Canada's National Health Program

An Address by the Hon. Paul Martin, Minister of National Health and Welfare, to the Annual Dinner of the Royal College of Physicians and Surgeons of Canada at the Chateau Laurier Hotel, Ottawa 7.30 p.m., Saturday, November 27, 1948

I. The Doctor's Place in Federal Health Plans

The new National Health Program has been acclaimed in all parts of Canada. Provincial governments, Canadian health leaders, the average Canadian citizen—all recognize in this program an historic advance towards good health. Abroad, Canada's prestige—already high in the fields of health and social welfare—is higher because of this action. Only two weeks ago—in recognition of Canada's new health plan—the American Public Health Association recorded this fine tribute:

> "*RESOLVED, that the American Public Health Association extends its hearty congratulations to the Government and the people of Canada for a step which makes the year* 1948 *memorable in the annals of public health on this continent.*"

Tonight, at this Annual Meeting of the Royal College of Physicians and Surgeons of Canada, I take the opportunity of making the first progress report on this plan. No one could have a greater stake in health than you who have crowned years of medical training with intensive instruction before taking positions of special trust in the life of your country and community. As leaders in the medical profession you must always be aware of every important health development and active in its support.

Canada's health services rest firmly on the foundations that you have laid. Government action cannot supplant your enthusiasms nor your effectiveness. The first essential of any government health program is to strengthen the hands of those most immediately responsible for health leadership. My talk tonight is about our tremendously significant federal health plan, but, through each of its members, the Royal College represents more than 3,100 important individual health programs.

The first point in my progress report is to note that the new national plan does not in any way lessen the role or lighten the responsibilities of the individual doctor, dentist, nurse or health worker. In bringing better health to its citizens, a government must look to your profession for leadership. Without your confidence and collaboration, no health program could be fully successful. I can assure you that no action taken by the present Government under this or under any other program to improve health services in Canada will stifle or destroy the liberty of the individual doctor. All of us in our own respective fields must, of course, recognize our social responsibilities in the

service of society, whether we be public servants, or professional persons in the larger areas of service to humanity. We must adjust our disciplines, our patterns of performance in recognition of this growing sense of social responsibility. Yet this must be accomplished without restriction of our liberty and freedom. Health advances take their inspiration from the imagination, industry and integrity of each member of your profession. Regimentation of the doctor would be ruinous to health progress. In any sensible health plan the doctor holds a responsible position. *Will we not want to see that doctors should continue to be free to serve their patients—not that they should become mere servants of the state.*

II. The Provinces and the Federal Program

The second point in my progress report is that the National Health Program does not lessen the momentum of provincial health services. Our program for health must start with the individual citizen. In taking account of all his working and living conditions, health planning can best be done on a local or regional basis. Except for long established federal health services —such as the inspection of food and drugs, quarantine, and health care for sick mariners and Indians—it would be folly to attempt to administer from Ottawa all Canada's far-flung health activities.

While health is a national concern, it is primarily a provincial responsibility. And rightly so. Our health services are soundly established in each province; as they are based in large part on local need and related to local conditions they should be administered locally and provincially. This is as sound as it is sensible. Health administration in Canada is a vastly complex inter-locking system of the multiple activities of voluntary health agencies and of the municipal, provincial and federal governments.

If, in trying for an illusionary efficiency, we pressed for an overall central administration, we could only confuse the health picture. Such centralization would badly serve the Canadian citizen. Our federal plan does not disturb the proper Dominion-Provincial balance of health services. It does not attempt to do ponderously for the provinces what they can do efficiently for themselves. There are, however, important health duties incumbent on every government in Canada. Through the Department that I have the honour to administer, the Federal Government has a clear responsibility—apart from its own health services—to cooperate with provincial authorities in the co-ordination of efforts to improve the public health of Canada. In recognition and in discharge of this responsibility, the National Health Program was inaugurated.

III. The Program in Outline

Before going into detail of results achieved, I shall review the major objectives of this program and the provisions made to reach them:

1. *Comprehensive and searching surveys are to be made of the Canadian health scene.* Each province is given financial assistance to make a close study of its health services and of its hospital needs, and to formulate its health plans for the future. For this purpose, federal grants totalling $625,000 have been provided.

2. *Provincial health services are to be strengthened and extended.* New developments are to be encouraged. There will be concerted campaigns to widen the range of preventive medicine and to cure disease. Federal grants starting at $16,500,000 and rising to $22,000,000 will be available each year for public health research, for public health projects, to train professional health workers, to help crippled children, to fight venereal disease, to control tuberculosis and cancer, and to manage mental illness.

3. *Great increases in hospital accommodation are to be encouraged by annual grants to the provinces, totalling* $13,000,000 *a year*. In order to provide a powerful incentive towards building 40,000 badly needed hospital beds, the Government will pay up to $65,000,000 over a period of five years, at the rate of either $1,000 or $1,500 for each bed—on condition that the provinces match these grants.

In recent years the Federal Government has widely surveyed the Canadian health scene. Everywhere it found evidence of real achievement. The provinces have been doing admirable work, increasing their health services and hospital facilities, but it was seen that—if the pace of their health progress was to be accelerated and neglected areas cared for—federal financial aid was essential.

IV. Progress Report on National Health

It is only four months since this program got underway, but already there is every evidence that it is succeeding admirably in its main purpose—to raise the entire level of health activity in Canada. From every province plans and projects are coming into Ottawa. During the past ten days, for example, the number of such requests has varied from 10 to 37 a day. It is an inspiration to receive, from all parts of Canada, details of projects that reflect the imagination and initiative of provincial health departments, eager to take full advantage of this federal assistance to expand their present services and to strike out in new directions.

From the projects coming to us it is evident that each province is carefully reviewing its health operations, while searching out and training personnel for the new activities planned. New equipment is being sought, administrative machinery is being expanded; weak points in provincial programs are being searched out and corrected. Neglected territory is being brought within the orbit of these new health plans.

It takes time to assess and strengthen provincial programs and this might prevent full and immediate use of the monies available. When I asked Parliament to approve the whole amount for this fiscal year I did so for a special purpose—to indicate how anxious the Government was to see its grants fully utilized this year if possible. This year's allotment of $30,000,000 is our target figure—the amount of money that we believe should be expended to bring our health services up to desirable levels. While all of the health survey grant and much of the national health grant monies will be expended in this fiscal year, it seems possible that some provinces will be unable to use all of their hospital construction grants. So, to achieve the results desired, the Government will carry over the unexpended portion of the hospital con-

struction grants to make a total of $65,000,000 available by 1953 to increase hospital accommodation.

