartfelt sympathy.

Signed { W. H. HATTIE,
JOHN STEWART,
F. W. GODDWIN,

Committee of N. S. Branch B. M. Association.

March, 1903.

What Do You Bid?

Life is like a game of cards,
When you're in love it's Hearts;
When you're engaged it's Diamonds;
When you're married it's Clubs;
When you're dead it's Spades.

Occipito--Posterior Positions*

By Dr. F. J. O'Leary, Toronto.

PROBABLY the oldest problem in obstetrics is that of delivering a baby presenting in the occipito-posterior position. Notwithstanding the study given to this condition, it is still the bete noir of maternity work, and is the cause of many injuries to the mother and child—foetal deaths, and maternal morbidity.

Failure in diagnosis is largely responsible for difficulties encountered during delivery—the safe policy is always to have occipito-posterior positions in mind—even go so far as to suspect every case as posterior until proven otherwise. There is usually a complication or an accompanying problem associated with a posterior position. This may be the real factor in the non-descent of the head, and failure to recognize or solve this problem makes delivery difficult or impossible.

There are many signs and symptoms that are suggestive of a posterior position—any one of the following may give the accoucheur his warning, and put him on guard for difficulties ahead:—

- (1) Foetal movements felt all over the abdomen.
- (2) Early rupture of the membranes.
- (3) Persistent headache throughout labor.
- (4) Contractions of poor quality causing slow dilatation of the cervix.
- (5) Non-engagement of the head with or without good pains.
- (6) Failure to advance in the second stage.

Regarding the last sign it is not uncommon for a labor to advance normally, the caput to appear at the vulva, and after a delay, forceps are applied. The forceps slip or the head fails to advance. Careful examination will reveal an unsuspected occipito-posterior position.

- (7) Abdominal palpation is helpful, but how difficult it is occasionally, especially with a primipara in active labor, to be sure of the exact position. Some observers claim that the majority of right positions are posterior.

The problems that so often complicate a posterior position and demand consideration during labor are:—

*(Published in the St. Michael's Hospital Medical Bulletin, Toronto.)

- (1) A funnel pelvis—a roomy inlet, a deep symphysis and a narrow outlet. This type of pelvis is more common than is generally suspected, and often the head engages readily with very little moulding. The doctor is thrown off his guard thinking labor is progressing normally. The head is poorly flexed, and becomes wedged in mid-pelvis with the sagittal suture pointing transversely. This condition is called transverse arrest.
- (2) Flat pelvis. Here engagement is difficult due to the protruding promontory and when it does occur, rotation of the head anteriorly is not complete.
- (3) Justo minor pelvis.
- (4) Early rupture of the membranes robs the patient of the natural dilator of the cervix, and also takes away from the lower uterine segment the stimulus which ensures pains of good quality.

No one form of treatment will cover all the problems arising out of an occipito-posterior position. A few general principles are applicable to all cases, then each patient must be studied individually. Careful ante-partum pelvimetry will help one determine whether or not a woman should deliver per vias naturales and thus render unnecessary vaginal examinations during labor. A policy of watchful waiting is necessary during the first stage, twenty or thirty hours may be required to accomplish full dilatation—but this should be permitted, only with assurance that the patient will eventually deliver. If a Caesarian section is to be done, let it be considered early, so that the test of labor will be to determine what the patient can accomplish, not what she can endure. Likewise when she reaches the second stage, steady progress, even though it be slow should be made, otherwise assistance should be rendered, especially at night when the patient would ordinarily sleep. Toward the end of the first stage, ether by rectum, according to the Gwathmey technique, will make her comfortable for several hours without affecting the contractions.

If the first stage of labor with a persistent occipito-posterior position be a test of the obstetrician's patience, the second stage is a trial of his art and skill. If the patient is not progressing, some method must be considered toward helping her. The one to be adopted should be the simplest manoeuvre necessary for delivery and which will endanger neither mother nor baby.

Occasionally one meets a case where due to sheer exhaustion the patient is unable to bear down. A tight binder to the abdomen and counter-pressure to the knees while she is encouraged to push will sometimes cause the head to rotate anteriorly and descend. Pressure

to the sinciput to increase the flexion and manual rotation will correct slight defects in the mechanics of delivery.

If delivery is obstructed arrest occurs at the inlet, mid-pelvis, or low in the pelvis. In the latter condition, rotation anteriorly is effected manually or according to the Scanzoni technique. The forceps are applied in the occipito-mental diameter lifting up, to flex the head, then rotating the handles through a wide circle. The occiput is then anterior but the blades are inverted and must be removed, then re-applied. This manoeuvre is successful with many obstetricians but there is danger of extensive vaginal lacerations, also of the head rotating backward while changing the forceps.

(2). The "single application" as advocated by Bailey and Williams of Bellevue, inserting the hand alongside the baby's head over the posterior ear, then raising the hand anteriorly, carrying the head to a transverse position. The posterior forcep is then passed along the palm of the hand with the pelvic curve toward the occiput, and when the hand is removed the blade is steadied by an assistant holding the head in place. The other forcep is then allowed to wander into position, the handles are crossed and locked. Moderate traction will complete the rotation and delivery follows.

(3). Deep transverse arrest is a common and difficult lie in which to find the head. Very often a pelvic deformity, either flat or funnel pelvis, together with poor flexion of the head, are the accompanying problems. Forceps should be applied as in the "single application," but this is made difficult by a lower blade being deflected by the promontory. When the forceps are in position, it is found that the upper blade is in advance of the lower, and it is impossible to lock the handles. Here the Kielland forceps are of undoubted value due to the lightness of the blades and the absence of a pelvic curve. Even though the forceps are inserted to unequal depths, the sliding lock allows the handles to close. Traction will then complete the rotation anteriorly as in the "single application."

(4). If the head is arrested in or at the inlet, three courses are open; high forceps, version and breech extraction, or Caesarian section.

If there is a disproportion between the head and inlet and the head is floating or dipping, Caesarian section is indicated if undue manipulation has not endangered the patient as a surgical risk.

The application of high forceps is becoming a more discredited operation every day, but in selected cases one is sometimes lucky enough to secure a good application on the occipito-mental diameter and with moderate traction draw the head into the pelvis.

It is then rotated and delivered as described above. The Kielland forceps are invaluable in this manoeuvre, traction downward and backward is aided by a deep episiotomy. If there is no disproportion at the inlet, version and breech extraction serves many cases unsuited

to high forceps. The success of this operation depends on many factors as emphasized by Potter, namely,—patient must be in the lithotomy position in mobile supports—deeply anaesthetized,—catheterized,—perineum well relaxed or incised,—the hand well lubricated with liquid green soap before introduction,—both feet seized at the fundus—slow version performed between contractions—with no jerky movements—delivery of the arms by rotating the shoulders anteriorly when the angle of the scapula shows outside the vulva—then delivery of the head by suprapubic pressure directly backward toward the floor.

A popular method of handling high posterior positions is to insert the hand into the vagina, pass it through the inlet displacing the head—rotating the shoulder manually—then allowing the labor to proceed normally. Since the introduction of the Kielland forceps and the perfection of version and breech extraction, this manoeuvre has lost popularity with many obstetricians due to the added risk of infection,—the necessity of a second anaesthetic, and the difficulty of holding the head and body in the anterior positions.

Flat pelvis which is often found with a posterior lends itself well to a version and breech extraction, and thus many women are delivered who otherwise would be faced with a series of Caesarian sections.

