WHERE will you find another man to match the average doctor? He lives the true altruistic life, devoting himself unreservedly to others. His skill and time are yours on the shortest notice, in the blackest hour of night and in the worst weather. His devoted unselfishness, ready sympathy and healthy good humor but increase his gray hairs.

—Hon. Alton B. Parker.

The Abdominal Problem

George H. Murphy M. D., C. M., Halifax, N. S.

(Being an Address delivered before the Western Counties Medical Society at Yarmouth May 26, 1925, and the Eastern Counties Medical Society at Antigonish October 6th, 1925).

THE paper you have been kind enough to ask me to give at this meeting I have named the Abdominal Problem. I take this title rather as a heading to write under than as a subject to be discussed and completed in one short address. For it is a big subject. So much of past and current literature is devoted to this subject that you may well ask "why pick so much on the abdomen, and is there anything new to say?" Well, first, the abdomen is often with all our modern methods, a good deal a mystery; and taking the lid off to see what is kicking up the fuss may be considered, in the main, a reproof to that diagnostic acumen which we like to think is a mark of modern medicine. And, second, while there may be nothing new to say one finds after a good many years of clinical experience and during the process of endeavouring to lead students along the network passages of the Diagnostic Art that problems are approached in a way which in time takes on an individuality. Becoming part of ones being, then, he goes about his work doing good or ill, according to the soundness of his judgment, and with the assistance of that subtle sixth sense which comes only with what is called experience. A not too dependable entity this sixth sense, but about the rugged facts of clinical evidence it spreads a light which often brings hidden things into relief, reveals connections in the pathological chain, and gives unity and finality to the clinical picture. The old observers in our profession with only their own mental resources to guide them found the abdomen's "construction on the face," and hence the facies hippocraticae comes to us not only as a real diagnostic entity, but as a voice out of an inspiring past to examine the whole picture and examine it fully. The background may help you to interpret the real parts of the picture. No part is too significant to seek and observe; for in the study of abdominal conditions, one sometimes finds the clue to a definite diagnosis turning on what at first seemed an important bit of clinical evidence.

The background in the picture of the acute abdomen is the patient's past clinical history. He who has developed a correct and definite faculty of taking a history is far on the way to becoming a good diag-

nostician. Let it be granted then that we are face to face with an acute abdominal condition. What of the history? If this be the first time the patient has had an illness which can even remotely, be linked up with the abdomen then our starting point is right here; and we seek and interpret the evidence as it appears freshly from the exact time the patient is first conscious of trouble. If there be a past history we must hie back through the weeks, months or years until we find where pathology first crossed the threshold of normal health. In the language then of Sherlock Holmes's famed associate, Dr. Watson, we set about making observations. The furniture and all household equipments are just as they were when the criminal entered and committed the assault. The finger and foot-rpints are fresh. There are signs of a struggle and perhaps the weapons used are found nearby. There is no evidence of any defensive measure anticipating the attack; and the victim has not yet had time to build up defence work, to barricade his doors and put bars on his windows.

Or perhaps there has been no real assault up to the present. The criminal has been stealthily entering the household, destroying valuables, and generally upsetting the integrity and comfort of the home. In the language of the clinician, has there been previous attack of acute abdominal symptoms pain, nausea, vomiting, tenderness, rigidity of muscles, constipation, etc? Get the history well. If an acute attack, and a first one, very likely you will be able to make a definite diagnosis of the patient's first abdominal experience. The symptoms at this stage are likely to be of the classical type and order. They are not yet masked or distorted by peritoneal abhesions or by the changes an abdominal organ and its near neighbours may undergo from repeated attacks. You are seeing not as through a glass darkly, but face to face. You are on the top of the elevation where normality and pathology have met, and you build your observatory here. Is the last attack the same as the first? If not, it is essentially the same, the symptoms having been modified somewhat by resulting organic changes and adhesions?

I have seen more than one case of appendicitis where frequent micturition and deep seated pain in the loin were early symptoms. The question of differential diagnosis with a renal ureteral condition had, of course, to be considered. A previous attack of appendicitis when these symptoms were absent would suggest the appendix as the guilty one; unless, of course, you can adduce positive evidence of involvment of the right renal tract. The variation in the symptoms may be due to the formation of dense adhesions from previous inflammation in a long sub-caecal appendix which has practically buried itself into the retro-peritoneal tissue at or near the ureter. Symptoms of gall bladder disease may be simulated in much the same way, when the appendix long, retro caecal and retro colic, extends to the liver region. I have seen cases of appendical abscess arising from the perforated tip of an appendix so placed which defied differentiation clinically

from an acute gall bladder. The history of a previous attack, when such is obtainable, will often help materially, through the symptomatic clarity incidental to first attacks, to throw light on the picture.

We must tighten up the confines of the pathological territory when we begin to search. Obviously the seat of what is called the acute abdomen will most frequently be found within the peritoneum between the under surface of the diaphragm and the bottom of the pelvis. Consequently our maximum efforts are generally concerned with solving the problems contained therein. Acute abdominal symptoms may be stimulated by conditions lying outside the boundaries of this region. I find it convenient therefore to enquire (1) is the trouble above or below the diaphragm? (2) if below, is it within or without the peritoneum? In adults the difficulty of differentiating between acute pleuropulmonary and pericardial conditions and those that lie below in the abdominal viscera is not great. But in children it is not so easy, and may sometimes be well nigh impossible. An acute pleuro pneumonia with involvment of the disphragmatic pleura, particularly on the right side, may be very hard to distinguish from acute appendicitis. If there is much lung involvment the stethescope and X-Ray may give you the necessary evidence. But if the pleura is alone involved you may get little or no evidence from these two agents, particularly in the first day of the attack, and even later. And these are the hours when the importance of diagnosis is paramount. If the child has a supra diaphragmatic inflammation with reflex abdominal pain and rigidity of right rectus one finds as a rule that the thoracic symptoms predominate. Pain, vomiting, constipation, a certain amount of stiffness of the abdominal muscles and tenderness may be common to both. But in the pleuritic condition the face is flushed, temperature is high, respiration increased considerably (most significant when child is sleeping) pulse rapid and full; and the tongue has a more swollen brownish appearance than one should find in acute appendicitis. The presence of herpes on the lips, and a small raspy cough are of course, very diagnostic. The knees may be drawn up in both conditions, and one should not attach too much importance to this sign. The leucocyte count is likely to be much higher in a pleuritis than in an appendicitis. But with all those signs I submit that unless one is able to discover a definite lung or pleura lesion he should not rule out the appendix. Besides, the two may co-exist. And a pneumococcus appendicitis is a close cousin of a similar infection above the diaphragm. I get my best information from a thorough examination of the abdomen. It cannot be done in a hurry. Sitting by the bedside for perhaps half an hour gently palpating the abdomen may give one much information. The right rectus has a secret to tell and with patience and tact you may coax it away. It is the staunch and faithful protector of the delicate and highly-sensitive peritoneum, and if this organ is not being attacked it is likely to relax the vigil it has temporarily taken on in sympathy with a remote organ and thus give the

information away. Muscle hardness is more significant than pain or localized tenderness. One finds much diversity in individual susceptibility to pain. Doubtless most patients with an acute appendicitis or a strangulated hernia or a perforation of the stomach will suffer severe pain. But the exception may puzzle one. Recently I had a lumberman in my service at the Victoria General Hospital sent in from the woods with a strangulated femoral hernia. With the other signs of strangulation present he had practically no pain, even from the beginning of the attack twenty-four hours before. The loop of strangulated small bowel revealed at operation, was in a border line condition as regards the question of returning it to the abdomen. Two years ago I saw a middle age man three hours after a perforation of the pylorus. His knees were drawn up, abdomen scaphoid and as rigid as a board. He said he had some pain when the attack started, but was comfortable now. He had had no morphine. A history of fifteen years of gastric ulcer and a clinical picture he presented made a diagnosis of perforation inevitable, even in the absence of severe pain. I had great difficulty in convincing him and members of his household that his condition called for immediate operation. He refused to have an ambulance called and drove to the hospital in his son's car. When I turned from the telephone where I had been giving instructions for preparations at the hospital and saw him walk out and down the path to his gate without assistance, I had an uneasy sense of being on the wrong track. The operation an hour afterwards disclosed a perforation in the pylorus which was leaking fast. Already there were puddles of stomach contents in the peritoneal fossae, and a large one in the bottom of the pelvis. The upper peritoneum had that angry, irritated look, which once seen is never forgotten and which is the usual phenomenon when an irritating chemical substance breaks its bonds and runs amuck in the ungarded peritoneal cavity. I take this case from a number of acute perforations of the stomach because it illustrates the observation that, while severe pain is the rule, it may not always be a marked symptom even in perforations; and that in all acute conditions of the peritoneum it is less diagnostic and less reliable then the reflex process which throws a part or the whole of the abdominal musculature on guard. Let me emphasize then palpation—careful, patient, prolonged palpation.