(a) Health Survey Grants

First of all, it is encouraging to see the energy that is being put into the provincial health surveys. *Planning shows the way to health progress.* At a three-day conference held this week in Ottawa, the directors of all these survey groups showed a determination to get at the facts about their health services and hospital facilities and to search out remediable conditions. They were assisted by the newly-formed National Consultative Committee, made up of representatives of the principal national professional associations. In every province, health services and hospital accommodation are being reassessed and related to present and future needs, especially in view of the federal support now at hand. The National Health Program was based on the best information and the best advice available but the provincial health surveys will provide an additional mass of accurate and useful information from which further health advances can be more easily planned.

(b) Hospital Construction Grants

The necessity of completing preliminary surveys of their needs has, until recently, prevented some of the provinces from putting forward their programs for hospital construction grants, but Nova Scotia, New Brunswick and Manitoba have made important requests for federal aid. These are now under consideration. I am expecting submissions from Ontario and Quebec in a few days. In spite of the difficulties that delay construction work of any sort in Canada, great importance is attached to helping the provinces increase their hospital accommodation by 40,000 beds in the next five years. We will encourage every province that finds it impossible to utilize its full grant in the first year to expand its building program in subsequent years to use the available federal grant—that can be carried over each year—in order to build the accommodation so urgently needed.

(c) National Health Grants

There can be little doubt that even in the few months that have passed notable advances have been,initiated through the National Health Grants. In reviewing each grant I shall attempt to illustrate by typical examples—chosen from scores of projects—the sort of activities that are now under way.

(1) To Underwrite Research in Public Health

In the present year, $100,000 has been set aside for research in public health in addition to the funds provided through the National Research Council. Projects are shaping up to make good use of this money. As research facilities and trained personnel are augmented, this grant will rise to $500,000 annually. The need for research is fully recognized throughout the federal program, for research is an essential part of any forward-looking health plan.

(2) To Train Professional Health Workers

As provincial programs expand, personnel must be trained to staff them.

For this purpose, there is, in addition to training provided under other grants an annual federal grant of $500,000 a year. Already, in several provinces projects have been approved that will train more than 250 people in health work. These cover a great variety of avocations—from laboratory technicians to medical specialists. Sanitary inspectors, public health engineers, public health nurses, dentists, doctors, veterinarians—all are included in current projects.

(3) Better Care for Crippled Children

In Canada there are perhaps 50,000 crippled children. As soon as new programs can be developed, the federal grant of $500,000 annually can be translated into preventive work to discover conditions that—if neglected—would lead to crippling. More adequate treatment will become available for those already crippled, and rehabilitation services will be provided on a larger scale.

(4) More Active Control of Venereal Disease

By more than doubling the existing federal grant for the control of venereal disease, the Federal Government has made increased control possible. Established programs for education, for the provision of drugs and for follow-up service are being continued. Part of the increased grant is being used in Manitoba and British Columbia for penicillin. In Prince Edward Island, blood tests will be made of every person admitted to hospital. In Alberta, a new clinic is being established at Lethbridge, and a mobile clinic is being sent into the northern part of the province. In general, this increased grant is widening the reach of skilled treatment and extending to clinics and private physicians expert instruction in new treatment techniques.

(5) Increased Efforts to Eradicate Tuberculosis

The death rate for tuberculocis in Canada has declined strikingly, but this disease still represents a major national health problem. More than 4,000,000 patient-days a year are expended in tuberculosis institutions alone. As its causes are known and as cures are possible in most instances when it is discovered in time, the federal grant of from $3,000,000 to $4,000,000 a year should yield impressive results in the fight against tuberculosis. In the past 20 years the tuberculosis mortality rate has been reduced by 46%. Let me spell out this impressive story: 1927, 68 deaths for each 100,000 of our population; 1932, 56; 1937, 49.5; 1942, 42.5; 1947, 36.8. This is the pattern of progress. In the next generation we should almost completely banish pulmonary tuberculosis from this country.

Projects that have been approved under the Health Plan include the distribution of streptomycin in five provinces. New equipment is to be provided in several provinces in very considerable amounts. Ontario hospitals will be equipped and assisted to give routine chest X-rays to all admitted, and Ontario's chest clinics are being expanded to cover its entire population. In British Columbia, a pool of X-ray survey equipment is being built up for the use of all general hospitals, and eleven new tuberculosis control units are being formed. In Alberta, free sanitorium treatment will be made avail-

able for non-pulmonary types of tuberculosis, making treatment for any form of this disease free in that province. New Brunswick has come forward with a variety of projects that fully utilize its grant of $142,00 this year for tuberculosis control. These are some—but by no means all—of the fundamental and far-reaching steps being taken as a result of the Federal Government's Health Plan. Now, to continue—

(6) Acceleration of Campaigns Against Cancer

In contrast with tuberculosis, deaths from cancer have shown a marked increase in recent years—although this probably is partly due to improved diagnosis and to the aging of our population. Cancer is curable in some degree but great discoveries in cancer research must be made before this disease can properly be brought under control. Important steps have been taken to accelerate our campaign against cancer. Nearly two years ago, I met with representative leaders in the medical and other fields to assist in forming the National Cancer Institute of Canada, which has already launched 43 significant research projects. I expect all of the provinces will agree to assign a percentage of their cancer control grant to support research under the Institute. Our hope is that if Canada—in common with other countries—puts enough energy into the study of cancer, in good time more of its secrets can be discovered.

Large-scale projects are now being put forward to utilize the annual $3,500,000 cancer control grant. Prince Edward Island has received approval for the organization and operation of two diagnostic cancer clinics. A doctor is to be given special training before becoming director of a cancer control division. Free cancer laboratory services are to be made available. New Brunswick is purchasing cancer therapy equipment for five new cancer treatment centres, and also purchasing a supply of radium. It is setting up six cancer diagnostic clinics. There are important cancer control projects for Manitoba and Quebec. Other provinces are preparing projects in cancer control under this national health plan that will have very far-reaching effects.

(7) Management of Mental Illness

Another major health problem is the prevalence of mental illness. At the beginning of January, 1948, there were 54,667 patients in mental institutions in Canada—nearly half the total number of people in all Canadian hospitals. A federal grant rising in stages from $4,000,000 to $7,000,000 a year has been provided to fight this disease—especially by preventive measures. This federal expenditure should bring about important changes. Expert mental health care should extend beyond the mental hospital to become a living part of medical care in the general hospital and more easily available to the average citizen in his own community. For example, the federal plan makes possible a travelling mental health clinic in Prince Edward Island as part of a proposed mental health division. In Ontario, a large-scale program is underway at the University of Toronto to give special training in mental health to psychiatrists, physicians, psychologists, psychiatric social workers, nurses, and teachers in psychiatry and public health. In Manitoba, extensive work in occupational therapy is being developed in

mental hospitals. In Saskatchewan, three teacher-psychologists are to be trained to act as liaison officers between mental health clinics, the school and the community. Part of this training is made possible by the Professional Training Grant.