A word about the diagnosis of an occipito-posterior by vaginal examination. This is sometimes difficult due to the obliteration of the fontanelles by caput succedaneum. The depressed occipital bone can generally be differentiated from the frontal by the absence of a suture dividing it. If diagnosis is still in doubt, a hand slipped alongside the head posteriorly will reach the ear and careful manipulation of the meatus and larger freer portion of the auricle will decide the position. If the manual rotation is then done, the hand can be held in position to guide the forcep over the malar bone.

In conclusion, I wish to emphasize the importance of careful pelvimetry and early diagnosis. This is not only in the best interest of the mother and baby, but that the family may be warned and reconciled to a long slow labor.

If instrumental delivery is indicated, study the methods best adapted to the condition, and to your own skill.

The General Medical Council of England at its May half-yearly meeting will deal with the case of Doctor Dorothy Logan, Harley St., London, for a misdemeanour. Last fall Dr. Logan was fined £100 for announcing she had swum the English Channel in record time, which was a premeditated hoax. Presumably the "misdemeanour" is in demonstrating how easy it is to fool people. Why fine her for proving what we all know is true? Then why further discipline by the Medical Council!

The Nova Scotia Medical Bulletin

Official Organ of The Medical Society of Nova Scotia.

Confined to, and Covering every Practising Physician in Nova Scotia.
Published on the 5th of each month. Advertising Forms close on the
20th. of the preceding month. Subscription Price:—\$3.00 per year.

EDITORIAL BOARD.

Editor-in-Chief - - - GEORGE H. MURPHY, M. D., C. M.
Associate Editors - - - S. J. MACLENNAN, B. A., M. D.
H. B. ATLEE, M. D., C. M.
A. BIRT, M. D.
Secretary to Editorial Board - SMITH L. WALKER, B. A., M. D.

VOL. VII.

AUGUST 1928

No. 8

Looking Back

(Guy De Chauliac, A.D., 1300-1370).

IF it be correct to measure a man's genius by his influence on the thought and action of succeeding generations, it would seem that Guy De Chauliac's place is assured. For we are told that his *Chirurgia Magna* was the standard text book in Europe up to the eighteenth century. He is credited with being the first to produce a complete work on surgery. Others wrote on surgical topics before him, as a part of general medical practice, but De Chauliac was a surgical specialist, and wrote and practiced as such. His influence was all against the degradation of surgery by placing operative work in the hands of ignorant men. His example and teaching in this regard must have had an enormous effect. For in point of general and educational attainments, he had few peers in his time. Besides, his position in the church carried the weight of his influence into wide fields, and gave a tinge of authority and eminence to his teaching. He was physician, successively, to Popes Innocent VI, Urban V, and Clement VI, from whom he received various ecclesiastical dignities. He was at Avignon, in 1348, and while here wrote a treatise on the Black Death, which is incorporated in his surgery. Garrison said he clung manfully to his post, while many were deserting, and fought with what skill and science he knew, the terrors of those trying times.

"Fallopian compared De Chauliac to Hippocrates. Friend, in 1725, called him the Prince of Surgery; Malgaigne said that, Hippocrates excepted, there was no book in Greek, Latin or Arabic to be put above, or even on the level with Guy De Chauliac's Surgery. By all, he is regarded as the 'Father of Surgery,' as Hippocrates was the 'Father of Medicine.'"—*Brennan*.

But apart from the scientific merit of his work, surgery owes him much. He made it a fit thing for men of the highest culture to practice. He, himself, was a scholastic, his whole life and career having followed hard on the perfection of scholastic philosophy as taught by Thomas Aquinas and others. He recognized that the healing art was an honest, and even a holy calling, and for them that would make it a cloak to cover up immoral practices, he had nothing but contempt.

His high ethical principles need no better exemplification than is shown in his Introduction to his *Ars Chirurgia*, which may be appropriately quoted here. Perhaps, too, in the spirit of the Scholastic, it might be well for the surgeon to stand aside, from time to time, to look into those principles and motives, which however, unconscious he may be of them, nevertheless govern the work of his brain and hand; for they are rooted deep in the past, and hold up proudly and firmly the beautiful superstructure of the medicine and surgery of our own time.

What the surgeon ought to be, is thus set forth by Guy De Chauliac: "The conditions necessary for the surgeon are four: first, he should be learned; second, he should be expert; third he must be ingenious, and fourth, he should be able to adapt himself. It is required for the first that the surgeon should know not only the principles of surgery, but also those of medicine in theory and practice; for the second, that he should have seen others operate; for the third, that he should be ingenious, of good judgment and memory to recognize conditions; and for the fourth, that he be adaptable and able to accommodate himself to circumstances. Let the surgeon be bold in all sure things, and fearful in dangerous things; let him avoid all faulty treatments and practices. He ought to be gracious to the sick, considerate to his associates, cautious in his prognostications. Let him be modest, dignified, gentle, pitiful and merciful; not covetous nor an extortionist of money; but rather let his reward be according to his work, to the means of the patient, to the quality of the issue, and to his own dignity."

G. H. M.

WHEN OCTOBER COMES.

It is the function of the BULLETIN primarily to serve the profession in this province. Consequently at this early date we desire to remind our medical confreres of the postponed Annual Meeting of the Medical Society of Nova Scotia that takes place in Halifax, in October. Doctors

will recall that the postponement was due to the desire of the profession in the province to help out the C. M. A. meeting in Charlottetown in June. Holding it in Halifax instead of Annapolis as decided last year, is due to two very significant facts. The Dalhousie Medical School celebrates its golden jubilee this year, its 60th anniversary. The Medical Society of Nova Scotia celebrates its 75th anniversary. So we have here two outstanding occasions.

The Refresher Course of Dalhousie comes off in October and it is now being arranged to combine all three functions, and make it a memorable event both in the history of our Society and of the Medical School. The unveiling of a bronze tablet commemorating the founding of the Medical College will be one of the interesting functions of the occasion.

Later on a detailed program will be printed in the BULLETIN, Meanwhile we hope the doctors will keep the matter in mind and plan to be present.

G. H. M.

This is a useful application for ordinary dandruff.—

Salicylic Acid 15 to 30 grains.
Ammoniated Mercury 30 to 60 grains.
Rose Ointment to make one ounce.

It should be applied by parting the hair and rubbing into the scalp lightly from one to three times a week. Shampoo every five or six days with ordinary toilet or a tar soap. (*A. M. A. Journal*).

What is the Order of the Bath? First the water's too hot; then it's too cold; a towel short; you step on the soap, finally the telephone rings!

There is a very general demand that medical education shall be made cheaper. Young men to-day starting to practice medicine cannot go out on their own in some country district because they owe so much money they must secure appointments for the sake of the salary. For years they are handicapped by this debt burden. Yet the demand by the public is for men better trained than ever before. Therefore the medical course can never be made cheaper because it can never be made shorter. So says Dr. Hugh Cabot of Ann Arbor, Michigan.

Fuller Gloom. "There's no much pleasure in smokin', Donald," said Sandy. "Hoo dae ye mak' that oot?" questioned Donald. "Weel if ye're smokin' yer ain bacca, ye're thinkin' o' the awfu' expense, and, if yer smokin' some other body's, ye're pipe's rammed sae tight it wanna draw."

Echoes and Side Lights

The C. M. A. Annual Meeting.