The rectal examination, never to be ignored when differential diagnosis is at stake, I find particularly valuable. In a child in determining the presence or absence of appendicitis, the examining index finger can readily reach the right iliac region. A mass can easily be detected and tenderness noted. As between an acute appendicitis and a right sided diaphragmatic inflammation the rectal examination frequently clears the issue at once. I think one should say right here that no search for pathology within the abdomen is complete without a rectal examination. In chronic abdominal conditions I am sure it is routine with you all. Not so well observed in acute conditions,

although the need may be much greater. Chronic conditions in the abdomen offer the doctor much scope for speculation and arm chair cogitations. He can carry the evidence of his clinical investigation home with him; and, while the patient is being therapeutically beguiled with a perfectly harmless mixture, he has time to work out the diagnosis. The laboratory man and the X-ray man come in with their findings, and the doctor sifts out the evidence and delivers the judgment. All of which is to the good; perfectly scientific and practical, and suggests the ample resources of our profession. The patient's life is not immediately at stake, and reasonable leisure in arriving at conclusions may be a real diagnostic asset.

The essential difference in the acute abdomen is that time is our remorseless enemy, and we must beat him to it. Without early diagnosis, then, a proper surgical action at its heels many of our acute abdominal patients will die. It is an enormous responsibility to bear, and an appaling disaster when a life is lost because we failed to grasp the gravity of the situation at the proper time. The problem of the acute abdomen is largely the problem of early diagnosis.

With all that has been spoken and written on the subject I think the appendix still may lay claim to the greatest number of disasters. It is by far, the most frequent acute abdominal ailment. It is, too, the most curable of them all. Until some better means come the inflammed appendix should be removed at once. To let it go on waiting for resolution is, to say the least, a precarious business. Unless there be an operative contra indication of great magnitude, it should not be done. And I think it may be said of the practitioners in Nova Scotia that they act on this principle. How are we to diagnose appendicitis early? There is a dictum to the effect that given an acute abdomen and the clinical evidence is not diagnostic of any condition in particular, you are safe in calling it appendicitis. There are many reasons why the symptoms of appendicitis may be erratic, I have already mentioned some of them. Never lose sight of the fact that it is not a real organ, but a tail which may vary much in length; may hang down into the pelvis; may reach across the middle line; may curl up under the caecum; may attach itself to the omentum and be pulled about with the ebb and flow of entra abdominal pressure; may bury its tip into the retroperitoneal tissue and becoming inflammed there, set up a real and most serious cellulitis in this region. Its inherent powers of mischief are very great, and it setms to me there is no end to the pathological vagaries of an inflammed appendix. The surgeon is the only one that can know the real pathology of the appendix, because he sees it in action. He sees it in its favorite role of infecting other organs. He sees it in its relation to its neighbours, which is as good an observation in pathology as it is in sociology.

Between the ages of 2 and 70 a history of acute abdominal pain, vomiting (or nausea without vomiting) slight rise in temperature and pulse, constipation, tenderness and some muscle hardness about

the McBurney region means appendicitis. Where these symptoms are present and coming in order there is hardly any room for error. Your evidence is positive and the diagnosis certain. With a clear cut type of case one should control the situation. Yet even here are causalities, and the trouble is due to two fallacies that may lurk in a reasonably good procedure (1) that you have about 36 hours within which to operate, and (2) that the beginning of the attack coincides with the beginning of the symptoms. We know that the appendix may ulcerate and open into the peritoneum without any symptoms up to that point which arouses the patient's fears. Hence the very first symptoms the doctor may find, perhaps an hour after the "beginning" of the attack may lead him into the error of diagnosing an acute appendicitis with the usual 24 hours or so of safety in which to operate. I had a very striking example lately of this kind. A college professor with a history of attacks of "indigestion" felt a little abdominal discomfort during the afternoon while attending to his work. He thought it was one of his usual attacks coming on and took the precaution of easing up on his regular evening meal. That evening he was seized with severe abdominal pain, vomiting, slight temperature, some increase in pulse and localized tenderness about McBurney's. He was seen by a physician who diagnozed acute appendicitis; and, feeling there was still a few hours of safety, gave him morphia, and decided to wait the developments of the night. The morning picture showed a very hard abdomen, particularly the lower half, and a very sick man. He was operated on at once. The appendix was found without an adhesion and a large sloughed out perforation. He had a stormy time, but he came through. I think the moral is sufficiently clear (1) be sure that you are at the beginning of the attack before you put your marks down; and (2) after being quite certain on the point, just assume that you might be mistaken and operate right away. Leave the 24 hours grace as a consolation balm for those cases that, owing to extraneous causes, cannot reach the operating table earlier.

The differential diagnosis of acute appendicitis from acute pelvic conditions in the female may present difficulties. Frequently operative urgency is common to both, so the patient's interests are safe whatever the daignosis be. On at least two occasions I recall operating for acute appendicitis and finding a right sided ovarian cyst (Goose egg size) rotated on its pedicle, free fluid in peritoneal cavity and local redness of peritoneum. The mistake is most likely to be made, I think, where the strangulation of the ovarian pedicle is not complete. Where the strangulation is complete, the symptoms are more violently abrupt and localize themselves earlier than in acute appendicitis. I find the following observation always useful in differentiating between the acute appendix and acute pelvis: When a patient tells me the pain began in her right side, and either has remained there or spread over the abdomen, and I find on close questioning that there was no initial

pain about the unbilicus; in other words, that the pain did not start about the middle of the abdomen and "spread" to the side, I assume that this is not appendicitis until I have proven it is nothing else. The pain of a pregnant tube, congested overy, salpingitis, stone in right ureter, right pyelitis, usually proclaims its location when the patient first becomes conscious of it. The occasional pain of a chromic appendix, (kinked concretion or adhesions) is felt primarily in the vicinity of right illiac fossa, but in the acute condition the rule that it is felt just about the middle and settles secondarily about McBurney's, is pretty reliable. When a pregnant tube has ruptured and there is a large hemorrhage the diagnosis should be easy enough. Pregnancy of the uterus or tube is essentially concerned with the genital tract, and you will generally find some suggestive sign or symptom associated with the function of this tract. A missed period is of value only in a patient whose menstruation has been previously regular; and uterine discharge is not always present in a pregnant tube. This should be remembered before ruling out tubal pregnancy. Free blood in the peritoneal cavity does not throw the muscle of the abdominal wall into the same degree of rigidity as obtains where there is a real peritonitis, or where a perforated stomach or bowel is pouring out its irritating contents. For the patient's interest no great harm comes where, under exceptional symptomatology, one is unable to decide between an acute appendix, twisted ovarian cyst and an ectopic. Each condition beckons the surgeon into the abdomen; and, while we aim at perfection in diagnosis, we must not stand by to await further evidence when action is the urgent call. My own greatest trouble has been to differentiate between a tubal and a uterine pregnancy. Given a uterine pregnancy with some pre-existing damage to a fallopian tube, and an abortion threatening and you may have a clinical picture which will be hard to interpret. Considerable pain may be present to the right or left of the uterus. Inability to decide between the two is a reasonable indication to "wait and see." If uterine, the evidence will soon be conclusive and the danger of waiting and watching for a few days is not particularly great in the early stages of an ectopic.

Intestinal obstruction is a common enough cause of the acute abdomen. Early operation is imperative. There may be local evidence of the condition as where a loop of bowel or bit of omentum is caught in a hernial opening. Indeed no examination of an acute abdomen is complete without thorough examination of the hernial sites. The absence of a lump in or about the inguinal and femoral canals is no guarantee that a strangulated hernia does not exist. The finger should be worked well up through the external ring. It is not easy to do this in the case of the femoral ring; but, if a small knuckle of bowel or omentum is caught here you will detect local tenderness. The presence of abdominal scars suggest either a strangulation in a badly healed wound or from adhesions within the peritoneum. Remember even the most perfect operator leaves behind him when he finishes

his operation, enough trauma of the peritoneum to produce a crop of adhesions. And there is a most striking difference in the capacity of individuals for forming adhesions. In some patients they are absorbed readily after serving doubtless, a useful purpose. In others they persist indefinitely forming sometimes pockets or nests into which coils of intestine may become herniated and strangulated. I need hardly say, of course, that adhesions may also exist where there has been no previous operation. Other causes of internal strangulation may be due to rents in the messentery and herination into the foramen of Winslow, volvolus, etc.

Another role of adhesions in the abdomen is to mix up pretty badly our text books description of gastric and duodenal perforations. As an ulcer reaches to or near the peritomeal coat adhesions may form about the area. The omentum with almost conscious precision may take a big part in the barrier, and by and by when the ulcer breaks the peritoneal coat and stomach contents begin to sieve through, the classical symptoms of acute perforation are not present. Instead, there ise vidence of localization. Later, pyrogenic organisms enter the area and a real localized abscess results. I saw one such case a few years ago which had been diagnosed as an appendical abscess. The leak had worked down through a block of adhesions from the duodenum, and in the manner indicated went on to suppuration, forming a swelling under the right rectus well down the abdomen. The operative technique here is important and difficult; for soiling of general peritoneum is hard to avoid. Carefully getting into the abscess cavity, cleaning out and packing with gauze is about as much as one has any right to attempt. A subsequent operation may be called for when the field is rendered surgically clean.