The mental health grant is bringing more expert psychiatric knowledge to the patients in mental hospitals. Hospital staffs are being strengthened and given additional training. The equipment and facilities of mental hospitals are being improved. Because of this federal aid, more attention can now be given to prevention in mental illness work and to treatment and rehabilitation.

(8) Extension of Activities in Public Health

In the present year, $4,400,000 is being provided for provincial work in general public health. This grant will increase until it reaches $6,500,000 a year and then continue on the basis of 50 cents per capita yearly. This grant is helping to expand existing public health facilities, and to put much greater emphasis on preventive medicine. For instance in Prince Edward Island, branch laboratory services are being provided in the provincial and general hospitals. In New Brunswick, an integrated program of public health education and preventive dental hygiene is provided for. Saskatchewan has also established a division of dental hygiene. Bacteriological services in Regina are being improved and extended and the city's health services strengthened. In Alberta, a new health unit is to be set up to serve Drumheller and district.

British Columbia has already utilized 60% of its public health grant of $365,000. Public health education is being extended. A division of preventive dentistry is being established. Special equipment is being provided to extend the facilities and services of local health units. To build new units, to expand the staff of those already in existence, and to expand public health nursing services, 15 additional nurses and 14 sanitary inspectors will be added to health unit personnel in British Columbia.

V. The Pattern of Progress

These examples do not yet indicate any completely coherent pattern in the advances made possible in provincial health fields by the National Health Program. They are representative of some of the first proposals that have been received and approved. From a study of all these projects and from a review of the 100 or so that came in during this week, I can say that all across Canada health activity is being greatly stimulated by this federal program. It builds on good foundations, for Canada's health levels are among the highest in the world. In the past twenty years our life expectancy has continued to advance. The general death rate is down by 17%. Infant mortality is down by 44%. Maternal mortality is down by 42%. These are milestones in Canada's health history.

In some major diseases—notably, tuberculosis—there has been marked improvement; in others—particularly cancer—the reported death rate has considerably increased. In any event, while great progress has been made in

controlling childhood diseases, it is clear that the incidence of many of the other diseases is still far too high. It is also clear that it is now within our power because of the federal grants to broaden greatly the scope of preventive medicine and to support more vigourously provincial campaigns against disease.

Ill-health makes inroads on human effectiveness and human happiness. This is a matter of concern both to the individual and to the nation. The National Health Program, by adding $30,000,000 annually to the large amounts of money now being spent by all governments in Canada, is proof of the Federal Government's intention to help free as many people as possible from servitude to illness. There is no better justification for the expenditure of public funds than this great plan to assist the provinces in breaking down the barriers to good health, in finding out the cause and the cure of the killers and cripplers, and in strengthening the defences against all major and minor ailments that hinder human beings from full activity of body and mind.

VI. Importance of Preventive Medicine

I have made this broad survey of typical projects to show what has been accomplished thus far under the federal plan and to keep you advised of the progress that is being made. I have not attempted to relate these new developments to your particular interests, although many of the projects outlined will mean much to you personally since you will help to bring them to fulfilment.

The fellows of the Royal College of Physicians and Surgeons, who lead in specialized fields of medicine will, I know, give intelligent guidance to medical training to keep it abreast of modern developments and current need. I hope that the new directions and new opportunities given to health action in Canada by this program will receive full consideration in medical teaching. I believe that the general practitioner—the "family doctor"—would like to play a greater part in public health work. If so, the first encouragement of this interest would be to put more emphasis in medical instruction on preventive medicine and public health generally.

It should be your concern, as leaders in Canadian medicine, above all else to guard against any action—whether it be by private agencies or by government—that would lower the standard of medical practice. All our health programs would fail if the intangibles of medical progress—the quality of medical training, the doctor's instinct for selfless service—should in any degree be allowed to deteriorate.

For those who, like myself, serve this nation in a public capacity, there is a clear duty to see that the nation's health receives the attention and the financial support it deserves. For everyone who, like the fellows of this college, serves the cause of better health, there is an equally heavy responsibility to support each progressive movement to bring health services to all Canadians who need them—regardless of their ability to pay.

Behind our thinking in setting up the National Health Program was the conviction that the energy our people had shown in war could find equally fruitful expression in peace through efforts such as this to widen for every citizen the opportunities for good health. Access to good health is a funda-

mental human right. And it is a right that every government must guard. When it became evident that the sturdy provincial defences against disease required reinforcement to protect the health of Canadians, the Federal Government took determined action in the manner I have described.

Time, I am convinced, and the furtherance of our freedom from disease will amply justify the bold and generous outpouring of this nation's resources in the cause of health through voluntary agencies, municipal and provincial governments, and through this far-reaching Federal Program.

This program represents, I believe, an important milestone in our attitude towards health care in this country. *It emphasizes that this is the era of preventive medicine.* I look forward to increased cooperation and unity of outlook between all who serve the cause of health, for all have a common objective —to achieve better levels of health for every Canadian.

Nutrition for Vision

The eyes are composed of many types of tissue, all requiring nutrition. Hence, a balanced and adequate diet is as essential to healthy eyes as to the health of the rest of the body, physicians say.

Although they may not be specific for the prevention of ocular diseases, vitamins influence the health of the eyes and vitamin therapy frequently helps in overcoming eye difficulties. Vitamin A, for example, is essential for the nutrition of such structures as the cornea, as well as for efficient adaptation to darkness and light.

Temperature Tips

The human body is constantly generating heat, even when it rests. When physical work is being performed the heat production rises considerably. In order that the body temperature may remain approximately constant as it must if health is to be maintained, this heat must be dissipated as quickly as it is produced.

Otherwise, experts point out, there would be a storage of heat and the body temperature would rise, possibly to a dangerous level. On the other hand the rate of heat loss must not be too rapid or chilling will result.

Delayed Reaction

It may take several years before it becomes apparent how well a child has been fed, doctors say. This is especially true in giving cod liver oil. Cod liver oil is remarkably effective in preventing rickets but it acts mainly upon the bones and teeth where the effect is not always fully apparent until years later

Because of this, mothers are often lax about giving it regularly. Unless cod liver oil is given in the full dose every day, the child may not develop a strong, well shaped body. His resistance to disease may also be lowered.

Guillain-Barré Syndrome

G. M. Moffatt, M.D.*

POLYNEURITIS, or multiple peripheral neuritis (as differentiated from an interstitial neuritis, which is likely to be confined to a single nerve) is usually caused by a toxin. A toxin may result from diphtheria or other infections, from alcohol, lead or arsenic poisoning, or from a metabolic disturbance as in diabetes. Avitaminosis may cause a polyneuritis. Occasionally a case may occur for which no obvious cause can be found. The symptoms and signs of polyneuritis are paralysis, wasting of the muscles, anesthesia, inco-ordination, loss of reflexes, and trophic disturbances.

