



DR. C. B. STEWART  
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## Doctor Chester Bryant Stewart

THE Bulletin is happy to announce that one of its associate Editors, Doctor C. B. Stewart, was appointed Dean of the Faculty of Medicine of Dalhousie University on May 8, 1954. His appointment was to be effective on June 1, but the sudden death of Doctor H. G. Grant made it necessary for him to assume his new duties earlier. While he is well known to many members of the profession in Nova Scotia only a few are aware of his entire list of achievements and the distinction they confer on his new position.

Doctor Stewart, who has been Professor of Epidemiology at Dalhousie, was awarded the degree of Doctor of Public Health, last year, by Johns Hopkins University, Baltimore. He is believed to be the only physician in Canada with that distinction. He was also granted a Fellowship in the American Public Health Association and is certified in Public Health by the Royal College of Physicians and Surgeons of Canada.

A native of Norboro, P. E. I., Doctor Stewart received his early education on the Island, was gold medallist at Prince of Wales College, and entered Dalhousie, on a George H. Campbell Memorial Scholarship and a Prince of Wales College Scholarship, in 1932. He won several prizes in each year of his medical course and, on graduation in 1938, was awarded the University Medal for highest standing in his class. In addition to the regular work of his course, Doctor Stewart undertook studies in medical research and, in 1936, received the degree of Bachelor of Science.

Following graduation, Doctor Stewart became a member of the National Research Council's Associate Committee on Medical Research, working under the direction of the late Sir Frederick Banting. In 1939, he was a member of the first Committee on Aviation Medical Research which initiated research in this field of Medicine in Canada. During the war years he served with the Royal Canadian Air Force, in the rank of Wing Commander, as commanding officer of medical research units responsible for studies of the medical problems of high altitude flying. He has been described as one of the international authorities on decompression sickness and has published some twenty papers in this field and about twenty-five additional publications in other fields of Medicine and Public Health.

Between 1949 and 1951, Doctor Stewart conducted research in the public health needs of Nova Scotia, as Director of the Health Survey, producing an exhaustive two-volume report on the hospital facilities and public health services of the province. During the same period he was active in the planning and supervision of the Canadian Sickness Survey in the three Maritime Provinces. In 1951 he was granted a year's leave of absence from Dalhousie to accept a post as research associate in Epidemiology at Johns Hopkins University. He is a member of the Advisory Committee on Medical Research of the National Research Council, the Specialty Board in Public Health of the Royal College of Physicians and Surgeons of Canada, the Examining Board of the Medical Council of Canada, and is associated with most of the medical and public health associations of Canada and the United States, holding executive positions in several. Recently he had the honour of being invited to participate in the deliberations of a committee to review the future programme of research

and teaching in Epidemiology at Johns Hopkins University. His status in medical research was also recognized in his appointment, in 1948, as chairman of a committee to survey medical research facilities in Canada for the National Research Council, Defence Research Board, and the Department of National Health and Welfare.

Doctor Stewart is married and has two daughters. Mrs. Stewart is the former Kathleen French of Regina.

The Editor and his other Associate Editor tender most sincere congratulations to Doctor Stewart on his new appointment and bespeak for him the support of the profession at large in his great new undertaking.

# Trends In Anaesthesia\*

DR. WESLEY BOURNE

Le Changement est la premiere necessite de l'existence

Anatole France. *Le livre de mon ami.*

WITHIN and around the living cell "mysterious waters" tell their ineffable tale but slowly. Although many of the activities in these waters have been explained by the biochemist, yet, other innumerable activities remain obscure; and, as all of them, undoubtedly, are of vital importance, it seems wise that these waters be guarded, so perhaps to influence their ripple or even surging sea, not only in health but also when drugs that are given inevitably ruffle the harmony—harmony in "the continuity between inorganic, biological, and social order; and similar in nature to the transition from lifeless proteins to the living cell." (Joseph Needham)—Evolution from the non-living to the living. Throughout, notwithstanding the many veritable evidences of growth and stability, change has been constant. The thought has been well put by John Masfield:

Out of the earth to rest or range  
Perpetual in perpetual change,  
The unknown passing the strange.

Water and saltness held together  
To tread the dust and stand the weather,  
And plough the field and stretch the tether,

— — — — —  
For all things change, the darkness changes,  
The wandering spirits change their ranges,  
The corn is gathered to the granges.

The corn is sown again, it grows;  
The stars burn out, the darkness goes;  
The rhythms change, they do not close.

They change, and we, who pass like foam,  
Like dust blown through the streets of Rome,  
Change ever, too; we have no home,

— — — — —  
*The Passing Strange*

This poet mentions water and salt, so let us not forget one of the interpretations which the biologist, A. B. Macallum, gave to some of his investigations in 1903, namely, that the blood plasma, with a closed circulatory system, is, in its inorganic salts, but a reproduction of the sea water of the remote geological period in which the prototypic representatives of such animal forms as first made their appearance. He stated that enough has been

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\*Given at the Victoria General Hospital Staff Conference April 2nd 1954 as part of the short course in anaesthesia.

advanced to make it extremely probable that the inorganic composition of the blood plasma of vertebrates is an heirloom of life in the primeval ocean.