Acute intestinal obstruction has its vagaries like most things in the abdomen. It seems strange that an annular carcinoma of the colon can go on and produce no symptoms until complete obstruction occurs. Unless there is twisting of the bowels at the site of growth there is no strangulation at first, and hence there is no severe pain then. Gradual distension, nausea, obstinate constipation, and finally severe pain. At the cancer age a patient with symptoms like this probably has cancer of the colon. If he gives a history of loss of weight, indigestion, constipation, etc., the evidence is strong, but its absence does not negative the probability of cancer.

Besides perforation of pelvic ulcers the upper abdomen gives us the problems of acute or chronic gall bladder conditions and acute or chronic pancreatitis. My impression is, that few clinicians go wrong on acute disease of the gall bladder. The signs and symptoms are pretty definite, and the text book descriptions are pretty well sustained and satisfactory. The chronic gall bladder like the chronic appendix opens up a vista of diagnostic speculations which I cannot touch here.

The presence of sudden violent epigastric pain, with shock, feeble pulse, sub-normal temperature, persistent vomiting, tenderness

over epigastrium, and, altogether, illness out of proportion to what you might expect from any other acute abdomenal condition, probably means acute pancreatitis.

No phrase of surgery call for more resource than abdominal injuries. It is a time of trial in one's professional life. If ever there is an occasion when one suspects the shortcomings of Design in not providing a peep hole commanding a view of the intra peritoneal contents it is just on such an occasion. The injuries naturally divide for clinical purposes in those (1) that perforate the abdominal wall, and (2) those that are not perforating. The latter belong to wounds by bullets, knives or such like. How should we deal with such cases? If one sees the case shortly after the wound has been inflicted and there is no reason to doubt that the bullet, or knife, or whatever the instrument was, has passed through the peritoneum, then exploratory laporatory is the rational precedure. It is surely playing a frenzied game with the gods of chance to stand off, and hope that, in some way, the closed up ranks of abdominal viscera have broken and side-stepped and ducked in order to let the invading weapon pass by. This rule should stand regardless of the symptoms at this time; for, unless there be a marked hemorrhage, the evidence of a severe visceral leison during the first two hours or so, may be vague and uncertain. If the case is seen first after from five to ten hours from the infliction of the wound, when there is time for symptoms to develop such as peritonitis, dullness in the flanks, muscle rigidity, tenderness, pulse and temperature, the question of operation should then, I think, be judged largely on the clinical picture, with operation at hand if you cannot negative the wounding of a hollow viscus.

When there is no perforating wound of the abdominal wall, the call on one's judgment is greater still. One should study carefully the exact nature of the blow, or crushing, or whatever the traumatic agent may have been. The liver and spleen are the ones most exposed to injury. Hemorrhage and shock are the early outstanding symptoms. When there is crushing, such as a heavy waggon passing over the abdomen, these organs can hardly escape injury. The kidneys and bladder, too, may be contused or ruptured. Each of us will approach the problem in his own way I suppose. Personally, I seek to eliminate if I can, the renal tract from the field of investigation. Catheterization of the patient will show reasonably well the condition of the bladder. It reveals good evidence too of the condition of the kidneys, taken with careful palpation of the loins. In other respects, the procedure is much the same as in the perforating wounds. If you are in doubt and the condition of the patient will warrant the extra trauma of an operation, it is probably true that his best interests lie in that direction. The presence of dullness in the flanks from hemorrhage is not in itself an indication for laporatory. Here again the time which has elapsed from the infliction of the injury is a big factor in determining the course you should pursue.

Three years ago a man was brought into the Victoria General suffering from profound shock, from which he died shortly after admission. He had sustained a blow on the abdomen from a piece of timber. The autopsy showed a piece of liver nearly as large as a fist, completely broken off and lying loose in the peritoneal cavity. There was but slight signs of injury to the abdominal wall itself.

In conclusion, let me apply the Hippocratic Aphorism to most acute abdominal disorders: "In acute diseases it is not quite safe to prognosticate either death or recovery."

As To Health

(An Editorial from The Spectator, Annapolis Royal,

IS it wise to believe the diagnosis of a physician? Of course if one does not do so and does not take the treatment prescribed, the disease may prove fatal. But if, on the other hand, where doctors differ as to diagnosis, or where a patient is told that his trouble is incurable, the question arises as to whether the life of the patient may not be shortened because of his belief as to his incurability and his abandoning of any hope of a cure. Would he not have been better off if he had not known that he was regarded as incurable? Suppose, for instance, a castaway on an island who comes to realize that he has some disease. His knowledge as to physiology is limited and he has no means of obtaining advice. Under the circumstances he does the best he can for himself, absolute cleanliness, abundant sleep, all the sunshine and sea air possible, all the exercise he can stand and the simplest food procurable, with copious drinking of water. Is it not reasonable to suppose that with such a simple life and continuance of work with an object, perhaps in building a boat to leave his island, he may become cured of his trouble without drugs or physician's medicines. Is it not possible that the same thing in lesser degree happens with the working man who cannot afford to consult specialists, but who says to himself: "Well, if I die, I die, but I might as well drop in my tracks as trying to mollycoddle myself." Take the thousands of cases of delicate young fellows who have gone to sea in the apparently hopeless endeavour to strengthen their constitution. Far removed from any doctoring more serious than a ship's medicine-chest which is

at the mercy of an ignorant captain, the young men after a drastic course of being seasick and being driven to work their human limit, find on reaching port again, that much to their surprise, they had forgotten they ever were delicate. The records of the ocean life show that ninety per cent. or more of those who have undertaken it have found that hard living, hard fare and hard work (such as used to be in the sailing-vessels at least) have resulted in hardy constitutions good for eighty years at least of useful life. Look, however, at those who have paid the most for physicians' treatment, and in many cases one will find that if by the drive of grinding poverty and those dependent upon them, they had had to work from early morn till late at night, they would have been better off. One seems then to be forced to conclude that no disease is beyond the possibility of a cure. One has to realize that many people have become well and strong after their cases had been abandoned by physicians as beyond all hope—and that also in this twentieth century the march of science may any day discover something hitherto undreamed of which may prove an absolute cure for something previously deemed hopeless. While it may be perfectly right therefore that a physician should tell a patient that in all human probability his days are numbered to so many, it would seem to be always the part of wisdom of the patient to reason that his blood pressure or hardening arteries or internal thing-a-bob-ism, or whatever it is that ails him, may be cured, and that a simple life, clear conscience and steady work may with long continued patience do the trick.

Prevention of Cancer.

(New York American).

Proof that the complete costume of modern woman, including dress, stockings, shoes and underwear, may weigh as little as 24 ounces causes the virtuous to grieve. But, even as woman in her changing moods cuts off her dress at top and bottom, may be comfort. The low-necked dress is partially justified by this fact, to which your doctor will testify. Cancer attacks women more often than men, and cancer of the breast, dreadfully frequent in civilized countries is quite unknown among female savages that wear no clothing above the waist. Sunshine seems to keep cancer away.

Presidential Address

Ferguson R. Little, M. D., C. M., Halifax.

(At the Annual Inaugural Meeting of the Halifax Branch of the Medical Society of Nova Scotia, Carleton Hotel, Nov. 4th, 1925).

Ladies and Gentleman:

Allow me first to express to you my deep appreciation of the honor of presiding at this, the annual meeting of the Halifax Medical Society. There are others far more worthy of this honor and certainly more capable than myself of fulfilling the duties of this position. Whilst realizing the great privilege of delivering the presidential address on such an occasion as this, one cannot truthfully say that it is an unbounded pleasure. I resemble, not in features, but in feelings, Tennyson's beautiful bride of Burleigh when:

> "A trouble weighed upon her
> And oppressed her night and morn
> With the burden of an honour
> Unto which she was not born."

Selecting a subject for the annual address has proved by no means an easy task, but it has had to be faced, and I have selected as my topic, to the discussion of which, I bespeak your kind indulgence—The role of the General Practitioner.

The General Practitioner travels no primrose path. His is a long and difficult course. His medical training as you know, requires six, and in some colleges seven, years before its completion. And the prescribed course is not itself faultless; I am not alone in thinking that the average student leaves college with a smattering knowledge of many subjects and has really mastered but few. The time is ripe for a change in the prescribed curriculum. The course should be planned with a view to the requirements of the student whose aim is that, not of the specialist in some particular branch of medicine or surgery, but of the General Practitioner. One of the first duties of the medical school, if not indeed the supreme duty, is to train men to do efficiently the ordinary work of the family doctor. The program now placed before the student also calls for revision from the standpoint of its too strenuous nature. The long hours of study involved, make heavy demands upon the physical and mental energies of the student, encroaching upon the time which should be devoted to bodily exercise and sleep, with the result that in many instances when the time for graduation comes, the unfortunate victim of the rigorous system is too frequently a nervous and physical wreck.

The high cost of medical education which is anywhere between six and seven thousand dollars is a giant obstacle in the way of many gifted and ambitious young men of the rural districts. Young men drawn from the "country stock," if one may use that phrase, have not infrequently in the past, proved themselves to be among the best general practitioners the profession has ever known. It will be a most unfortunate thing if the physicians of the future are to be recruited exclusively from one class.