In 1916, Guillain, Barré and Strohl presented two cases of polyneuritis. At that time, they drew attention to the cerebrospinal fluid finding of a high protein without a corresponding rise in the cell count (albuminocytologic dissociation). Prior to 1916, this dissociation phenomenon of the cerebrospinal fluid was considered to be limited to two conditions, the cul de sac of a blocked spinal canal, and Pott's disease. Since their paper was published, several investigators, both in Europe and North America, have reported cases of polyneuritis of the Guillain-Barré type. Many cases corresponded to those reported by Guillain and Barré but certain reports included cases which did not show the albuminocytologic dissociation. A number of deaths from the Guillain-Barré syndrome were reported by them.

In 1936, Guillain reported ten further cases re-emphasizing that the albuminocytologic dissociation of the cerebrospinal fluid and a favorable prognosis must be present to include a case under the so-called Guillain-Barré syndrome. Because several clinicans reported relatively low cerebrospinal fluid protein, Guillain states, "Hyperalbuminosis is constant and pronounced; the albuminoids usually amount to from 1 to 2 Gm. per hundred cubic centimeters, sometimes more. Cases with slight hyperalbuminosis, with an albuminoid of from 0.3 to 0.4 Gm. do not belong to the syndrome or must be regarded as instances of an abortive form."[1]

The Guillain-Barré syndrome occurs sporadically, it affects both sexes and all age groups. The polyneuritis usually follows an upper respiratory infection but a small number of cases do occur without preceding infection. Several cases of the syndrome have been associated with infectious mononucleosis, and, because of this a heterophile antibody determination is recommended in every case of the Guillain-Barré syndrome.

Sensory disturbances are usually the first neurological symptom to occur. Pain in the back of the legs, numbness of the extremities and diminished perception to pain and touch are frequently noted. The motor disturbances of weakness and loss of the deep reflexes occurs later. The neurological findings may be more marked in one limb than the other but the paralysis is usually bilateral and progressive. The sensory findings tend to be more marked distally and the motor findings more marked proximally. The cutaneous reflexes (corneal, abdominal, cremasteric, etc.) tend to remain intact and the Kernig's, Brudzinski and Babinski signs are absent. As a rule, the organic reflexes are not involved, but infrequently, there is a retention of urine necessitating catheterization. In this regard, on reviewing his original two cases,

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Guillain states: "In case 2 reported in 1916, the patient was able to urinate without aid but did not perceive the passage of the urine; in several instances since, I have observed difficulty and slowness in micturition and loss of perception of the passage of the urine."[2] Of the cranial nerve palsies, lower motor neurone facial paralysis is the most common finding. This may be unilateral or bilateral. The involvement of the trigeminal, glossopharyngeal, vagus, spinal accessory and hypoglossal nerves is uncommon.

Case Report:

Mrs. R. F., age fifty, a housewife, was admitted to the Victoria General Hospital, June 25, 1947, complaining of pain between the shoulder blades, numbness of the lower limbs, back and abdomen and also a numbness of the tongue, inability to walk without support, loss of the sensation of both defecation and micturition.

The family history and personal history were non-contributory.

On June 18th, the patient noted a dull ache in the upper right quadrant of the abdomen which occurred while she was painting a ceiling. This pain soon radiated to the back and was most severe between the shoulder-blades. On June 21st, this pain was of such severity to cause the patient to faint. The patient noted that her legs were becoming progressively weaker and although she could sit and stand without difficulty, she could not walk without support. Although there was no incontinence of the bowels nor retention or incontinence of the bladder, the sensation of defecation and micturition was lost. The patient also noted a numbness of the tongue.

Physical examination revealed a rather obese white woman of stated age lying comfortably in bed, who appeared in no particular pain or distress. The pain in the back was obviously aggravated by her turning in bed or sitting up. Temperature was 98.7° F., pulse 80 per minute, respiration 20 per minute. The general physical examination other than the neurological examination was entirely normal.

Neurological Examination:

The patient was neither euphoric nor depressed and she was very cooperative throughout the examination.

The cranial nerves were intact. (There was no hypoesthesia to pain or light touch on the tongue in the area of numbness complained of by the patient.) The opthalmoscopic examination was normal.

Motor Function:

There was normal strength in the upper limbs; the patient could stand but she was unable to walk without support. There was a definite weakness of the thigh muscles but the patient could raise her legs off the bed and hold them elevated for a considerable length of time. There was no weakness on plantar flexion or extension of the feet.

The cerebellar function was normal.

Deep Reflexes:

The biceps, triceps and pectoral reflexes were normal; the periosteal

reflexes at the radial styloids were also normal. The patellar and Achilles reflexes were absent bilaterally. There was no clonus at the knees or ankles.

Superficial Reflexes:

The corneal reflexes were present, the abdominal reflexes were absent and there was no response to stroking the soles of the feet.

Sensory Function:

There was a hypoesthesia to both pain and light touch in the lower limbs' which was more marked below the knees. There was also a hypoesthesia on the abdominal wall below the umbilicus and on the back about the left scapula. On admission, there was no hypoesthesia of the upper limbs. The vibration sense was normal.

There was no atrophy or tremor.

Laboratory Examination:

Blood: Hemoglobin 100%. Red Blood Cells—5,800,000 per cu. m. m.' White Blood Cells—7,200 per cu. m. m. Blood Smear—No basophilic stippling, no abnormal cells. Kahn-negative. The Blood Sugar, Non-Protein Nitrogen Sedimentation Rate were normal. The Widal was negative.

Urine: No albumen no sugar. The microscopic examination revealed only calcium oxalate crystals.

Electrocardiogram: Within normal limits except for a low voltage which was probably due to obesity.

Cerebrospinal Fluid Analysis:

	27th June, 1947	2nd July, 1947	15th July, 1947	6th Nov., 1947
Pressure.....	necessitated aspiration	normal	normal	normal
Quackenstedt....	unable to do	normal	normal	normal
Appearance.....	cloudy	clear	fluid clear with coagulum	clear
Cell count.....	nil per cu. m.m.	2 per cu. m.m.	——	none z
Red Blood Cells..	numerous	few	——	none
Protein.....	75 mlgms. %	100 mlgms. %	150 mlgms. %	40 mlgms. %
Chlorides.....	700 mlgms. %	insufficient	700 mlgms. %	730 mlgms. %
Sugar.....	normal	normal	normal	normal
Colloidal Curve..	11233321	22221000	01111000	11110000
Kolmer Wassermann.....	negative	unsatisfactory	negative	negative

Note:—15th July, 1947: The cell count is of little significance with a coagulum. The stained slide showed a rare pus cell.