THE BULLETIN reporter of the recent meeting of the C. M. A. in Charlottetown has never yet learned the art of presenting any subject in a strictly orthodox manner. His report in the July number is evidence of this. These few notes will also prove the same thing.

After the close of the Thursday evening Public Meeting, Dr. S. R. Jenkins invited the scribe to his pleasant home for a smoke and a chat. Here he found Dr. John Stewart of Halifax and Dr. R. W. Powell of Ottawa, two of the younger medical men of the Island, Mrs. Jenkins and several members of that charming family. A very pleasant two hours was spent mostly in listening to the older ones in reminiscent vein. The Ottawa representative kept up his end of the conversation, which, he intimated, he had been credited with doing on at least one occasion. Sometime ago he spent a very pleasant holiday with the Dean of the Medical Faculty of Queen's University. After a stay of two and one-half days the Dean finally asked,—“Look here, Powell, do you talk in your sleep?”

Some one spoke of names when one visitor remarked that a very prominent Professor in one of our universities was *named* “Mary Evelyn,” but his disappointed parents christened him—“F. N. G.”

Some time ago a well known Dean of Toronto was required to give evidence at a trial and the examining lawyer tried to trap him, but without success. Finally he asked what was really a nasty question, which the Dean answered by a straight blow to the chin and landed the lawyer on his back. As he picked himself up, the Judge only remarked,—“Proceed.”

Even in Charlottetown the tide goes out leaving quite a stretch of sand bare. They say a Jew visiting there paid the man in charge a quarter and bathed there for the first time, the tide, of course being in. A few hours later he returned and to his surprise seeing nothing but sand, he exclaimed,—“Mein Gott in Himmel! What a business he has been doing!”

We have all heard of the recently married young man forgetting to register his bride at the hotel when on their honeymoon. A glance over the registration book at the recent Medical Convention would

make one think that a recently married Doctor from Nova Scotia had committed the same omission. Even so it would be more excusable than the apparent course followed by a prominent surgeon and a medical Mayor of a large town, who modestly were registered twice for themselves and their wives.

During the week of the Association Meeting the Catholic Hospital Association for the Maritime Provinces held its annual Conference. The topics considered by the Nursing staffs of the Catholic hospitals were practical, a great deal of attention being given to the question of nurse education in the smaller hospitals.

We did hear the remark that the business of the C. M. A. was carried out by a few men from Ontario (Toronto) and Quebec (Montreal), and the remark came from a Maritime man. In the first place it is not a fact, although routine business must be done by local men. All matters of policy are considered by the Council or Executive which is as representative a body as ever characterized any Canadian organization. But the representatives from the West enunciate more new business for Council consideration than that submitted by the representatives mentioned above. They compel a hearing and get it and something more. The East-Quebec stands out and says, Come to us; and the C. M. A. comes. The Maritimes say nothing, they sit back and attend to their own business in very good shape, but have no influence, taking no initiative. Is it because we do not get together?

One of the Charlottetown daily papers, speaking of the Address delivered by Sir Lenthal Cheatele on "Pathological Changes in the Breast and their Clinical Signs," reported thus:—"The chief feature of the morning session was an address by an eminent English Surgeon, Sir Lenthal Cheatele, on "Diseases of the Breath, illustrated by X-Ray". It was suggested by a prominent internist, that the dispensing of Mr. John McNevin must have caused certain perceptions in the brain of the reporter, through his ol-factory sense. But why the X-Ray?

An interesting paper was that presented by Dr. Ross Millar, Director of Medical Services, D.S.C.R., Ottawa, recently of Amherst. He thought medical reports on disabled soldiers should show judgment tinged with sympathy rather than sympathy tinged with judgment. Which reminds us of a report Dr. Millar once sent in himself which raises the question as to its character.—"This man comes in occasion-

ally for more mental than physical comfort. I am afraid he has falling of the brain—into his bowels." Another Cumberland County Doctor reported of a patient as to his disability,—“He says he has leakage of the heart.” As to the probable duration of the disability,—“Till he gets a pension.”

A sectional meeting of the “Federation of Medical Women of Canada” was also held the last day of the meeting, Dr. E. P. Hopgood of the staff of the Nova Scotia Hospital, a native of Prince Edward Island, as President occupied the chair. This, we believe, is the second Annual Meeting of this organization. The officers for the ensuing year include Doctor Mabel Patterson, of Dartmouth, as Vice-President for Nova Scotia. The retiring President was named as Vice-President for Prince Edward Island.

Another section of the Association was duly organized with the approval of the Council. This was the Historical Section, Prof. J. W. Crane of Western University, London, was elected Chairman and Dr. J. H. Elliott of Toronto, Secretary. The object of this section will be the memorialization of the lives and achievements of medical men of the past. The illustrious figures in medical history will be studied and special emphasis will be laid upon the gathering of data on the medical practitioners of Canada. It is interesting to note here that Professor Crane will be one of the speakers at the Dalhousie Refresher Course this fall. His addresses will deal with the value of medical history to the medical practitioner and student.

S. L. W.

Dr. J. W. McKay, Roentgenologist at the Montreal General Hospital, with Mrs. McKay, has been spending his vacation in Nova Scotia, three weeks of the time being a guest at Armdale House, Halifax. Dr. McKay is a son of the late Dr. J. H. McKay of Truro. His mother is at present living in Halifax the guest of Mrs. S. L. Walker, Spring Garden Road. Golf and bathing kept them enjoyably busy during their stay in the city.

No Sae Bad: After going around the strange course the man from Aberdeen said,—“Weel it is a bit rough and I lost four ba’s but it’s no sae bad—I found six.”

Royal College of Surgeons, England

THE Executive of the Medical Society of Nova Scotia, has instructed the Secretary to present to the profession in Nova Scotia, through the pages of the BULLETIN, the latest pronouncement regarding special arrangements for Canadians taking in Canada the Primary Examinations leading to the F. R. C. S. These examinations will be held first in 1929 and we give in full the particulars as published in the C. M. A. Journal, May 1928, page 608. The Secretary will obtain for you any information you desire, or, as noted, you may obtain the same from the C. M. A. General Secretary.—

“ROYAL COLLEGE OF SURGEONS, ENGLAND.

PRIMARY EXAMINATIONS IN CANADA IN 1929.

We are authorized to announce that arrangements have been completed whereby the Royal College of Surgeons, England, will conduct in Canada the Primary Examinations leading to the F. R. C. S.

1. The Canadian Medical Association is the “Appointed Authority” to represent the Royal College in Canada, and to be responsible for the arrangements to be made in Canada, for the conduct of the examinations.
2. The Royal College will send from England, two (2) Examiners in Anatomy and two (2) Examiners in Physiology.

These Examiners shall be present or past members of the Board of Examiners in Anatomy and Physiology for the Fellowship.

3. A Professor of Anatomy and a Professor of Physiology (or such other persons as may be nominated) shall be appointed by the College, from names submitted by the Canadian Medical Association, to act as Assessors to the Examiners.
4. The Examination, written and viva voce, of each candidate in each subject shall be conducted by two English Examiners and one Canadian Assessor.
5. The questions for the written paper in Canada shall be set by the Board of Examiners in Anatomy and Physiology for the Fellowship at the same time as those for the written paper for the June examination in England and shall be taken to Canada by the Examiners sent from England.