Once graduated, the young man, with a real love for his calling, will find the medical profession most alluring and attractive and this in spite of the fact that his work will be both hard and exacting in its demands. Devoted to his profession, and with all the ardour, optimism, and energy of youth, he flings himself unreservedly into his work, and it is no exaggeration to say that many Doctors shorten their lives or become prematurely aged, just by reason of the tremendous over-work of their earlier years in the profession. Work, of course, is just as essential to the growth, well-being and development of the medical man, as invigorating breezes are to the vegetable world, but over-work is like a tornado which strips leaves, breaks branches and uproots the most sturdy trees—the same breeze which helps the growth of a tree in June has power to denude it of its leaves in October.

The amount of labor that braces and invigorates a man of thirty has power to incapacitate, paralyze or kill him at fifty. Each of you can doubtless recall many examples of the dire results of over-work in the profession. Indeed there are some even in this gathering to-night. Overwork has strewn the trail of the profession through the years with many victims. Splendid men have perished as drug addicts, others carry on—the depressed and nervous slave of cocaine or morphia. Still others, bound and burdened by the remorseless pressure of over-work, seem urged by some inner impulse to indulge in occasional reckless sprees—feeling this necessary to preserve their sanity. The exacting toll made by over-work in the medical profession, is one of its most tragic stories.

The general practitioner has to be prepared to sacrifice, in large measure, his home life. He is everybody's servant. He is expected to respond promptly and cheerfully to the beckoning call of anybody and everybody in the community. He can make no appointments or engagements with his family, because of the uncertainty of the calls that may be made upon him. The health, indeed the very lives of his family are constantly in danger from infection which he may unwittingly convey to the home. His own health, too, is always at stake. You remember, perhaps, those lines of Shakespeare:

> "By medicine life may be prolonged,
> Yet death will seize the Doctor too."

Those who study the art of prolonging the lives of others are themselves liable to die early. This is confirmed both by statistics and

experience. Rest and recreation, the broadening vision that comes from travel, the pleasure that is to be derived from books, music and the drama, are just as essential to his well-being as to that of others, but only on rare occasions does he get the opportunity to enjoy these much needed diversions.

Ingratitude is another cross the practitioner must carry. How quickly patients forget! How often, gentlemen, have you attended a patient over a period of years and have given of your best in time, in skill and in service without any reward, and then discover that a new Doctor has been called in. Could anything be more ungrateful? The public, one thinks, needs to be reminded of the old rhyme:

"God and the Doctor we alike adore
But only when in danger, not before;
The danger o'er, both are alike requited;
God is forgotten, and the Doctor slighted."

The assertion is sometimes made that the day of the General Practitioner is past, that he is disappearing, and that the once familiar figure of the family doctor is fast fading from our community life, and that he no longer fills the place in the popular imagination, nor enjoys the same hold upon the public, that his predecessors did. In these later years the specialist has leapt to the center of the stage and stood out prominently in the limelight. We now have specialists of all kinds, brands, and varieties:—Eye, Ear, Nose, Throat, Heart Specialists, Lung Specialists, X-Ray Specialists, Child Specialists, Stomach Specialists, Nerve Specialists, Urologists, etc., etc. But without any intention, or the least desire to minimise the importance of these various specialists in all these numerous branches of medicine, I respectfully submit that after due consideration, and in the last analysis, the General Practitioner is the chief anchor and main stay in the entire realm of medicine.

You may not all see eye to eye with me. Every man has the right to express his own opinion, and as the old saying puts it—"Who shall decide, when Doctors disagree?" It is however, no exaggeration to say that at least 90% of the people look to the General Practitioner for advice, guidance and help. Not more than 10% come directly into the hands of the Specialist. This percentage, as a general rule, is composed of just two classes—either the very rich or the poor who meet the Specialist in various hospitals and clinics. The vast majority depend upon the skill, efficiency, and integrity of the General Practitioner, and it should be obvious that he must be thoroughly qualified to diagnose and treat them in the broadest way. As a matter of fact a competent and well-trained General Practitioner is, and should be, qualified to do much of the work which is now largely done solely by the Specialist.

The General Practitioner who does not maintain his studies, who neglects his reading, and does not keep abreast of the times, pays the inevitable penalty of his own neglect and dilatoriness—he begins

to lose faith in himself. He loses confidence in his own ability to diagnose, and consequently takes the easiest path of passing his patient over to the advice and care of the Specialist. Because of this, far too many General Practitioners simply become, shall I say, "advance agents" for the Specialist. The economic aspect of this should not be overlooked. After treating a patient for a considerable period of time, and receiving the usual fee, the General Practitioner then turns the case over to the Specialist for advice and operation, and the Specialist generally draws a full fee for the services performed. In many instances the General Practitioner overlooks the fact that most Specialists only look through the glasses of their own specialty. To quote Shakespeare again: "As is your sort of mind, so is your search—you'll find just what you're looking for." Now, if the General Practitioner is efficient, well-equipped, and up to date, he need not turn over to the Specialist any, except the most unusua, lcases that he meets with in the course of his practice. He will thus earn for himself, a reward for healing which at present he all too frequently hands over to the Specialist. Let me say, however, that of course the General Practitioner is expected to, and must, diagnose early and he should not regard the Specialist merely in the light of being a last resort. The chief ideal to be aimed at is careful and early diagnosis.

Another thorn in the side of the General Practitioner is that he has to submit to all kinds of advertising schemes. To my mind it is gravely open to question, whether such schemes, promoted with unbounded publicity, such as "Tuberculosis Week," and "Cancer Week," etc., are in the best interests either of the public or the General Practitioner. In fact, a serious menace may quite easily lurk in these extensively advertised schemes. Every physician is well aware of the tremendous influence exerted by the mind over the body. A study of psychology has made that abundantly clear. It is a commonplace fact. During these special weeks, the attention of the public is drawn, caught and concentrated upon the subject of Tuberculosis, Cancer, etc. The nervous, or the more sensitively susceptible person, reads long lists of symptoms of one or other of these diseases, is warned of their wide prevalence, and told harrowing stories of sufferers—pictured sometimes with a wealth of lurid details. The unfortunate thing is that whilst it may be a good thing for the public to be warned of the stealthy, insidious and unsuspected approach and development of Tuberculosis, and Cancer, the good that might be accomplished is oft times offset by the conduct of some few unscrupulous Specialists who are quick to take advantage of the opportunity afforded them by the wide-spread publicity which these "special weeks" have given to their own chosen specialty. This, of course, works out detrimentally to the interests of the General Practitioner. For instance, I might mention the effect that "cancer week" has had on the public. Many persons, since this scheme was inaugurated, the moment they discover any kind of a Mass or Tumor, even though it be a simple Tumor such as:

Adenoma, Fibroma, Lipoma, etc., instead of consulting the General Practitioner, go direct to the Specialist, sometimes paying stiff if not exorbitant fees for a simple treatment which they could have received equally well at the hands of the General Practitioner. And in making this statement I am not drawing on my imagination, but am stating facts encountered in my own experience. I submit therefore, that any good that may have been accomplished by these "special weeks" has been largely neutralized by the conduct and methods of unscrupulous so-called Specialists. Not only the General Practitioner, but the medical profession as a whole, suffers from the willful misrepresentation, plausible trickery, and commercialized roguery of the heartless and unscrupulous Specialist. We will agree, I am sure, with the terse saying of a leading New York physician who recently declared that "Quack doctors are smart ducks who should become jail-birds."

I think perhaps, I have said sufficient to indicate what a difficult role is that which the General Practitioner is called upon to play. He is called upon to face a man's job, and if he is to achieve success in his chosen line he must face it in a manly way. We need opposition in order to develop our higher possibilities. Difficulties are stepping-stones in the pilgrimage of life, and the wise man recognizes them as such. The greatest assets of the Medical Practitioner are character, painstaking devotion to duty, and a constant desire of personal improvement. Can any Practitioner set himself a higher standard than this:—

> "To live as gently as I can,
> To be, no matter where, a man;
> To take what comes of good or ill;
> To cling to faith and honour still;
> To do my best, and let that stand
> The record of my brain and hand."

The development of personality should be a constant aim of the General Practitioner. Personal magnetism is undoubtedly the secret of the success which has been characteristic of the careers of the most outstanding men in the Medical Profession. I do not believe that this "attractive something" which we call Personality is a mysterious magical secret which can only be gained by the very few; it can be attained by all earnestly prepared to study it. Personal magnetism is a science. It may be reduced to a few workable laws and made a real factor in the life of each one of us. Personality does not mean an attempt to be "impressive." "Fuss and feathers" belong to the pompous and the superficial. Personality is never developed along these lines. Kindness of heart, love of humanity, naturalness of demeanor and thoughtful consideration for others—these are always and everywhere the chief characteristics of the magnetic man. Deal carelessly with no man. Respect man, and you will command the respect of men. There is no science after all like the science of the knowledge of human nature. An exercise of these qualities just named-will go far to secure the success of the General Practitioner and enable

that particular branch of the Medical Profession to retain its hold on the confidence of the public.