Course in Hospital:

The patient's condition remained unchanged until five days after admission, when on June 30th she complained of increasing numbness of both legs. On examination, the hypoesthesia had increased and the patient could not raise her legs off the bed without great effort. A right facial paralysis including the right forehead and right eyelid and a hypoesthesia of the right side of the face had developed. On July 9th, a slight left facial weakness became apparent.

Following the increased weakness which occurred June 30th, the patient became gradually stronger; on July 12th, the trunk muscles were stronger and the patient could turn more easily in bed and on July 19th, she could stand unassisted. On July 21st, although her legs were very weak, she could walk unassisted about the ward.

The patient was discharged from the hospital on July 24, 1947. At this time, she no longer required sedation for the back pain, the facial paralysis and the facial hypoesthesia had disappeared, there was no numbness of the tongue and sensation on the passage of the stool and of the urine had returned.

During the patient's first five days in the hospital, various opiates—morphine, codeine, pantapon and demerol—were prescribed to relieve the back pain. While in hospital, she also received massive doses of Vitamin B and multivitamins orally, Vitamin B Complex intramuscularly, and Nicotinic Acid, 100 mlgms, intravenously, daily. Vitamin B tablets were prescribed to be taken following her discharge from the hospital.

The patient returned to the hospital Sept. 3, 1947, Nov. 4, 1947 and Feb. 9, 1948, for a recheck. On Sept. 3, 1947, she still complained of weakness of back muscles. On physical examination, there were weakness and hypoesthesia of both legs below the knees and absence of the tendon reflex at the knee and ankle, bilaterally. On Nov. 6th, she still complained of a slight ache and weakness between the shoulder blades and also of numbness of the left heel. On physical examination, there was no hypoesthesia but the tendon reflexes at the knee and ankle were still absent, bilaterally. On Feb. 9, 1948, the patient was free of complaints. Physical examination did not reveal any weakness, there was no hypoesthesia and the knee and ankle tendon reflexes were present and normal, bilaterally.

Summary:

(1) A case of polyneuritis Guillain-Barré type is presented.

(2) The typical findings of motor weakness (more marked proximally than distally), hypoesthesia, and facial paralysis were present, the albuminocytolcgic dissociation was demonstrated and the prognosis was favorable. Several symptoms and signs were present which have been reported as occurring rather infrequently, namely, the numbness of the tongue, the numbness of the face and the loss of sensation with defecation and micturition.

(3) The highest cerebrospinal protein in this case was 150 mlgms. per hundred cubic centimeters. This finding is consistent with the many cases reported recently as the Guillain-Barré syndrome but it does not conform with Guillain's original concept where the cerebrospinal

fluid protein should be 1 Gm. or more per 100 cc's of cerebrospinal fluid.

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Read the Label

Whole grain breakfast cereals should not be neglected just because the weather is warm, nutritionists warn. Rolled oats or cracked wheat will probably not be desired as in the winter but there are whole grain prepared cereals.

Cereals coming under the classification of whole grain must contain a certain concentration of the B vitamins. Check the cereal box for nutritive value. Read the label on the box to see that you are getting a whole grain cereal.

Measles Menace

Although measles does not rank high as a cause of death, it can be very dangerous in infants and weak, undernourished children, not only in itself but because of the complications and after effects which may follow an attack. The chief complications to be feared, according to national health officers, are pneumonia, infected ears and mastoid, infected eyes and, occasionally, tuberculosis, while the after effects may include impaired eyesight and hearing and an increased susceptibility to diseases of the lungs. Parents should watch for this disease and call a physician when its symptoms appear.

Psychiatry in the General Practice of Medicine

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THE characteristic of psychiatry in the past was isolation. General practitioners have learned much from other medical specialties and have used this knowledge in treatment, but from psychiatry they have gained little. In fact psychiatric concepts have served only to confuse and antagonize. Much of this has been due to an unusual lack of understanding, but the terminology and methods of psychiatry have further isolated it. However, many factors in recent years have brought psychiatry into everyday life; two wars with their lessons of the great need for psychiatric treatment and prophylaxis —the establishment of university clinics, and the mental health movement have all contributed. An even greater factor has been psychiatric education and the results of psychiatric treatment, and some order has emerged from the chaos that grouped under "Insanity" any condition of mental abberation whether it was mental deficiency, drug addiction or general paresis. Even more important has been the treatment evolved and the changing attitude within psychiatry that has followed the writings and teachings in the last 50 years of Adolph Meyer and Sigmund Freud.

Psychiatric Treatment:

The foundation of psychiatric treatment is attitude. Why do so many physicians switch from a pleasant bedside manner with surgical cases, to brusqueness and intolerance with a patient suffering from vague and varied complaints? What results can be expected when the patients relate—"My doctor bawled me out," or "He made me feel ashamed" or "He said all I needed to do was snap out of it?" Why are these patients maligned only because their disease will show no abnormalities in the operating room or the pathology department?

For many physicians this brusqueness is a defense—a defense against a condition that they do not feel competent to handle, or about which they know nothing. Yet many physicians will not try to interest themselves in the diagnosis and treatment of nervous disorders. Granted that there was little practical instruction in the medical schools and granted that psychiatric terminology is horribly complicated, the fact is that at least half of the general practitioner's patients are suffering from disorders in which psychogenic factors are the main ones.

Nervous patients are not malingerers, they are sufferers. It is not "imagination" but intolerable inner tension that disturbs these people. This tension may reflect itself in tremors, muscular aches and pains, hypertension or gastric and intestinal disorders expressed as peptic ulcers or colitis.

What exactly is the best attitude? First, these people are not well and require the best of our healing art; secondly, they should be handled considerately. This means neither bullying nor babying. We should be honest with them and with ourselves. A long, expensive search for organic disease is not indicated, for example, in a man who goes to pieces when he loses his

job and becomes involved in financial difficulties. A long investigation was not made in combat soldiers who developed "battle fatigue." Instead psychiatric treatment was quickly started and with sedation, extra diet and the benefit of psychotherapy (support, reassurance and a sympathetic ear to their feelings) most of these men were salvaged as good soldiers and were not allowed to become chronic invalids as so frequently occurs in civilian life.

Of all the fields of medicine the one most prone to inherit iatrogenic (i.e., physician caused or aggravated) disease is Psychiatry. When a psychitrist sees a healthy strong man with hysterical paraplegia, you can imagine his ire when he finds that the condition followed a physician's unwise comment, as he dressed a superficial back wound, "another inch and it would have caught your spinal cord and paralyzed you." This is, I know, somewhat extreme but variations of the same pattern are seen frequently. It should always be avoided. We should *never* tell a patient what he "might have had."