6. The written paper examination will be held on the arrival of the Examiners in Canada, and the viva voce examination as soon after as convenient.
7. The result of the examination will be determined and announced by the Examiners in Canada upon completion of the examination.
8. The fee payable by each candidate before admission to examination or re-examination shall be \$100.00, such fees to be collected by the Canadian Medical Association.
9. A candidate desirous of being examined must deliver to the Secretary of the Royal College of Surgeons, Lincoln's Inn Fields, London, W. C., not later than May 1st, 1929, the following certificates:—

1. Of matriculation at a recognized university.
2. Of having completed the examinations in Anatomy and Physiology for degrees in Medicine and Surgery of a recognized university.
3. Of having dissected in a recognized medical school or schools during six terms or eighteen months;

Note—Dissections during the regular vacations will be accepted, provided the certificate shows that they have been performed under the superintendence of an authorized teacher in a recognized medical school.

4. Of having attended in a recognized medical school or schools:—
 - (a) A course of lectures on Anatomy during two terms;
 - (b) A course of lectures on Physiology during two terms;
 - (c) A course of Experimental Physiology;

Note—It is meant that the learners themselves shall, individually, be engaged on the necessary experiments, manipulations, etc., but it is not hereby intended that the learners shall perform vivisections.

- (d) A course of Chemical Physiology.
- (e) A course of Histology.

The first examination will be conducted at Toronto in July or August, 1929, provided the number of applicants warrants that such an examination shall be held.

Subsequent examinations will be held at the discretion of the two organizations concerned, but it is the present opinion that the interval shall be two or perhaps three years.

For further detailed information apply to the General Secretary, Canadian Medical Association, 184 College Street, Toronto 2, Canada."

Co-ordinated Health Work

THREE principal agencies are required to carry on Public Health Work to-day:—

1. **The medical profession**; through its recognized official representation, the Medical Society.
2. **The Department of Public Health**; through its local and provincial officials.
3. **Lay Organizations**; representing that portion of the general public desirous of aiding in improvement of health and the prevention of disease.

Unfortunately these do not always work harmoniously or effectively, and any one playing a lone hand or flying off at a tangent, will block real progress. In this connection attention has been directed to the work of the Milbank Foundation in Cattaraugus County (New York), which has been quoted for the purpose of discrediting lay organizations, engaging in health work. Yet, when you come to look into this individual case, it is found, that the real basis for objections to the work of the foundation is the outside medical men who came in did not meet with the approval of the local men, as regards their methods. We are compelled to admit that this particular instance points rather to a family disagreement, although it has been used as an indictment against the work of lay organizations.

A perusal of the following statement from the Medical Society of Kings County (New York) emphasizes the necessity of co-operation. While we have had this used as a criticism of lay organizations running health campaigns, it is in reality an acknowledgment that some *outside* medical men failed to meet the approval of some *local* medical men in a local health investigation or demonstration.

The following points are emphasized by this particular Medical Society:—

1. The essential part of public health work being preventive medicine there should be no failure on the part of official or unofficial health and welfare organizations to recognize the importance of the local practicing physician.
2. All those associated in the conduct of public health activities must recognize fully that preventive medicine is the doctor's rightful field and that laymen must at all times look to the medical men for guidance and leadership therein.
3. Public health work within a county involves three participating factors: lay organizations, official governmental agencies, and the members of the county medical profession.

4. The evolution of a county health program should be the evolution of medical forces within the county. It is the duty of the local physicians to assume leadership in the organization.
5. The function of lay organizations and employees of the county health organizations, acting under the leadership of the practising physicians of the county, includes assistance in educational work, in helping those who are unable to carry out the doctor's advice, and in providing means whereby the public health program may be carried out.
6. Lay organizations are needed in the county. Their co-operation is to be welcomed by the physicians. They are needed for the great educational work they can do, for their influence on public opinion, legislation and laws, and in many other ways. But preventive medicine must be controlled and guided by the medical men of the country.
7. As the function of the county health officer is not to exercise the function of the physicians of the county but to explain the facilities and stimulate the use of these facilities by the citizens, therefore, before any innovations are put into effect by a demonstration or other agency, they should first be thoroughly studied and discussed by the medical society and the professional membership of the county board of health.
8. All local publicity should be of fact and simply to inform the people of the county of public health work which is being done, why it is being done, and why it should be done.

Regarding the particular case under consideration the Medical Society of the State of New York passed the following Resolution:—

“Resolved, That the House of Delegates of the Medical Society of the State of New York sustains and endorses the protest of the Cattaraugus County Medical Society in its opposition to the Milbank Health Demonstration as at present conducted by the State Charities Aid Association, because it (the Milbank Foundation), has not governed itself either in spirit or practice by the principles laid down by this Society for the conduct of its members in their relation to Public Health work conducted by lay organizations.”

The point, to which attention is especially directed, is that it is not an attack against the co-operation of lay organizations with the profession. It appears rather to be, as intimated, a medical difference of opinion. Perhaps, then, undue significance has been given to it by some parties who have not taken its true inwardness sufficiently to heart

Well now, if you disagree with this, why not speak out.

S. L. W.

Civil Service Positions

THE Executive at a recent meeting considered a communication from the Secretary of the Civil Service Commission relative to positions available for Medical Officers in the North West Territories. While there was no opportunity of giving publicity to this matter while the appointments were open, still the publicity may attract some attention and solicit further inquiries. Besides it intimates that an eligible list may be prepared good for one year. Application forms may be obtained from the BULLETIN or the Civil Service Commission, Ottawa.

MEDICAL OFFICERS, GRADE 1—\$2,520.

14298. Three Medical Officers, Northwest Territories, Grade I, for the Arctic Regions, Department of the Interior, at a salary of \$2,520 per annum.

Duties.—Under direction, to be responsible for the general health and welfare of the Eskimo in an assigned area of Arctic Canada; to diagnose cases and prescribe treatment; to fit eye glasses, extract teeth, perform operations and instruct those engaged in treating and caring for the Eskimo; to instruct the natives on matters pertaining to hygiene and sanitation and to enforce the regulations respecting same; to instruct the natives on game and other laws and to impress upon them the importance of game conservation; to keep the Director informed on all matters affecting the life, customs and condition of the Eskimo; and to perform other related work as required.

Qualifications Required.—Graduation in medicine from a university of recognized standing; at least one year of post-graduate practice; preferably a knowledge of methods of Arctic travel; fitness, physically and temperamentally for life in the Arctic; ability to write reports; administrative and supervisory ability; tact and good judgment. While no definite age limit has been set for this competition, age may be a determining factor in making a selection.

Nature of Examination.—A rating on Education and Experience will be given from the sworn statements, supporting documents and other evidence submitted by applicants. Candidates must give full particulars regarding their technical training and experience, especially as they bear on the qualifications for and duties of this class of position. To those who qualify an oral examination will be given, if necessary in the opinion of the Commission.

A list of eligibles may be established which will be valid for a period of one year.

Although three temporary appointments only are to be made at the present time this examination will qualify for permanent employment. For permanent employment the initial salary of \$2,520 per annum will be increased upon recommendation for efficient service at the rate of \$120 per annum until a maximum of \$3,000 has been reached.

GENERAL DIRECTIONS.

Application forms properly filled in must be filed with the Civil Service Commission, Ottawa, *not later than June 7th, 1928*. Application forms may be obtained from the offices of the Employment Service of Canada, from the Postmasters at Prince Rupert, Vancouver, Victoria, Edmonton, Calgary, Regina, Saskatoon, Winnipeg, Quebec, Fredericton, St. John, Charlottetown, and Halifax, or from the Secretary of the Civil Service Commission.