You need no reminding, gentlemen, that ours is a great and noble calling. Apply the question of "service" to the profession of medicine. Is there any profession in which it is so easy to realize and to idealize as service, as a contribution to the needs of others? To relieve pain, to remove sores, to heal infirmities, to lengthen life, to increase the sum of working power and happiness—these are the gifts in its right hand. And among those who have devoted their lives to this high calling, not the least entitled to a foremost place of honor is the General Practitioner.

Lecturer, Specialist, or the General Practitioner—each man has his part to play and his place to fill. And the supremely important thing is that each should do his honest best, and no man can do more.

Let me in conclusion, quote the following verses which firmly set forth a worthy ambition for us all:—

Let's play it out—this little game called life
Where we are listed for so brief a spell;
Not just to win, amid the tumult rife,
Or where acclaim and gay applauses swell;
Nor just to conquer where some one must lose,
Or reach the goal whatever be the cost;
For there are other, better ways to choose,
Though in the end the battle may be lost.

Let's play it out as if it were a sport
Wherein the game is better than the goal,
And never mind the detailed "score's" report
Of errors made, if each with dauntless soul
But stick it out until the day is done,
Not wasting fairness for success or fame,
So when the battle has been lost or won,
The world at least can say: "He played the game."

The Canadian Me/dical Association

Dr T. C. Routley, Toronto.

FREQUENTLY, and in many parts of Canada, medical practitioners have been heard to ask this question, "Why should I join the Canadian Medical Association?" During the next few months, we shall endeavour from time to time, to present answers to this inquiry.

Historians record three interesting events which happened in the year 1867, namely,—Confederation in the Dominion of Canada, the Canadian Medical Association was founded, and the German states, more than twenty in number, banded themselves together as the German Republic under the rule of Prussia, later becoming the German Empire. During the past half century, the bonds of union in Canada have been cemented and strengthened, linking all the provinces together in nationhood. The German Empire, on the other hand, solidly united for world power and destruction of civilization, presents to-day a sorry plight. The Canadian Medical Association has gone quietly on its way, sometimes being held together by a slender thread, finally emerging from the after-war period with a depleted treasury, heavy financial obligations, and little other than a healthy spirit carried in the breasts of some few hundred idealists who proclaimed that the Canadian Medical Association must go forward. To-day, we number in our ranks 3,000 members, an increase of approximately 100% in the last few years.

Government bodies, both Federal and Provincial, recognize that the Canadian Medical Association speaks for Medicine in Canada. Licensing bodies, medical faculties, and Boards of Health are willing to turn to the Canadian Medical Association for leadership in conference. This was most wonderfully exemplified by the Conference which took place last year in the House of Commons, Ottawa, under the egis of the Minister of Health for Canada.

It is not always easy to present tangible reasons for membership in any organization, to the individual who asks not, "What can I put into this?" but, "What am I going to get out of it?" When the medical profession of Canada, in large numbers, recognize their privilege of putting much into their national organization, much will be returned, not only to them but to others.

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 20th of each month. Advertising Forms close on the 5th of month of issue. Subscription Price:—$3.00 per year.

Editor:—S. L. WALKER, B. A., M. D.

VOL. IV. DECEMBER 1925 NO. 12

The Bulletin—Watch it Grow

ON January first, 1922, the first "Bulletin" of the Medical Society of Nova Scotia was issued to all the doctors in the province. It was merely a small four paged circular announcing the action of the 1921 Organization Committee. A similar circular outling the business of the Society for 1922 appeared February 1st. 1922. Bulletin No. 3 was similar to number two and contained the report of the above committee and is dated March 30th, 1922.

The next is entitled "Volume 1. Number 4" and its 46 pages gave full accounts of Executive and Annual Meetings, as held at Sydney in July and it appeared in September. Number 5 appeared in December of that year, and contained the full minutes of the October meeting of the Executive.

Volume II for 1923 has five numbers with an average of 36 pages. Volume III for 1924 had eleven numbers averaging 40 pages. At the July 1924 Annual Meeting, it was decided to continue the publication of the Bulletin and to solicit advertising to assist in defraying the cost of publication. From the first there has never been any difficulty in finding material for local interest, to fill the average of 40 pages of each number, but each issue cost about $130.00 without any revenue, an impossible burden to 219 members of the profession out of 385 physicians actually in practice.

Advertisements first appeared in the 1925 January issue and by July first the revenue was about sufficient to pay one-half the cost of publishing. During the entire year the advertisements have been of the highest quality, and we trust has been a good investment in each instance. Already our Advertising Agency is soliciting new advertisements for 1926 and they expect a much larger revenue from this source for 1926.

The January issue, 1926, Volume V, Number I, will present the plans for the year which will undoubtedly result in a larger and better publication. The 1924 Bulletin was good, the 1925 Bulletin was better and the 1926 will be still better.

Just one word to the doctor who is reading these lines. What have you done to make the Bulletin better each year? Have you sent in any news notes or case reports? Have you boosted the Bulletin in your local Society? Are you a member of the Medical Society of Nova Scotia or are you one of the 175 who are not giving any service to the profession at large. If the Society has three hundred members it can easily meet all its obligations and be of much greater service to the people of Nova Scotia.

Next month will give you another opportunity to make your membership effective. Put both money and energy into the Society in 1926.

Health and Citizenship.

AN article, "Health in relation to Citizenship (Journal A. M. A.) is editorially commented upon as follows in the October C. M. A. Journal:—

"J. A. Ferrell, in an article, "Health in relation to citizenship" (Jour. Am. Med. Assoc., August 15th, 1925) urges the necessity for full time officers in the public health departments in rural communities and insists that the cost of such service should be borne not only by the rural community but in part by the state and by the adjoining towns on an equitable basis. In support of this doctrine he enunciates the following principles: Public Health is one of the most important of general community interests: community funds wisely used for health service will yield large returns. The scope of any health service in a community will vary with its special problems, its resources and its public conscience; but in all cases should include basic activities, and call for the employment of a well rounded unit of trained fulltime men. While rural communities are seldom able to finance such a department, it should be remembered that urban communities are dependent in great measure on their outlying country districts for food, raw materials and markets, and should render assistance. A high standard of sanitation in any country develops a high type of citizen with a full measure of prosperity and happiness arising from an education in health matters and the inculcation of good health habits. Our profession should insist that every rural child in every country should have equal privileges with the city child, both in education and sanitation.

When a second conference on our National Medical Services meets we commend the problems connected with an improved sanitary organization throughout the rural districts of the Dominion to the attention of those in office, as one of the most important subjects to be discussed."

ASSOCIATION NOTES.

THERE are approximately 9,000 doctors in Canada. At the present time, 3,000 of this number are members of the Canadian Medical Association. This, too, represents a gain of 22% over 1924. These figures suggest a few observations:—

Thirty-three and one-third per cent. of the medical population of Canada are carrying the load which should be shared by all. One Doctor in three is putting his shoulder to the wheel, while two others stand by. To wit, the following conversation:—

"Are the Doctors of Canada organized nationally?"

"O, yes, we have a Canadian Medical Association."

"Do you publish a medical Journal?"

"Yes, the Canadian Medical Association Journal, which, by the way, ranks quite highly compared with any other medical Journal in the world."

"Does your Association take any interest in Medical Education?"

"Yes, indeed, from every point of view,—both undergraduate and post-graduate. We are vitally interested in not only producing the best type of Doctor, but in keeping him up to date while he carries on with his practice."

"Are there ever occasions in which you find it necessary to protect the interests of the medical profession?"

"Yes, we have, during the last few years, had under advisement with the Federal Government, such questions as Income Tax, education of chiropractors, replacement of medical supervisors in D. S. C. R. Hospitals by laymen, the hospital care of Indians who are wards of the Government, and like problems."

"Are you doing anything to increase respect for the profession by the general public?"

"Yes, by addresses and printed articles, we have done a great deal, especially during the past year or two, to get our view point properly before the public."

"No doubt with such worthy objects, the Association is backed up by the majority of the profession."

"Well, no, we all admit that it is a splendid organization, very much needed in the country, has real possibilities,—but, two out of three of us are content to let the minority carry the load, financially and otherwise."

"I suppose you belong yourself."

"Well....., I have not, up to the present, but from now on, I intend to be a member."

"By the way,—I suppose it costs considerable to belong to the Association."

"Well, it costs $10.00 a year. I used to think this a bit stiff, but, really, when you come to think of it, it is not quite three cents a day. For that assessment there are so many things I can help to do

that I do not know of any better three-cent daily investment to which I can direct my energy and my finances."

"I suppose if the two-thirds who are not in, all have a change of of hearts during the coming year, the Association will be swamped with the support at its disposal."

"Well, I presume that it has bucked the line for so long with a limited amount of support, that it would take the risk of getting the whole hundred per cent in at one time."

"Here's good luck to you and your Association!"

The leading article in the January issue of the Bulletin, will be from the facile pen of Dr. W. H. Hattie, dealing with "Medicine in early Acadian Days." Perhaps this may be the early chapters of a book which will sum up all available information as to the history of medicine in Nova Scotia.