Psychomatic Medicine:

This term is being introduced more and more into medical literature. To many it is a "cleaner" word than psychiatry or psychiatric medicine, it is free from the taints that the latter words connote. If the medical profession is aware of this, then the term is useful but it must be borne in mind that the concept is not a new one. The "family doctor" practised it for years and only in the recent trend toward increasing specialization has the concept been neglected and the patient ceased to be "a patient," to become "a heart case", "a skin lesion", or "an ulcer". The reogranization of medical teaching with closer integration of courses is a return to treating the patient "as a whole" (Adolf Meyer's guiding principle).

There is a great danger that psychiatry may lose its new found prestige by bringing forward too many poorly established theories. As psychiatric concepts on psychosomatic subjects are still very new they must be received as hypotheses only. However, this does not mean that they should be met with intolerance, even if some of these concepts may be disquieting to us personally.

One of the commonest problems of the physician and one that has received a lot of psychosomatic investigation in recent years, is peptic ulcer. A brief discussion will tend to illustrate how the broad concepts of psychosomatic medicine may be utilized by physicians. Antagonism is anticipated as we speak of psychiatric treatment of a peptic ulcer, from the internist who treats the ulcer "medically", or the surgeon who operates, yet not for a moment is it proposed that psychosomatic concepts should *supplant* any established methods; they should *supplement* such methods, and so should be used concurrently in most cases.

Everyone has noted how emotional factors exacerbate gastric symptoms —and the physiology of this has been fairly well established—but how many have considered applying this observation to treatment? "To avoid anxiety" is commonly recommended in the medical texts. A very trite phrase indeed since anxiety is unavoidable; however, what we can do is to attempt to alter the level of anxiety these patients have. This requires more than Sippy powders and diet, it requires the genuine interest of the physician, a "supportive" relationship, which gives the patient a chance to "let off steam",

discuss his problems, and so gradually attempt to change, in this moderate way, his way of living. I say "his" because the commonest picture presented by an ulcer patient is that of an ambitious, worrying, intense businessman with no outside interests. To lower his intensity and increase outside interests is the best palliative treatment. To a casual observer these patients are very independent. However, deeper lies a need for dependency, a dependency that a physician can satisfy and thus definitely help the patient. It must be stressed at this point that the patient should *not* be *told* that he is tense, or dependent, etc., at the first interview. The relationship of physician and patient is the foundation of all therapy and it must be strongly laid. When any patient enters the office it means he trusts you and has some confidence in your professional skill. We must foster this confidence, and justify his trust with sincerity and ability. Once it is firmly established, he will bring his problems and they can be discussed. There is a great tendency to tell a patient what to do—this should be avoided. We help him most by being a good listener and when he asks a leading question concerning his personal life we should best reply by asking him what he thinks the answer might be. Our aim should be to have *him* see his problems objectively and solve them himself. The usual medical attitude of "curing" has to be modified in treating emotional ailments. To set aside our usual handling of patients will not come about easily. Gradually by repeated efforts we come to learn not impulsively to tell a patient what to do, but designedly to act as catalysts in the solution of emotional problems. Time and experience will increase proficiency.

One of the commonest complaints of patients is headache. After we've exhausted our investigations, sinus treatments and checked for glasses, etc., a great number of cases still remain unsolved. If the obvious organic conditions have been excluded and the patient has a headache "like a band around the head", or "a pressure feeling" or a caplike distribution, psychic causes may be very active. Encouragement of the patient to say how and under what circumstances the headache appears should be the first step. It has been found that many headaches are due to tension and these "tension headaches" are closely related with "bottled-up" hostility against someone to whom they are close. Again a blundering approach will drive the patient away but free "ventilation",—in which the patient tells his story with only a few encouraging words from the physician, may work wonders.

Do not expect results overnight—it may take more than several visits but a patient relieved from incapacitating headaches is a very grateful one.

Psychoses:

As yet little comment has been made concerning psychotic (i.e., mentally ill, or "insane") patients, as little seemed indicated in this paper, since its goal is the general practitioner and the cases he meets in his general practice.

However, every physician sees a few psychotics. Generally speaking they are much too sick to be cared for at home and require specialized care and treatment. This particularly applies in cases of depression, and that insidiously developing condition of the 'teens and twenties, schizophrenia. The treatment of these patients requires a great deal of skill and special hospital arrangements and, like chest surgery and neurosurgery, such treatment

should not be undertaken by the general practitioner, if any other solution is possible.

One more word—the prognosis in cases of psychosis is much more optimistic than is generally known; depressions especially, if kept from self-destruction and inanition, by some of the new treatment methods with careful hospital care, very frequently recover.

Conclusion:

From the "newest science, but the oldest art, in medicine" medical practice has much to gain, and a few of the commonest problems are here discussed and some practical applications of psychiatric methods suggested in their handling.

Systemic Symptoms

Everything that favors and promotes general health helps to keep the eyes in a healthy condition and enables them to function at their maximum, national health experts say. While the eyes are a part of the nervous system, they are affected also by other systems, especially the circulatory, digestive and glandular.

They are so sensitive to changes in these that ocular disturbances often provide early clues to systemic conditions. Eye infections may affect the general health and difficulties originating in the eyes may spread to neighboring tissues.

Food for Thought

You don't need an expert to tell you that your appetite is closely related to your emotions. But doctors point out that it is true if you are happy and serene, you are better able to digest your food than if you are emotionally upset. "Laugh and grow fat" is a cheerfully flippant phrase, but one which is backed by some scientific proof.

On this same basis, scientists comment, family disagreements, stories of children's misdeeds during the day, cajoling, lecturing, excitement and threats of punishment should be forgotten at meal time.

Society Meetings

Colchester-East Hants Medical Society

THE Medical Society of Colchester-East Hants held a regular semi-annual meeting at Pryor's Guest House, Pictou Road, on October 29th. A turkey dinner was served at 7 p.m. followed by the business and professional sections.

Those present were—President P. R. Little, J. B. Reid, Jr., J. A. Muir, R. F. Ross, E. M. Curtis, S. G. MacKenzie, Jr., T. C. C. Sodero, H. R. McKean, H. R. Peel, W. J. MacDonald, D. S. McCurdy, all of Truro, Doctors Dan Murray and A. M. Creighton of Tatamagouche, Doctor T. H. Earle of Upper Stewiacke and Doctor D. F. MacInnis of Shubenacadie.