Candidates must be British subjects, and preference will be given to those who have resided in Canada for at least three years.

According to law, preference is given among candidates possessing the necessary qualifications, first to persons who are in receipt of a pension on account of disabilities received as a result of war service, who by reason of such service are unable to continue their pre-war occupation, and who have not been successfully re-established, and secondly, to persons who have been on active service overseas or on the high seas. The age limit does not apply to such candidates.

Under the provisions of the Civil Service Superannuation Act, 1924, a deduction of 5 per cent. is made from the salary of every permanent employee entering the Service as a contribution to the Superannuation Fund.

By Order of the Commission.

W. FORAN,
Secretary.

Ottawa, May 14, 1928.

Following examination held in June by the Medical Council of Canada the following in Nova Scotia have been successful:—

Dr. J. M. Beadsley, Halifax, N. S.	Dr. C. S. McGill, Shelburne, N. S.
Dr. A. R. Campbell, Yarmouth, N. S.	Dr. C. M. Oke, Halifax, N. S.
Dr. A. E. Doull, Halifax, N. S.	Dr. J. W. Merritt, Springhill, N. S.
Dr. D. MacMillan, Lake Ainslie.	Dr. H. B. Whitman, Dartmouth, N. S.

The Evening News, New Glasgow, sends the following to the BULLETIN:—

Help! Quick!

—A certain West Virginia physician whose practice is confined entirely to the rural section in the southern part of the state is said to be responsible for this urgent appeal for consultory aid from a brother physician in a distant city. Here it is:

Dear Dock—

I got a payshunt whose physical signs shows that the windpipe has ulcerated off and his lungs has dropped down into his stummick. I have give him everything I know of without effect and his father is wealthy and infloeshial as he is a member of the assembly & God nose I don't want to lose him what shall I do ans by return male.

Yours frat
DOCK KENWARNE.

OBITUARY

ANDREW LOVE, M.D., C.M., McGill, 1891, New Glasgow, N. S.

MANY physicians in Nova Scotia felt the loss of a friend when the news was announced that Dr. Andrew Love of New Glasgow had passed away on June 16, 1928. To many it came as a shock and to Dr. John Stewart, who only learned of the sad event after his arrival in Charlottetown to attend the C. M. A. Meeting, it was a great shock. It necessitated his return to the mainland on Monday in order to be present at the funeral. In their desire to pay the tribute of respect to the departed a number were compelled to cancel their proposed attendance upon the medical conference.

Andrew Love was born in Linacy, Pictou Co., Feb. 14, 1865. He was the son of William Love and Mary Faulds, both of whom were born in Scotland. He was in his 64th year.

As intimated above he graduated from McGill in 1891 and his first practice was in Westville and then Bridgeville. In 1903 he settled in and became a prominent citizen of Sydney Mines where he remained until 1916. Here he was in the Town Council for several terms and was Mayor in 1912. Then came the war and in 1916 Dr. Love went Overseas and served in several units, both in England and France.

On his return he settled in New Glasgow where he felt most at home and at once he entered into the full life of the community serving it in many ways.

In the first place he gave of his best in his profession. He commanded the respect and esteem of his fellow practitioners as well as his patients. He was a quick clear thinker and readily grasped the salient features of each difficult case, hence his opinions were of value to his confreres. He had moreover, a charming personality, a most genial disposition, and the ability to inspire hope and confidence in his patients, which means a great deal.

As in former years elsewhere, so in New Glasgow, he actively identified himself in community affairs. He served in the Town Council and was willing to enter the larger field of provincial politics when his party's prospects were not as promising as they subsequently became. With Doctors Day, Whitman and others he actively supported the Boy Scouts and was a tower of strength to the friends of Church Union.

A former school teacher in the school section of Linacy Glen, Pictou County, recalls that in 1877 and 78 out of 33 scholars, two became ministers of the Gospel and two medical doctors. One of the latter was Andrew Love and the other Dr. J. Prescott Grant now a Professor of Surgery in Johns Hopkins. An Editor recalls days spent with him in 1885 at Pictou Academy. The *Bellman* (Rev. John A. McGlashen) writes so kindly and sincerely in *The Chronicle* of Dr. Love, that we cannot refrain from quoting his tribute.

"The Bellman has heard with sincere sorrow the sad announcement of the sudden call of his boyhood and schooldays chum Dr. Andrew Love of New Glasgow. It seems but a brief day since we looked over a common line fence at each other, walked to and from school together, and played and scrapped, learned the same lessons and loved the same girls and boys. And now my dear friend has finished fighting death for others, and has taken the count himself while still a young man.

Dr. Love and I enjoyed the benefit of Pictou schools and the old Academy together. Our ways then parted, and he went into the healing profession via McGill University, while I went to Dalhousie. We graduated the same year, and he took up service in Stellarton, and I—but that's another story.

Dr. Love was gifted by nature with physical as well as intellectual vigor. But his connection with overseas service during the great war left him, as it did many, open to attacks of disease from which otherwise he would have been immune. Another casualty is thus scored up against the barbarity of war.

Dr. Love was a fine type of citizenship. He was gifted with attractive social qualities and had an enthusiasm for life in all its wholesome phases. His fine work among boys and his inspiring influence on the Pictou County Boy Scout movement were characteristic of a nature touched to fine issues. He was the first President of the Pictou County Boy Scout Association, and was Commissioner for the County since 1925 until his death."

To his widow a daughter of Graham Fraser, first President of the Nova Scotia Steel & Coal Company, a daughter, Jean, and a son, Donald, the readers of the BULLETIN will extend sincere sympathy.

**DANIEL ANGUS McAULAY, M.D., C.M., Dalhousie 1910,
Baddeck, N. S.**

The death occurred in Harbor View Hospital, Sydney Mines, June 16th, 1928, after a short illness from septicaemia, of Dr. D. A. McAulay of Baddeck. He was born in Englishtown 44 years ago, being the son of Donald McAulay a retired customs collector of that place. He received his early preliminary college training at the North Sydney Academy. Upon graduating in Medicine from Dalhousie in 1910 he first supplied with the late Dr. Wm. McKay of Reserve, then with Doctor Rockwell at Maccan and River Hebert. He also practised for a time at Neil's Harbor, North Victoria County. He enlisted in the R. A. M. C. in 1914, subsequently transferring to the C. A. M. C. Upon his return from overseas he located at Baddeck.

Besides his father he is survived by three brothers and one sister. His mother died two years ago and a brother, Dr. Phillip McAulay died about ten years ago. Of him the *Sydney Post* states,—

"As a physician he was beloved by all. He was kind, charitable and efficient, his name is a household name throughout the County of Victoria. Many a heart is sad in the Doctor's native county to-day for one of her sons who was always willing and ready to give his best, not for the love of money, but in the service and for the love of his fellow men."

Many confreres of the veteran Dr. Evan Kennedy of New Glasgow, as well as the entire local community, were grieved to learn of the death on June 26th of Mrs. Kennedy, at the advanced age of 83 years.

She was born at Wallace and was a sister of the late Rev. Stephen Heustis, D.D., who died a few months ago. She had been a resident of New Glasgow for over forty years and held a high place in public regard. She was a great reader and evidenced much literary taste and ability, her own poetical efforts being highly regarded.