Also in the next issue will be found the paper read by Dr. C. J. Fox of Pubnico before the recent meeting of the Western Nova Scotia Association entitled,—"Some Early Professional Recollections."

Suggesting that a doctor should not ask his consulting patient what he complains of, lest the answer be,—"Why doctor that's what I came ot have you find out," Dr. F. N. G. Starr says the question should be,—"How does your trouble affect you?" Once, however, he got a rebuff, when a farmer with cowhide coat, cap and muffler replied to the query,—"I ain't going to tell you a derned thing." Dr. Starr told him he should see a specialist and gave him the address of a well-known veterinary surgeon. Upon his return and complaining, that the Specialist was a "horse doctor," Dr. Starr's retort that he was an Ass and needed a horse doctor, was quite sufficient to remove his disinclination to talk for at least an hour.

Opium and Narcotic Drugs Act

Halifax, N. S.
November 24, 1925,

Dr. Smith L. Walker,
Assoc. Sec'y., Medical Society of Nova Scotia,
Metropole Building,
Halifax, N. S.

Dear Sir:

At a meeting of the Provincial Medical Board held on the 19th November, I was instructed to request that the following be published in an early issue of the Nova Scotia Medical Bulletin:

The Federal Department of Health, which has been entrusted with the administration of the Opium and Narcotic Drugs Act, has on a few occasions notified the Board of violations of the Act by some members of the medical profession in Nova Scotia. The number of such complaints has been small, and the great majority of the profession remain free from criticism in this particular. The Board, nevertheless, feels that an offence against this Act really amounts to "infamous professional conduct", and might properly be dealt with as such. In the sincere hope that no necessity may arise for drastic action on the part of the Board, the physicians of Nova Scotia are reminded of the existence of the Act referred to, and are earnestly requested to comply fully with its requirements.

Yours very truly,

(Signed) W. H. HATTIE,
Secretary and Registrar.

Not So Bad.

"Mirandy, why yo' all name dat chile Opium?"

"Cause, they say opium comes from de wild poppy, and dis chile's poppy sho' am wild."

Western Nova Scotia Medical Association

THE Western Nova Scotia Medical Society met for its fall session in the Board of Trade Chamber, Yarmouth, on Tuesday, November 3rd, at 2 P. M. with the President Dr. C. A. Webster in the chair. After the reading of the minutes and the disposal of the regular and special business, the President called upon Dr. E. V. Hogan, surgeon to the Victoria General Hospital, Halifax, and President of the Nova Scotia Medical Society, to contribute his paper.

Dr. Hogan's paper was entitled "Surgical Technique and Procedure" and dealt with the preparation of patient, the hospital and surgical routine procedure, and the experience gleaned from 25 years surgical experience on the staff of the Victoria General Hospital, Halifax, Dr. Hogan then discussed the pitfalls in diagnosing acute abdominal conditions and dwelt at some length on the differential diagnostic symptoms one met in acute abdominal diseases. Dr. Hogan particularly emphasized the question of drainage (Inter and extra Peritoneal) and made passing reference to the choice of Anaesthetist, and duration of stay in hospital, both before and after operation.

Following Dr. Hogan's very appropriate paper, a general discussion followed in which Drs. A. R. Campbell, Webster, Farrish, Fuller, LeBlanc, Williamson and Melanson joined. Many points of practical importance were made and Doctors Campbell and Webster particularly emphasized their success with Mercurochrome as an antiseptic. After Dr. Hogan's concluding remarks, a vote of thanks was unanimously passed thanking him for coming to Yarmouth and complimenting him on his practical and thoroughly-enjoyed paper.

The second paper was contributed by Dr. C. J. Cox of Pubnico and was entitled "Some early Professional Recollections" and covered the period of active practice through which he had passed from 1876 when he first went to Pubnico until the present time. Dr. Fox is still in active practice. In a few months he will have completed his 50th year as a general practitioner. Dr. Fox's paper is appearing in another part of this issue of the Bulletin, and will be read with keen interest by your readers. Following the paper, a hearty vote of thanks was tendered Dr. Hogan and Dr. Fox for their splendid contributions to the programme.

A committee composed of Dr. A. R. Campbell and Dr. C. J. Fox was appointed to set a date for the meetings of the Society in the

future. Their report was discussed and it was moved by Dr. DeWolf, and seconded by Dr. Harris, that the Western Nova Scotia Medical Society hold three meetings per annum, and that the executive arrange all details regarding the business and scientific programme.

Dr. Webster from the Chair thanked the physicians who attended the meeting and spoke about the next meeting in May. Dr. Hogan on behalf of the Nova Scotia Medical Society, congratulated the Western Nova Scotia Medical Society on the progress being made, and assured them of the closest co-operation from the parent society.

EXTRAORDINARY TO SAY THE LEAST

A Nova Scotia newspaper publishes the following:—

> "Leeds.—Doctors in Leed Infirmary have just dealt with what they themselves describe as their most amazing case. A man entered the hospital and calmly announced that he had broken his neck. He explained that he was Charles A. Coates, 53, a farm labourer, employed at Loscoe Farm, Normanton. He had fallen off a haystack, a distance of 15 feet. He got on the train at Normanton, arrived at Leeds Station, and thence walked to the Infirmary. Coates had told nobody of the occurrence, and when he entered the Infirmary his head was hanging on one side and only partly supported by the bones and spinal cord. His head was restored to its normal position by the use of a plaster cast. The vertebrae bones were smashed, and had they come into contact with the spinal cord, the man would undoubtedly have lost his life."

Cancer in Canada.

STATISTICS of disease are necessary and convey definite information which must be heeded. This is particularly true of infectious diseases including Tuberculosis, but frequently true in the case of Cancer. Recently some Canadian statistics on Cancer have been prepared which should constitute a warning to the medical profession. The original article appeared in the Public Health Journal of June 1925 and was editorially mentioned in the C. M. A. Journal of September.

The statistics refer to 16 Canadian cities with a population in 1921 of 2,200,000 and cover a period of 15 years. In 20 years up to 1924, deaths from cancer increased in the first decade at the rate of 14.5

OBITUARY

FREDERICK DANIEL PARKER, M. D., C. M., McGill 1913, Oceanside, California.

As a result of falling off a train, Dr. F. D. Parker, a Nova Scotian, died Nov. 29th, 1925. A Wolfville despatch to the Chronicle gives the following particulars,—

> Dr. Fred Parker was a son of the late William F. Parker, well-known as a member of the Bar of Nova Scotia, who practiced in Halifax until failing health compelled his retirement, following which he removed to Wolfville, where he died a few years ago. The paternal grandfather of Dr. Fred Parker was the late Hon. Dr. D. McN. Parker. His mother, now deceased, was a daughter of the late Prof. Weldon, of McMaster University, Toronto.
>
> Dr. Fred Parker was a graduate of the Medical School of McGill University. He practiced his profession for some time in Needham, Mass., afterwards going to Brookline, Mass., and subsequently removed to Oceanside, California, where he was practicing at the time of his death.
>
> Dr. Parker is survived by his wife, daughter of the late Dr. W. B. Boggs, a missionary to India; by a young daughter, and by two brothers—Arthur of Wolfville; and Allan, of Toronto.
>
> Mrs. MacCallum Grant, of Halifax; Mrs. Kierstead, of Toronto; and Miss Fannie Parker, of Wolfville, are aunts of the deceased."

The death occurred at Mahone Bay on December 6th, 1925, of Mrs. Anna Louisa Gray, aged 79 years. Mrs. Gray was the widow of the late Dr. Charles Gray of Mahone Bay, who was accidentally killed by being thrown from his waggon 28 years ago, while on his way to visit a patient.

The death occurred at Goshen, Guysboro County, on November 25th, of Mrs. James A. Sinclair, after a long illness. She was a woman of strong Christian character and greatly esteemed by all who knew her. Dr. George A. McIntosh of the Victoria General Hospital Staff, is a brother of the deceased.

The death occurred in Vancouver, November 21st, of the wife of Dr. Hugh L. Dickie of that city. Mrs. Dickie was a sister of Louis Trenaman of Halifax, and was a daughter of the la e Dr. Thomas Trenaman of Halifax who died in 1914.

The death occurred in Pugwash late in October of a very estimable lady in the person of Mrs. Catherine L. Pears. She was a daughter of the late Dr. Daniel MacDonald of Tatamagouche. Dr. J. A. Munro of Amherst is a nephew of the deceased.

PERSONALS

October 29th, 1925, to Dr. and Mrs. H. C. S. Elliott, in Halifax, a son.

Dr. Wm. J. McDonald, Dalhousie 1925, formerly of Truro, has now settled at Elmsdale, N. S.

Mrs. Chute, wife of Dr. F. F. Chute of Canning, was recently a patient in the Victoria General Hospital, Halifax.

Dr. M. G. Tompkins of Dominion, attended the October meeting of the American College of Surgeons and received a Fellowship.

Dr. R. S. Gass who has been an interne at Aberdeen Hospital, New Glasgow, is removing to the new town of Corner Brook, Nfld.