Two items of business were of special interest:

1. The new scale of fees as received from the Nova Scotia Workmen's Compensation Board.

At our last meeting this subject had been discussed and a strong, unanimous resolution passed requesting that the proper authorities press for a revision in compensation fees to a level of the D.V.A. schedule. The one submitted is an improvement in many ways, but it is still unsatisfactory to the general practitioner especially in the mileage. Perhaps those who decide on this matter do not fully realize that as far back as 1888 mileage for medical men was practically the same as to-day. The new schedule does not give any increase although much of the year the same mode of transportation has to be used for trips to lumber camps as was used a half century ago. This item should be further considered and an organized effort made to have it adjusted to a more suitable and just amount which would obviate to some extent the difficulty now had in securing medical attendance in remote regions.

2. A committee was appointed to examine and bring in a 1948 scale of medical fees for our Society.

It is of interest to note previous to 1889 our fees were—home visits 50c; obstetrical cases $8.00. In 1889 a revision increased them to $1.00 and $20.00 respectively. In 1907 some little increase was made and again in 1932 a scale of home visits, $2.00-$5.00; obstetrics $20.00 to $30.00, the minimum fee being the usual one charged.

The professional section of our programme consisted of:

1. Substernal and Epigastric Pain, by Doctor J. W. Reid of Halifax.
2. Tuberculosis and Streptomycin, by Doctor H. D. Lavers, Fundy Divisional Medical Health Officer.

Doctor Reid as our guest discussed his subject in a most interesting, instructive and helpful way. His ready sense of humour, his review of recent thought on this subject and his differential diagnosis from the many possible conditions in the abdomen and chest made a live subject of what otherwise might have been facts and figures.

Doctor H. D. Lavers presented two cases of tuberculosis, with X-ray findings, which were treated successfully with streptomycin. Both the kidney case and the pulmonary case progressed satisfactorily.

Considerable discussion followed these two subjects and the Society enjoyed a very successful meeting.

D. S. McCurdy
Secretary-Treasurer

Cape Breton County Medical Society

At a recent meeting of the Cape Breton County Medical Society held at North Sydney 21st October, 1948, the following resolution was unanimously endorsed:

Resolved, that nominations to the House of Delegates of the Maritime Medical Care Incorporaed be made by separate Branch Societies of The Medical Society of Nova Scotia, and not from the floor of an open meeting of The Medical Society of Nova Scotia, or by the executive of The Medical Society of Nova Scotia.

Further, that a copy of this resolution be sent to the Secretary of The Medical Society of Nova Scotia for publication in the Nova Scotia Medical Bulletin and also a copy be sent to the President of the Board of Directors of the House of Delegates of Maritime Medical Care Incorporated and also a copy sent to the Secretaries of all Branch Societies.

The certificates concerning the deduction of expenses of attending the annual meeting at Keltic Lodge for income tax purposes may be obtained from the Secretary. If, when applying for them, the doctor would state how many days he was in attendance at the meeting, the certificate can be filled in and sent to him.

LOCUMS REQUIRED FOR FOUR MONTHS

Doctor C. S. Smith of Liverpool would like a locums for three months beginning January 1, 1949. Following this Doctor J. C. Wickwire, also of Liverpool, would employ him for one month. For further particulars apply to Doctor Smith.

Behind Dark Glasses

Sun glasses should be used only during periods of exposure to bright sunlight unless a more continuous use is recommended on the basis of a careful eye examination. The color of the lenses is largely a matter of choice, sun glasses should not alter the hues of natural scenery.

Physicians say that indiscriminate use of sun glasses may tend to lower the tolerance of the eyes to light. They are meant for daytime use only and in night driving are a hazard rather than a help.

Personal Interest Notes

DOCTOR Ralph P. Smith of Halifax has been recognized amongst the list of Founding Fellows of the College of American Pathologists. This recognition was given "in absentia" in Chicago on October 11th, and Doctor Smith is the first Canadian to be given this recognition. The College of American Pathologists, which was formed last year in the United States, is the counterpart of the American College of Surgeons, a group which includes the leading surgeons of the continent. Doctor Smith graduated from Glasgow University, with honours, and for submitting the outstanding thesis of his class, he was awarded the Bellahouston Gold Medal. He received his public health diploma from the Royal College of Physicians and Surgeons, a group jointly sponsored by Glasgow and Edinburgh Universities. After graduation, he was assistant to the professor of pathology at Glasgow University and later held a similar post at Durham University, Newcastle-on-Tyne, England. On his arrival in Canada 21 years ago he was certified as a specialist in pathology in the United States, before there was such a group of the College of American Pathologists.

The many friends of Doctor H. K. MacDonald of Halifax will regret that he has been a patient in the Victoria General Hospital since October 26th, as a result of being struck by a truck as he was about to enter his own car. We are very glad to report that he is progressing favourably, and we expect to see him around again within a short while.

Doctor J. F. Hogg of Antigonish has been appointed a member of the Nova Scotia regional fracture committee, a branch of the fracture committee of the American College of Surgeons.

We are sorry to learn that Doctor F. R. Little of Halifax is at present a patient at the Halifax Infirmary.

Among the naval reservists who joined ships of the R.C.N. Pacific fleet for the recent cruise to Pearl Harbour was Surgeon Lieutenant Commander Charles M. Harlow, R.C.N.(R.) of Halifax. In private life Doctor Harlow is on the staff of Camp Hill Hospital and Dalhousie University.

Doctor William H. Frost has been appointed medical officer in charge of quarantine, immigration medical and sick mariners' service in Halifax for the Department of National Health and Welfare, to succeed Doctor J. L. Cock, O.B.E., who has been superannuated. Doctor Frost graduated from Dalhousie Medical School in 1939 and in public health from the University of Toronto, and has been with the Federal Health Department for the past eight years.

Doctor John Peter Debly of Saint John, Doctor Allan Simpson MacIntosh of Waverley and Doctor John James Macneil of Glace Bay recently passed the examination set by the Medical Council of Canada.

Doctor B. F. Miller recently returned to Halifax from England after completing over two years in the post-graduate study of Orthopaedic Surgery. Doctor Miller was graduated from the University of Liverpool with the degree

of Master of Orthopaedic Surgery, received his Fellowship in the Royal College of Surgeons of Edinburgh and also spent six months as Assistant Orthopaedic Surgeon at the Orthopaedic Hospital, Stoke-on-Trent.

Doctor Clement MacLeod, medical superintendent of Camp Hill Hospital since 1938, has been transferred to Westminster Hospital, London, Ontario. Doctor T. E. Kirk of Montreal, has been appointed to succeed Doctor MacLeod.

Doctor Norman H. Gosse of Halifax was elected a governor of the American College of Surgeons at a meeting held in Los Angeles in November.

Doctor J. C. Worrell of Halifax was appointed Deputy Medical Examiner for Halifax and Dartmouth according to a list of appointments released recently by the Provincial Secretary's office.

Doctor J. G. MacDougall of Halifax has been appointed a member of the Provincial Medical Board by the Provincial Government to succeed the late Doctor M. G. Burris.