Of her it was said, "She was ever ready to lend a helping hand to those in sorrow or trouble and her influence always made for the best things in life." Besides her husband she is survived by two daughters and one son, Dr. Walter Kennedy of Calgary. We regret to learn that Dr. Kennedy has not been enjoying the best of health recently. We wish to assure him that at this time he has the sincere sympathy of every member of the Medical Society of Nova Scotia.

The death occurred, June 14th, 1928, at Richmond, Surrey, England of Dr. Lewis G. Hunt at an advanced age. Dr. Hunt was the eldest son of the late Rev. A. S. Hunt, a former superintendent of education for Nova Scotia. He was born in Canning when his father was a minister there to the Baptist Church. His brothers who predeceased him were well known, being, the late Judge Johnston Hunt of Halifax, the late A. S. Hunt, accountant at the Nova Scotia Hospital, and the late Rev. Ralph M. Hunt, D.D. of Boston. One sister, the wife of the late Judge Savary of Annapolis died a few years ago. One sister alone remains of this talented family, in the person of Mrs. Chute, wife of Rev. A. C. Chute D.D. of Wolfville.

Dr. Hunt was one of the oldest graduates of Acadia having received his B.A. sixty years ago. He graduated in Medicine from McGill and later studied in Edinburgh and London. He at once settled in Sheffield and for many years enjoyed a large and responsible practice. At the same time he took an active part in civic affairs. Upon his retirement from active medical practice a number of years ago, he still further concerned himself with local affairs in the town of Richmond, Surrey, filling many local positions with honor to himself and profit to the community. Both in Sheffield and in Richmond his home was visited by many former Canadian friends. The late Dr. John Black of Halifax always visited him when in the Old Country. He made a quite extended trip through Eastern Canada last year spending several weeks in Nova Scotia.

We regret to learn of the death of Lieutenant-Colonel Paul Weatherbe, whose illness was mentioned in our July issue, which occurred at Digby on July 14th, 1928. He was a brother of Dr. Philip Weatherbe of Halifax.

At the great age of 96 years on July 16th, 1928, Mrs. Mary Jane Payzant passed to the rest beyond. She was a woman of sterling merit and well remembered by the older generation. Dr. H. A. Payzant of Dartmouth is a son of the deceased to whom the BULLETIN extends sympathy.

Locals and Personals

MANY of the members of the profession who have known Dr. Murray MacLaren of Saint John, will be interested to know that he is the beneficiary to the extent of one million and a half dollars from the estate of a brother who recently died in England. Doctor MacLaren was the O. C. of No. 1 Canadian General Hospital of which a number of Nova Scotians were on the strength, as Nursing Sisters, or N. C. O's and men.

Born.—To Dr. and Mrs. B. C. Archibald, 5 Prince Street, Glace Bay, Nova Scotia, a son, May 27th, 1928. Congratulations.

It may be remembered that Mrs. Archibald received her B. A. from Dalhousie in 1918, also her LL.B. 1921, and is a niece of Dr. W. B. Moore formerly of Kentville, now living in Bournemouth, England. Dr. Archibald is a Dalhousie graduate of 1921.

A very interesting address was given the Rotarians of Kentville recently by Dr. H. R. Corbett. The exact title of his address being "X-Ray and its place in Modern Medicine." It is an indication of the marked interest the public is taking in the accomplishments of modern medical science that service clubs have addresses of this nature presented to them.

We are glad to know that Dr. Eric MacDonald who was ill for a time in June, a patient in St. Joseph's Hospital, has fully recovered. We trust he has been able to secure some one to supply for him while he takes a much needed vacation.

Among recent visitors to Cape Breton, was Doctor Henry Dixon, of Honolulu, accompanied by Mrs. Dixon, two children and a Japanese maid. It is quite evident, as the *Glace Bay Gazette* news item stated, "he is a physician in a very large and lucrative district of Honolulu." He is a graduate of McGill University and he and his family will spend a considerable time visiting his parents, Mr. and Mrs. Eldridge Dixon, in Louisburg and visiting friends in other portions of Cape Breton.

In the latter part of June Dr. W. J. Barton of Halifax, with his two children, had a narrow escape from death or serious injury when motoring in Digby County, about eight miles from Digby town. The local press also refers to a recent illness of Mrs. Barton.

Dr. M. A. B. Smith, of Dartmouth, attended a very interesting historical gathering in Annapolis Royal, in June. He conveyed greetings to the Annapolis Society from the Historical Society of Nova Scotia, of which he has been for many years a prominent member.

Dr. W. W. Barraclough, Toronto, has been awarded a fellowship by the Rockefeller Foundation and will study at Johns Hopkins and the Boston Psychopathic Hospital. On his return to Toronto he will undertake special investigations in Epilepsy. He practised in Nova Scotia for a time after the Great War.

Dr. Don Campbell, formerly of Halifax, now of Richmond, Virginia, arrived home in June for a short vacation, accompanied by his wife, who is a daughter of William Glassey, of Halifax. The Doctor has returned to his new home leaving Mrs. Campbell here for an extended visit with her parents. He speaks very interestingly of the health work that is now being carried out throughout a number of the Southern States.

The *Sydney Post* gives a partial list of the Cape Breton medical men who attended the meeting in Charlottetown. After stating the Convention to be most successful, the reporter says,—“He also waxed eloquent on the cordial reception accorded the delegates, and how untiring the citizens of Charlottetown were in their efforts to make the brief stay of the visitors an enjoyable one.”

Behind the Man!

Back of every man—back of every family—back of every home, stands the Bank—the guardian of fortunes, the counsellor and friend of those who, realizing the uncertainty of to-morrow, provide for its emergencies out of to-day's sources.

You Will Like Banking At The Royal.

The Royal Bank of Canada

Serving Canada from Sea to Sea.

Dr. W. H. Cole, New Germany, deserted his practice the latter part of June and visited in Liverpool, Milton and vicinity for several weeks. During this holiday, it is creditably stated, he hooked 42 salmon and grilse and was successful in landing 24. This was surely a good vacation.

The marriage was announced to have taken place on July 6th of Miss Gertrude Murray, formerly of Campbellton, N. B., to Mr. F. W. Kirkpatrick of the Canadian Bank of Commerce in New York City. The bridegroom is a son of the late well-known Eye, Ear, Nose and Throat specialist, in Halifax, Dr. E. A. Kirkpatrick.

Dr. Harold Scammel a graduate of Dalhousie in 1927, who has been practising in Pictou for the past year, has been appointed Assistant Medical Superintendent in the Victoria General Hospital. He took up the duties of this position the latter part of June.

Dr. J. Fabian Bates of Glace Bay and Dr. C. J. Sparrow of Reserve, were delegates to the annual meeting of the Canadian Legion held in Saint John in June last.

Summer Boarder:—"But why are those trees bending over so far?"

Farmer:—"You would bend over too, Miss, if you wuz as full of green apples as those trees are."

Dr. T. H. McDonald, now in practice in Somerville, Mass., has been visiting his former home in New Glasgow. It is stated he motored in his Cadillac covering the 575 miles of the home trip in one day. He spent his vacation with his mother and sisters.

On June 27th the Sutherland Memorial Hospital was formally opened and dedicated, with enthusiastic, yet dignified ceremonies. The hospital is beautifully situated on the site of the old marine hospital on Beaches Road. From this position a splendid view of Pictou Harbor is obtained and beauty of surroundings will tend towards restfulness and peace of mind. Those taking part in the opening were, John D. McDonald, Chairman of the finance committee; Hon. J. C. Tory, Lieutenant-Governor; Dr. John Stewart and Dr. K. A. McKenzie of Halifax; Col. Thomas Cantley, M.P. of New Glasgow, and others.