Dr. A. J. Fuller of Yarmouth, accompanied by Mrs. Fuller, spent November in New York, receiving special treatment for his failing sight.

Dr. A. F. Miller of the Nova Scotia Sanatorium, returned the latter part of November from a visit of some weeks in the New England States.

Dr. M. A. MacAulay of Halifax, has been sick for a number of weeks, and on December 5th, left for New York and Boston for further advice or treatment.

Dr. K. P. Hayes, Dal. 25', supplied for Dr. J. S. Munro at Neil's Harbor, for the month of November, and will supply for Dr. L. W. Johnston, Sydney Mines after Christmas.

Miss Hildred Young, daughter of Dr. M. R. and Mrs. Young of Pictou, has entered the Toronto General Hospital Training School for nurses.

Literary Societies still flourish in many places in Nova Scotia, Canning, N. S. has had one for a number of years. At a recent meeting Dr. H. N. Gosse was the speaker, his subject being "Evolution and Religion."

Dr. C. B. Trites of Bridgewater, spent a few weeks recently in New York. The local press called it a vacation. It was probably such a vacation that many doctors take, and use to get some further brushing up to enable them to give the people better service.

Dr. M. D. Morrison of Halifax, presented a most interesting paper before the Nova Scotia Historical Society, December 4th, on the migration of Scots from St. Ann's to New Zealand, under the leadership of Norman McLeod, between the years 1851 and 1860.

Dr. Charles S. Morton of Halifax, with Mrs. Morton, returned home December 1st. From New York they travelled by steamer to San Francisco, returning by rail via Detroit, Toronto, and Montreal. The doctor states he has fully recovered from the effects of his recent serious illness.

The many friends of Dr. John W. McKay of New Glasgow, regretted to learn of his very serious illness the latter part of November. They will be glad to know that he is now convalescing, although his hand will be disabled for some time. His son, Dr. Hugh McKay, returned to his post-graduate work early in December.

Dr. D. J. Hartigan, New Waterford, was married November 25th, 1925 to Miss Catherine Phalen of Port Morien. The bride was a recent graduate of St. Joseph's Hospital Training School. A wedding breakfast at the Glebe House followed the ceremony, and the bridal part motored to the Strait where they took the train for the United States. The honeymoon is being spent in Washington and other cities. Congratulations.

St. Martha's Hospital, Antigonish, during the year ending September 30th, 1925, admitted 1425 patients. 1220 were discharged as cured, and 146 improved. Eliminating deaths from chronic diseases, and those occurring within 24 hours of admission, the death-rate was one and one-fourteenth per cent. 760 surgical operations were performed with a death rate of one and one-half per cent. Average stay of patients in hospital was 15 days, giving a total 22,223 hospital days' treatment.

Dr. Evan Kennedy of New Glasgow, on December 3rd was seriously injured by an engine. He was returning from Aberdeen Hospital and walked under the long bars of the railway crossing signal directly into the engine. He was at once taken to Dr. Bell's office, close at hand, and then to the hospital. Besides the severe shock he had several ribs broken. While considering his age, his recovery may be slow, his many professional friends will hope it will be complete. Dr. Kennedy was a graduate of the University of Boston in 1876, and has practiced continuously in New Glasgow.

The Editor of the Truro News, has made some references recently to persons from that town who have figured in Dalhousie University foot-ball matters. Mention is made particularly of doctors who have

Captained the Dalhousie team. Dr. J. L. Cock of Halifax, formerly of Truro, is stated by one correspondent to have been the last "Medico" Captain. This was for the year 1901-02. A correspondent signing himself "1910" includes two more Truro men as piloting the Tigers to victory, namely,—Dr. S. G. McKenzie of Westville, formerly of Truro, and Dr. Joseph W. McKay of Truro. The correspondent states that perhaps "Seymour and Joe" would object to this publicity The Associate-Secretary would add to these notes, that Dr. S. L. Walker formerly of Truro, played on the Acasia College team in the first Intercollegiate Rugby Foot-ball game in Nova Scotia against Dalhousie. Evidently Truro Medicos were foot-ballers as well as cricketers and curlers in the olden days.

A change has recently been made in the administration of the affairs of the Nova Scotia Sanatorium, by the appointment of Mr. E. H. Munro as Business Manager. Mr. Munro was formerly Chief Engineer at the Sanatorium, installing its lighting system, also supplying light for the town of Kentville. More recently he was Town Manager, Clerk and Treasurer and Vender for Kentville. It may be a little hard to appreciate the amount of business required to run such an institution as the Nova Scotia Sanatorium. That Dr. A. F. Miller, despite physical handicaps, has been such a successful general Superintendent, is really marvellous. The success, however, of the new method depends wholly upon the co-operation of the medical and business heads, it is a partnership in one business only, that of caring for the sick.

THE CANADIAN MEDICAL ASSOCIATION

President—J. F. Kidd, Ottawa.
President-Elect—David Low, Regina. Annual Meeting, Regina, 1925.
Vice-Presidents ex-officio—Presidents of Affiliated Associations.
Honorary Treasurer—A. T. Bazin, 836 University Street, Montreal.
General Secretary—T. C. Routley, 184 College Street, Toronto.

THE COUNCIL

A. Primrose, Toronto, *Chairman*.
J. F. Kidd, Ottawa.
David Low, Regina.
A. T. Bazin, Montreal.
A. D. Blackader, Montreal.
T. C. Routley. Toronto.
H. B. Anderson, Toronto.
J. F. Argue, Ottawa.
L. J. Austin, Kingston.
J. Bell, New Glasgow, N. S.
R. J. Blanchard, Winnipeg.
G. S. Cameron, Peterborough.
A. M. Campbell, Winnipeg.
J. G. D. Campbell, Halifax.
G. F. Dewar, Charlottetown.
W. J. Egan, Sydney.
W. J. Elliott, Brandon.
F. J. Farley, Trenton.
W. A. Gardner, Winnipeg.
W. Hackney, Calgary.
T. G. Hamilton, Winnipeg.
V. E. Henderson, Toronto.
A. W. Knox, Weyburn. Sask.
T. M. Leask, Moose Jaw.
J. H. MacDermot, Vancouver.
N. J. MacLean, Winnipeg.
A. A. Macdonald, Souris, P. E. I.
M. MacLaren, St. John, N. B.
A. F. Menzies, Morden.
H. K. McDonald, Halifax.
J. S. McEachern, Calgary.
F. W. Marlow, Toronto.
C. F. Martin, Montreal.
D. P. Miller, Prince Albert.
A. S. Munro, Vancouver.
L. R. Morse, Lawrencetown, N. S.
T. A. Morrison, Regina.
S. E. Moore, Regina.
G. H. Murphy, Halifax.
T. A. Patrick, Yorkton, Sask.
J. I. Pratt, Port Arthur.
W. D. Rankin, Woodstock, N. B.
W. N. Rehfuss, Bridgewater, N. S.
W. G. Reilly, Montreal.
W. H. Secord, Winnipeg.
H. B. Small, Ottawa.
F. N. G. Starr, Toronto.
D. A. Stewart, Ninette, Man.
W. Turnbull, Winnipeg.
J. M. Ulrich, Regina.
C. H. Vrooman, Vancouver.
S. L. Walker, Halifax.
T. W. Walker, Saskatoon.
N. W. Warner, Winnipeg.
A. MacG. Young, Saskatoon.
Geo. S. Young, Toronto.

EXECUTIVE COMMITTEE

W. G. Reilly, Montreal, *Chairman*.
J. F. Kidd, Ottawa.
David Low, Regina.
A. Primrose, Toronto.
A. T. Bazin, Montreal.
T. C. Routley, Toronto.
G. S. Cameron, Peterborough.
T. G. Hamilton, Winnipeg.
C. F. Martin, Montreal.
S. E. Moore, Regina.
J. S. McEachern, Calgary.
M. MacLaren, St. John, N. B.
F. N. G. Starr, Toronto.
S. L. Walker, Halifax.

SPECIAL COMMITTEES

Lister Memorial - - - - - - - - R. J. Blanchard, Winnipeg.
Conference on Medical services - - - - A. Primrose, Toronto.

MEDICAL SOCIETY OF NOVA SCOTIA

ANNUAL MEETING, JULY, 1926, AT HALIFAX

OFFICERS FOR 1925-1926.

President............................Dr. E. V. Hogan, Halifax.
1st Vice-President....................Dr. J. J. Roy, Sydney.
2nd Vice-President....................Dr. L. R. Morse, Lawrencetown.
Secretary-Treasurer..................Dr. J. G. D. Campbell, Halifax.
Associate-Secretary..................Dr. S. L. Walker, Halifax.

EXECUTIVE

Cape Breton.
Dr. E[illegible]. M. McDonald, Sydney.
Dr. [illegible]D. R. McRae, Sydney Mines.
Dr. Dan. McNeil, Glace Bay.

Eastern Counties.
Dr. J. J. Cameron, Antigonish.

Colchester-Hants.
Dr. C. H. Morris, Windsor.
Dr. E. D. McLean, Truro.