Doctor Ian E. L. H. Rusted, Dal. 1948, of Carbonear, Newfoundland, has been awarded a three year scholarship at the Mayo Clinic, starting October, 1949. Doctor Rusted will continue his research studies at McGill University until that time.

The Bulletin extends congratulations to Doctor and Mrs. F. J. Barton of New Waterford on the birth of a son on November 22nd; to Doctor and Mrs. P. G. Loder (Joan Cooley) of Kentville, on the birth of a son, Paul Godfrey, on October 6th; to Doctor and Mrs. E. P. Nonamaker of Halifax on the birth of a daughter on October 8th; to Doctor and Mrs. C. M. Leighton (Laura MacKenzie) of Montreal, on the birth of a son, Robert MacKenzie, on September 28th; and to Doctor and Mrs. J. F. L. Woodbury of Halifax, on the birth of a daughter, Mary Gail, on December 1st.

Doctor L. B. W. Braine of Annapolis was recently guest of honour at a banquet staged by leading citizens of Annapolis, where he has practised for the last thirty years. Doctor Braine will take up residence at St. Margaret's Bay where he first practised after graduating from Dalhousie Medical School in 1900.

Doctor H. B. Atlee of Halifax was guest speaker at a banquet of The Order of Good Cheer held at Annapolis on November 24th, when he gave an address filled with humour and inspiration.

We regret that Doctor W. H. Eagar of Wolfville is at present a patient in the Victoria General Hospital.

The marriage took place in Antigonish on November 23rd of Miss Olive Petrie, R.N., daughter of Mrs. Petrie, New Waterford, and the late Patrick Petrie, and Doctor Martin S. MacDonald, son of Mr. and Mrs. John A. MacDonald of Halifax. Doctor MacDonald graduated from Dalhousie Medical School in 1945 and is at present connected with the Glace Bay Medical Clinic.

Recent Fellowships in Surgery, Royal College of Physicians and Surgeons of Canada

Edgar Paul Nonamaker of Halifax, Dalhousie 1942, four years with the R.C.A.F., two years graduate training in surgery at the Victoria General Hospital, now practising in Halifax.

Seymour Gordon MacKenzie of Truro, Dalhousie, 1940, overseas with the R.C.A.M.C., one year graduate training in surgery at the Victoria General Hospital, now practising in Truro.

Recent Certification in Surgery, Royal College of Physicians and Surgeons of Canada

Gordon Wallace Bethune, of Baddeck, B.Sc., Acadia, 1939, Dalhousie, September 1, 1943, overseas with the R.C.A.M.C., two years graduate training in surgery at the Victoria General Hospital, now practising in Halifax.

John Herbert Charman of Halifax, Dalhousie, September 1, 1943, overseas with the R.C.A.M.C., two years graduate training in surgery at the Victoria General Hospital, now practising in Halifax.

Recent Admissions Royal College of Physicians and Surgeons of Canada

Doctors C. E. Kinley, N. H. Gosse, T. M. Sieniewicz and G. B. Wiswell, all of Halifax.

Announcement is made by Federal Security Administrator Oscar P. Ewing that Dr. James A. Doull, Chief of the Office of International Health Relations, Public Health Service, has been detailed to the American Leprosy Foundation (Leonard Wood Memorial) as Medical Director. His appointment becomes effective November 1, with headquarters in Washington.

In his new position Dr. Doull will carry on studies designed to fill in several gaps in the present knowledge of the epidemiology of leprosy, to evaluate current methods of treatment and to give assistance to countries where leprosy is a problem. The Foundation is now supporting epidemiological studies in the Philippines and special bacteriological laboratory at the Harvard Medical School. Dr. Doull plans to work closely with the Public Health Service in its leprosy control work.

Dr. Doull has headed the Service's Office of International Health Relations since 1945, with the rank of Medical Director. He was an alternate delegate to the first World Health Assembly in Geneva this summer. He represented the United States at the International Office of Public Health and was an alternate member of the United Nations Technical Preparatory Committee on Health, both held in 1946 in Paris. He was chairman of the medical advisory board, American Leprosy Foundation from 1940-43.

A former professor in Western Reserve University's School of Medicine, Dr. Doull has also served as special mission officer, Lend-Lease Administration, and as medical consultant to UNRRA and Foreign Economic Administration. He joined the Public Health Service in 1943. Dr. Doull graduated from Dalhousie University in 1914.

Obituaries

Dr. George William Tooker Farish

THE death occurred in Yarmouth on November 19, 1948, of Dr. George William Tooker Farish. Dr. Farish was in his 87th year and with his passing his native town, county and province have lost an outstanding figure and a respected and well-loved son.

In the words of an old saying Dr. Farish came by his career in the medical profession honestly, since his family tree was very liberally ornamented with physicians. Now for the first time in 140 years Yarmouth has no Doctor Farish. Somewhere, however, there is still a doctor of that name, for many will remember that at the Annual Meeting of The Medical Society of Nova Scotia held at White Point Beach in 1944 there was present a young man in the uniform of the medical branch of the navy, who bore the name Farish and who was if my memory is correct, a nephew or a grand nephew.

In spite of a very busy life as a popular practitioner Doctor Farish never failed to find the time to support any worthwhile cause, and for some projects he provided energetic and sustained leadership. Such a project was the establishment of a local hospital, and the modern institution which Yarmouth now enjoys must have given him real satisfaction.

During the war I was occasionally in Yarmouth in connection with the Blood Donor Service. On my first visit Dr. Farish was present at one of the meetings. He took a great interest in the nature of the idea and its execution and gave it his enthusiastic support. Such encouragement is often gratefully remembered, and long. There must be many who have such cause to remember Doctor Farish.

The Bulletin extends sympathy to Doctor G. A. Barss of Rose Bay, on the death of his wife and also to the son, Doctor A. H. Barss of Riverport, which occurred suddenly on October eighth, although Mrs. Barss had been in poor health for some time. Also sympathy to Doctor W. H. Eagar of Wolfville on the death of his brother, Mr. M. W. Eagar of Grande Prairie, Alberta, which occurred recently, to Doctor F. R. Little of Halifax on the death of his brother, Mr. Guy A. Little, on November 19th, and to Doctor W. E. Fultz of Glace Bay on the death of his father, Mr. W. S. Fultz on November 13th.

THE NOVA SCOTIA MEDICAL BULLETIN

INDEX VOL. 27, 1948

(Numbers refer to pages)

Abbreviations used: Ab. for abstract; anon. for anonymous; biog. for biographical note; C. for correspondence; C.R. for case report; diagr. for diagrams; Ed. for editorial; illus. for illustration; Obit. for obituary; Pers. for personal item; port. for portrait;rev. for review.