It is a solid brick, fire-proof building consisting of a cellar and three storeys, conveniently divided into a nurses' home in the east end, administration in the centre and patients in the west end. It is now equipped for twenty patients at an initial cost of \$60,000.00. It should serve the needs of the western part of Pictou County for many years. It is again noted that not a single medical man is named on the Hospital Board. We think it time this anomaly ceased.

Ayerst

CAPSULES No. 280

“CALCIUM A”**TONIC NUTRIENT NERVINE**

The therapeutic value of these capsules is now well established in cases where increased calcium and phosphorus assimilation is desired.

They are widely prescribed with marked benefit during pregnancy and lactation and in many cases of neurosis and loss of weight.

Each small capsule contains 275 Vitamin A units with a potent antirachitic content, provisionally known as Vitamin D. This approximates the vitamin potency of one and one-half teaspoonful of cod liver oil of the U. S. P. biological standard. Associated with this is 0.07 Gm. of available calcium and phosphorous salts.

The usual dose is one or two capsules three times daily before meals as directed. Children as young as five or six years of age can take these readily.

Supplied in dispensing boxes of 100 capsules.

A CANADIAN PRODUCT BY

Ayerst, McKenna & Harrison

Limited

Pharmaceutical Chemists

MONTREAL

CANADA

By permission of the Journal of the American Medical Association and with the approval of the author, a copy of Macomber's paper on the "Effect of a Diet Low in Calcium on Fertility, Pregnancy and Lactation in the Rat" will be forwarded to any Canadian physician on request.

The local press announced that Dr. A. M. Marshall, 90½ Gottingen Street, Halifax, left for the Hawaii Islands for several months, to be in charge of a local hospital for that time.

Dr. Ross Collins with his wife (nee Dr. Margaret Chase) arrived home late in June from Syracuse, N. Y., and spent a month in their former homes in Port Williams and vicinity.

Dr. A. S. Burns of Kentville, Dr. C. S. Morton and Dr. T. B. Acker of Halifax, attended the recent Rotary Conference in St. John's, Nfld.

Dr. D. M. Rowlings of Sheet Harbor is taking an indefinite rest from five years of rather hard country practice. We have not been advised as to his successor.

Congratulations are due Harry S. Morton, son of Dr. C. S. Morton of Halifax, upon his success in passing his Primary examinations for his F. R. C. S., London. He received his B.A. from Dalhousie in 1925 and his M.Sc. in 1927. He is at present touring Europe with his mother.

Mr. D'Arcy Sullivan, second eldest son of Dr. and Mrs. M. T. Sullivan, Glace Bay, graduated this Spring from Harvard and has been appointed to a large mercantile business in New York City.

Dr. D. S. Sutherland, Dalhousie 1925, recently located at Seabright and the Head of St. Margaret's Bay, has settled in Chester.

Dr. Victoria Ernst of Bridgewater was recently a patient in the local hospital undergoing operation. We trust she has made a full recovery.

According to the Journal of Organotherapy for June 1928, we are surely progressing:—It is announced that German clinicians hope to "succeed in preparing from urine the hormone which is present in relative abundance in the urine of pregnant women."

Dr. G. W. T. Farrish of Yarmouth, the last of June, took a hurried trip to New York, where he met Mrs. Farrish who, with her daughter had been spending several months in England, was returning home. Miss Maude remained in England for a time.

Last month we noted that Dr. C. W. Bliss of Amherst was the first patient to be operated upon in the temporary quarters occupied by Highland View Hospital after their fire. He is now spending some time convalescing with his son, Dr. Gerald, in Altoona, Pa.

An Open Letter

To the Members of the Professions of Medicine,
Dentistry and Pharmacy and Boards of Directors
of Hospitals.

Gentlemen:

In the Finance Chronicle of Montreal dated March 9th, 1928 is an interesting article upon the common law liability of individuals to the public in the pursuit of their calling and performance of their duties.

Particular reference is made to your liabilities and the risks attached to your duties. We quote:—

“No physician, surgeon, dentist or druggist, however high his standing, is immune from the danger of a patient charging him with malpractice, error or neglect. Such claim or suits are usually without merit and are often brought at the instigation of some “ambulance chasing” lawyer or by patients who attempt by this method to evade paying bills for professional services.”

Instances of these sorts of claims are increasing alarmingly.

It is not necessary for us to cite cases which have arisen in this Province. You are familiar with those which have reached the Courts and know also of some which have been compromised.

It is part of our business to take care of this risk for you, by—

1. Indemnifying you for damages from liability.
2. Defending or settling without expense to you all claims charging breach of your legal liability.

We are prepared to call upon you, whenever you wish to discuss this matter, and further explain our contract. A phone message or a note is all that is necessary.

Yours sincerely,

THOMPSON, ADAMS & CO., Limited

Phone S. 1221.

Insurance Brokers.

166 Hollis St., Halifax, N. S.

Dr. and Mrs. H. L. Roberts, now living in the States, spent a short vacation in July at their former home in Digby.

Should any member of the Society desire a reprint of Dr. Grant's address in the July BULLETIN please drop the Secretary a line.

Mrs. Amyot, wife of Dr. Gregory Amyot of Isle La Cross, Sask., arrived in North Sydney early in July to spend the summer with her parents Dr. and Mrs. Dan McDonald.

Mother:—"Don't mumble your prayers, Helen, I can't hear a word you say."

Helen:—"I wasn't speaking to you, Mummy."

Readers of the July Journal of the Canadian Medical Association were delighted to see Dr. Hattie's name signed to several contributions. What he writes on Medical Education and requirements for registration is worthy of very careful consideration.

Dr. John Stewart of Halifax observed his 80th Birthday at his home 28 South Street, July 3rd, 1928. It was fitting that he should receive letters, telegrams and cables from friends in Canada, the United States, England and Europe, extending him congratulations and good wishes. During the afternoon and evening many friends presented their greetings personally. A number of members of the staff of No. 7 Canadian Stationary Hospital paid their respects to their former Officer Commanding. Through the BULLETIN all members of the profession in Nova Scotia wish to join in extending good wishes.

Born.—At Annapolis Royal July, 12th, 1928 to Mr. and Mrs. Charles Clarke of Tatamagouche, a daughter. Dr. L. B. Braine of Annapolis is thus a grave, but admiring, grandfather.

Upon his return from St. John's, where he attended the Rotary Conference, Dr. A. S. Burns of Kentville was met at Halifax with the unhappy news that his daughter, Evelyn, was a patient in the Victoria General Hospital. We are glad to know she has made a good recovery.

Dr. Garnet Morse, Haney, B. C., accompanied by his wife and family has recently been visiting with his brother, Dr. L. R. Morse, of Lawrencetown. Dr. Morse, has been some time in New York and after a short vacation here will return to his post graduate work there, his family returning to their home in British Columbia.

Born: At Moncton, N. B., July 18th, 1928, to Dr. and Mrs. Charles R. Baxter, a daughter. Dr. Baxter is a Dalhousie graduate of 1925.

THE
LIVER EXTRACTS

ABBOTS—CONNAUGHT Laboratories—STEARNS

We Dispense
Mercks PYRIDIDIUM Tablets
to your patient for \$6.00.