Cumberland County.
Dr. J. A. Munro, Amherst.
Dr. W. T. Purdy, Amherst.

Lunenburg-Queens.
Dr. R. G. McLellan, Lunenburg.

Valley Medical.
Dr. M. R. Elliott, Wolfville.
Dr. W. F. Read, Digby.
Dr. F. S. Messenger, Middleton.

Halifax Branch.
Dr. V. L. Miller.
Dr. J. L. Churchill.
Dr. A. R. Cunningham.
Dr. P. Weatherbee.
Dr. F. G. Mack.

Pictou County.
Dr. H. H. McKay, New Glasgow.
Dr. G. A. Dunn, Pictou.

COMMITTEES

Cogswell Library.
Dr. A. G. Nicholls.
Dr. J. R. Corston.
Dr. John Stewart.
Dr. Philip Weatherbee.
Dr.C. S. Morton.

Public Health.
Dr. A. C. Jost, Halifax.
Dr. E. Kennedy, New Glasgow.
Dr. M. E. Armstrong, Bridgetown.
Dr. J. K. McLeod, Sydney.
Dr. W. N. Rehfuss, Bridgewater.

Arrangements.
Halifax Medical Society.

Editorial Board—C. M. A. Journal.
Dr. W. H. Hattie.
Dr. G. H. Murphy.
Dr. J. G. McDougall.
Dr. K. A. McKenzie.
Dr. E. V. Hogan.

Workmen's Compensation Board.
Dr. G. H. Murphy.
Dr. E. V. Hogan.
Dr. M. G. Burris.

Members of C. M. A. Council.

Dr. E. V. Hogan (Ex-Officio)	Halifax.
Dr. J. G. D. Campbell (Ex-Officio)	Halifax.
Dr. S. L. Walker (Ex-Officio)	Halifax.
Dr. W. J. Egan,	Sydney.
Dr. L. R. Morse,	Lawrencetown.
Dr. H. K. McDonald,	Halifax.
Dr. G. H. Murphy,	Halifax.
Dr. Ross Millar,	Amherst.

Nominated to Education Committee C. M. A.
Dr. K. A. McKenzie, Halifax, N. S.

Nominated to Legislative Committee C. M. A.
Dr. J. G. McDougall, Halifax. Dr. W. H. Hattie, Halifax.

MEDICAL SOCIETY OF NOVA SCOTIA

DIRECTORY AFFILIATED BRANCHES

CAPE BRETON

President..........................Dr. Allister Calder, Glace Bay.
1st Vice-President..................Dr. D. A. McLeod, Sydney.
2nd Vice-President.................Dr. D. W. Archibald, Sydney Mines.
Secretary-Treasurer................Dr. J. G. B. Lynch, Sydney.

EXECUTIVE

The Officers with Doctors McDonald, Patton and Curry. Nom. Provincial Executive:—Dr. E. M. McDonald, Sydney, Dr. D. R. McRae, . Mines, Dr. Dan. McNeil, Glace Bay.

COLCHESTER-HANTS

Officers 1924-25

President.............................Dr. R. O. Shatford, Londonderry.
Vice-President........................Dr. E. E. Bissett, Windsor.
Secretary-Treasurer...................Dr. H. V. Kent, Truro.

Executive Committee

Dr. J. B. Reid, Truro. Dr. F. R. Shankel, Windsor.

Nominated to Provincial Executive

Dr. C. H. Morris, Windsor, and Dr. E. D. McLean, Truro.

CUMBERLAND COUNTY

Officers

President..........................Dr. Wm. Rockwell, River Hebert.
1st Vice-President..................Dr. J. R. Gilroy, Oxford.
2nd Vice-President.................Dr. M. McKenzie, Parrsboro.
3rd Vice-President.................Dr. W. V. Goodwin, Pugwash.
Secretary-Treasurer................Dr. W. T. Purdy, Amherst, N. S.
Members of Executive Medical Society of Nova Scotia:
Dr. W. T. Purdy, Amherst.
Dr. J. A. Munro, Amherst, N. S.

EASTERN COUNTIES

Hon. President....................Dr. Geo. E. Buckley, Guysboro.
President..........................Dr. W. F. McKinnon, Antigonish.
Vice-Presidents....................Dr. J. J. MacRitchie, Goldboro.
Dr. John McDonald Sr., St. Peters.
Dr. M. E. McGarry, Margaree.
Dr. M. T. McLeod, Orangedale.
Secretary-Treasurer................Dr. P. S. Campbell, Port Hood.

Executive Committee

Dr. J. S. Brean, Dr. J. A. Proudfo t. Dr. A. J. McNeil, Dr. Alex. Kennedy, Dr. Owen Cameron, Dr. R. C. McCullough, Dr. B. A. LcBlanc, Dr. P. A. McGarry.
Nom'nated to Provincial Executive:—Dr. J. J. Cameron, Antigonish.

MEDICAL SOCIETY OF NOVA SCOTIA

DIRECTORY AFFILIATED BRANCHES

LUNENBURG-QUEENS

Officers fo· 1923-24

President........................Dr. J. S. Chisholm, Mahone.
Vice-President....................Dr. F. T. McLeod, Riverport.
Secretary-Treasurer..............Dr. L. T. W. Penny, New Germany.

Ex·cutive

The above Officers with:

Dr. A. E. G. Forbes, Lunenburg. Dr. F. A. Davis, Bridgewater.

Annual Meeting is held on the second Tuesday in June of each year, and other Meetings on the second Tuesday of August and January, the time and place of the two latter Meetings to be decided by the Executive.

PICTOU COUNTY

Officers for 1924-25

Priesident........................Dr. Clarence Miller, New Glasgow
Vece-President....................Dr. M. R. Young, Pictou.
Secretary-Treasurer..............Dr. John Bell, New Glasgow.

Members of Executive and nominated to the Provincial Executive:—
Dr. H. H. McKay, New Glasgow and Dr. G. A. Dunn, Pictou.
Benvie, S. C. McKenzie, G. A. Dunn, C. W. Stramburg, F. B. Day.

Meetings:—First Tuesday in January April, July and October. Annual Meeting in July.

VALLEY MEDICAL SOCIETY

President........................Dr. E. DuVernet, Digby.
Vice-Presidents..................Dr. G. K. Smith, Grand Pre.
" " ....Dr. H. L. Roberts, Digby.
" " ....Dr. W. C. Archibald, Annapolis.
Secretary-Treasurer..............Dr. C. E. A. DeWitt, Wolfville.

Representatives on Executive of Medical Society of Nova Scotia:—
Dr. M. R. Elliott, Wolfville. Dr. W. F. Read, Digby.
Dr. F. S. Messenger, Middleton.

WESTERN NOVA SCOTIA MEDICAL SOCIETY

President........................Dr. C. A. Webster.
Vice-Presidents..................Dr. H. J. Pothier, for Digby.
" " Dr. C. J. Fox, for Yarmouth.
" " Dr. L. P. Churchill, for Shelburne.
Secretary-Treasurer..............Dr. T. A. Lebbetter, for Yarmouth.

Nominated to the Executive of the Medical Society of Nova Scotia.
Dr. A. R. Campbell, of Yarmouth.

DALHOUSIE UNIVERSITY
MEDICAL LIBRARY
HALIFAX, N.S.

HALIFAX MEDICAL SOCIETY

1925 Officers 1926

President.. Dr. F. R. Little
1st Vice-President .... Dr. P. Weatherbe
2nd Vice-President............................. Dr. S. R. Johnston
3rd Vice-President................................ Dr. V. L. Miller
Secretary-Treasurer................................ Dr. W.L. Muir

Executive

The above Officers with
Dr. H. W. Schwartz
Dr. G. W. Grant

PROGRAMME FOR 1925-1926

NOV. 4th. Opening Meeting - - - - - - - - Carleton Hotel
President's Address

NOV. 18th. Nova Scotia Hospital.
Clinical Evening

DEC. 2nd. Victoria General Hospital.
Clinical Surgical

DEC. 16th. "Paralytic Deformities, especially in Childhood."
Dr. J. Appleton Nutter
Orthopaedic Surgeon to the Montreal General Hospital.

JAN. 13th. "Purulent Disease of the Accessory Nasal Sinuses."
Dr. H. W. Schwartz

JAN. 27th. Victoria General Hospital.
Clinical Medical

FEB. 10th. Dental Symposium—"Focal Infection, Deformities, etc., etc."
Drs. W. W. Woodbury and J. S. Bagnall

FEB. 24th. "X-Ray Diagnosis of Bone Conditions."
Dr. S. R. Johnston

MAR. 10th. Subjects to be Announced.
Dr. John Stewart
Dr. Murdoch Chisholm

MAR. 24th. "The Surgery of Putmonary Tuberculosis."
Dr. J. H. Allingham
Saint John, N. B.

APR. 14th. "Recent Advances in the Physiology of Gastric Secretion."
Dr. Boris Babkin
Professor of Physiology, Dalhousie University.

APR. 28th. Annual Meeting.
Election of Officers, Etc., Etc.

DALHOUSIE UNIVERSITY
MEDICAL LIBRARY
HALIFAX, N.S.