MACLEOD, BALCOM, LIMITED
HALIFAX and BEDFORD'

in Diabetic Diet

Listers

for STARCH FREE FOODS

Listers prepared casein Dietetic Flour is strictly free from starch, selfrising and easily made into a variety of attractive and palatable foods. Recipes are furnished in each carton.

Large Carton **Listers Flour** (enough for 30 bakings) **\$4.85** Small Carton **Listers Flour** (enough for 15 bakings) **\$2.75**

May be purchased from your local druggist or direct from
LISTERS Limited **Huntingdon, Quebec** **CANADA**

The BULLETIN has received the 1927 Report of the Venezuela Gulf Oil Company Hospital at Maracaibo. Besides the usual statistics and returns it has several short articles on subjects of particular interest to men in practice in the tropics. The report was of interest to the BULLETIN as Dr. Arthur J. Walker, McGill 1924, is a member of the medical staff. Just a few days ago Miss Terese Curry, R.N., New York, a daughter of Mr. and Mrs. Curry of Glace Bay, sailed from New York to join the nursing staff of this hospital.

Congratulations are offered to Mr. F. Ronald Hayes who has been awarded a Rockefeller fellowship in Science at the University of Liverpool, England. He is a son of Dr. Joseph and Mrs. Hayes, of Halifax.

Dr. J. W. Merritt, Dalhousie 1928, is locating in Halifax and is occupying the office of the late Dr. McLarren on Barrington Street.

Dr. B. E. Goodwin of Amherst has removed his office from Crescent Avenue and is now located at 170 Victoria Street, East.

The marriage took place on July 7th, 1928, of Miss Dorothy Trenholm of Amherst to Mr. Percy Siddal of Southampton, Cumb. Co. Part of their honeymoon was spent in Maitland, Hants County, where they were the guests of Dr. A. M. Siddal, brother of the groom.

Dr. William McDonald, Dalhousie 1925, formerly of Truro, Nova Scotia, now resident in West Virginia, accompanied by Mrs. McDonald, spent the July vacation visiting relations in Truro.

On the evening of July 14th there was an informal reunion of a number of Dalhousie graduates at a dinner in the Isle Royale Hotel, Sydney, which was followed by a social evening at the Cape Breton Yacht Club.

Dr. "Bert" Corbett of the staff of the Nova Scotia Sanatorium, is Acting Secretary of the Kentville Rotary Club.

The announcement is made of the engagement of Dr. A. F. Miller, Superintendent of the Nova Scotia Sanatorium to Miss Lyla Proctor, daughter of Mr. and Mrs. L. J. Proctor, Henry St., Halifax. It is stated the wedding will take place at an early date.

Following the C. M. A. meeting in Charlottetown, Dr. G. Harvey Agnew of Toronto, Associate-Secretary of the C. M. A. visited most of the hospitals in the Maritime Provinces. The Hospital Section of the C. M. A. promises to be of great value to our smaller institutions.

Born: At Yarmouth, Nova Scotia, July 14th, 1928, to Dr. and Mrs. A. R. Campbell, a son.

Nova Scotia Nursery

1086-1090 Barrington St., Halifax, N. S.

Telephones: Nurseries, Lorne, 2358 and 2359 Residence, Lorne, 2890

Plants and Cut Flowers
Floral Designs a Specialty

Long Distance Phone Orders Solicited.

Even in the Glorious Summer Time the NOVA SCOTIA NURSERY may be of Service to you in Decorations for Parties, Dinners, Teas and Weddings.

in cystitis and pyelitis

TRADE **PYRIDIDIUM** MARK

Phenyl - azo - alpha - alpha - diamino - pyridine hydrochlorides. Manufactured by the Pyridium Co., Ltd.

For oral administration in the specific treatment of genito-urinary and gynecological affections.

Sole distributors in Canada

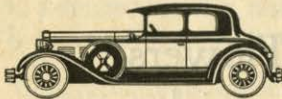
MERCK & CO. INC. Montreal

412 St. Sulpice St.



DR COLLECTEM

Why not a new car
this year, Doctor?



The Medical Audit Association will
bring you in the money—by collecting
your past-due accounts.

Mail us your list To-day!

THE MEDICAL AUDIT ASSOCIATION
44 Victoria Street, Toronto

Homewood Sanitarium GUELPH, Ontario



Nervous cases including Hysteria, Neurasthenia and Psychasthenia.

Mild and incipient mental cases.

Selected habit cases will be taken on advice of physician.

For rate and information, write

Harvey Clare, M. D.
Medical Superintendent

PROPHYLACTIC POLLEN EXTRACTS

in a New Package

Group 1

GRASSES
(Bio. 360)

Group 2

CHENOPODS
(Bio. 362)

Group 3

RAGWEEDS
(Bio. 364)

Group 4

WORMWOODS
(Bio. 366)

THERE are five or more different pollens in each group, but the atmospherically prevailing pollen predominates—in group 1, timothy; in group 2, Russian thistle; in group 3, the common and giant ragweed; and in group 4, mugwort.

The glycerin extracts retain their activity throughout the season, and every package is dated. Complete course, \$9.00.

For Diagnosis. The same groups are supplied for diagnosis in glycerin-boric acid paste form, in small collapsible tubes, singly (at 75c each) or in a package containing all four of the groups (at \$2.00). *Single pollen extracts* in tubes can also be had.

Complete directions for use are given in the circulars accompanying the packages and in our booklet on Pollen Extracts in Hay Fever

PARKE, DAVIS & COMPANY

CERVICITIS and ENDOCERVICITIS

do not cause acute pain but by reason of extension of the infection by way of the lymphatics into the parametrium there is often considerable sensation of weight and bearing down in the pelvis. In these conditions it is surprising what relief can be given by the insertion of the Antiphlogistine tampon, which, on account of its marked hygroscopic property, induces an abundant serous transudation.

Antiphlogistine

with its 45% c.p. glycerin, is ideally adapted for the vaginal tampon, combining as it does, the much needed mechanical support with the *prolonged* glycerin action. Leading obstetricians and gynecologists generally concede its practical value in all those cases where prompt depletion is a paramount consideration.

Antiphlogistine is antiseptic, non-irritating and by virtue of its thermogenetic potency may be relied upon to maintain moist heat longer than any similar preparation now available to the medical profession.



Analysis

C. P. Glycerine.....	45.000 %	Essence of Menthol..	0.002 %
Iodine.....	0.01 %	Ess. of Gaultheria..	0.002 %
Boric Acid.....	0.1 %	Ess. of Eucalyptus..	0.002 %
Salicylic Acid.....	0.02 %	Mineral Clay.....	54.864 %



SAL LITHOFOS

AN IDEAL
EFFERVESCENT
SALINE
LAXATIVE

Indicated in the treatment of
Rheumatism, Gout and Lumbago.

THE WINGATE CHEMICAL CO. LIMITED
468 St. Paul St. W., Montreal

Nonspecific Protein Therapy is most safely and dependably realized by **AOLAN**

a lactalbumin suspension, free of bacteria and of bacterial toxins
therefore *producing no by-effects.*

Aolan is indicated in all forms of infection.

SUPPLIED: Ampules of 1 cc; 5 cc; 10 cc;
25 cc; 50 cc;
in boxes of 1's and 5's.

Please ask for free trial quantities and literature.

MALLINCKRODT CHEMICAL WORKS, LTD.
468 St. Paul Street West. - Montreal