In complementary mode, Sir Charles Sherrington has written as follows: "Obstacles to life's adventure we might have supposed insuperable were overcome. One of those old difficulties was that life at its beginning has been wholly aquatic, though so long ago that the very saltness of the sea was then much less than now. There the lives in it, for instance those of our own primitive stock, multiplied, flourished, and evolved. Later this life invaded the land. Some of our earlier stock took part in this invasion. Life, as chemistry is, so to say a dynamic 'steady-state'. The moving equilibrium of the cells' life in our early stock was almost literally an energy-eddy in the sea. The water of the sea conditioned it. Its energy-exchanges were based upon the sea. How if cut off from the sea could such a life exist? The Canadian biologist, Archibald Macallum (says Sherrington), gave a reading to the riddle. The salts dissolved in our blood today commemorate it, in kind and in concentration. They are those of the ocean of that long past geological epoch."

Now, in like manner to the combination of continuity with stability of a flux, in like manner to the first step in the evolution of vertebrates from an invertebrate form, along with the persistent stream of actuality in anaesthesia, there flows an ever-increasing diversity of mutation, a salutary plurality of discoveries, enhancing the unity, where so much is great and so much is strange *in the boundless realm of unending change* (Shelly).

Not for naught has there been good relationship between the laboratory worker and the anaesthetist, who, in spite of his extensive interest in things scientific, is primordially a technologist. But he will ponder as did Henry David Thoreau: "Facts which the mind perceive, thoughts which the body thought,—with these I deal." There could hardly be a better definition of the way whereby he spanned the gap between the idea and the object.

*Thought alone is eternal* and, like a running stream, change goes on and on. Change is universal in time and place. My epigraph, taken from Anatole France, has it that "Change is the first necessity of existence." Recently, Henry K. Beecher, Professor of Anaesthesia at Harvard Medical School, wrote me asking for an expression of opinion, from the anaesthetists of Paris, on what they consider the ten or a dozen main trends in anaesthesia over the last fifty years. Accordingly, I sent out a questionnaire. From the replies, the general belief seems to be in the following order:

1. Provision of opportunity for young doctors to learn anaesthesia.
  - a. Organization of Centres.
  - b. Establishment of laboratories for research.
2. Use of Oxygen.
3. Elimination of carbon dioxide.
  - a. Absorption.
  - b. Non-rebreathing.
4. Knowledge of the effects of drugs used in anaesthesia on the vital functions.

5. Discovery of muscle relaxants.
6. Pre- and post-operative care.
  - a. Employment of psychotherapy.
  - b. Parenteral feeding—blood, etcetera.
  - c. Establishment of recovery rooms.
  - d. Application of new methods of control—oximetry, E.C.G., E.E.G.
7. New Methods of Anaesthesia.
  - a. Tracheal intubation.
  - b. Non-rebreathing; Non-resisting valves.
  - c. Intravenous anaesthesia.
  - d. Assisted and controlled respiration.
  - e. Controlled hypotension—"High Spinal" or ganglioplegies.
  - f. Potentialized artificial hypo-thermia.
8. New anaesthetic agents.
  - a. Short acting barbiturates.
  - b. Cyclopropane.
  - c. Ethylene.
  - d. Vinyl ether.
  - e. Trichlorethylene.
  - f. Regional anaesthetics.
9. Improvements in Regional anaesthesia techniques—Intra-the-cal, epidural.
10. Complemental Combinations of anaesthetic agents and methods.

Evidently there is a great deal of overlapping in this list and there was some difference of opinion about the order given here. But this is not a serious matter. We can all agree that such important trends have been in action and such improvement, that the surgeon's work has been enhanced and extended, and that the patient is assured of increased ease and safety.

In 1948, at the annual session of the California Medical Association, held in San Francisco, I said, and still feel the same way, that "I do believe that the best of all that's new in anaesthesia *is the new and widespread interest in the provision of opportunities for those who desire to learn anaesthesia.*" For each young aspirant, let us increase the timeliness to unfold inclination and to develop thought. Then, with feeling, he, the young aspirant, may say with Emerson:

I am not poor, but I am proud.  
Of one inalienable right,  
Above the envy of the crowd,—  
Thought's holy light.

Better it is than gems or gold,  
And oh! it cannot die,  
But thought will glow when the Sun grows cold,  
And mix with Deity.

*Thought.*

Lately, Stuart Cullen (Recent advances inesthesiology, Wisconsin Med. Jour. 50: 351, 1951) wrote that "the truly significant advances have been the result of the introduction into clinical practice of new and revised fundamental concepts in the basic sciences."

These two quotations tend to support answer one of the questionnaire and it is most encouraging to note that increasingly more and more teaching centres are being organized and that research in anaesthesia is being intensified. Augmentation in these directions has meant development and advancement of the speciality, has made it so that the other questions could be answered as they have been and gives assurance of growth and fruition.

In revision of the literature on anaesthesia, it is noteworthy how interwoven this specialty has become in recent years with other branches of the profession. Common frontiers exist with the different realms of diagnosis and of therapy in obstetric and in the surgical specialties.

With research workers of the basic sciences, there is a common interest in the elucidation of our problems; in the rational use of drugs and in the execution of methods. Indeed, collaboration continually increases. Finally, it is the common court of pathology which divulges some of its secrets to aid the practice of anaesthesia.

And now, some more specific instances may be given: By electroencephalographic studies in health and disease, during sleep, and in subjects under the influence of various drugs, various patterns have been obtained and classified. These are suggestive if not always pathognomic of underlying foci of abnormality and of the different stages of anaesthesia. Such studies are being utilized not only for the observation and surgical control of cerebral conditions, but also for the investigation of cerebral influences upon the autonomic nervous system and in the accurate control of anaesthesia levels.

The effect of drugs upon the cerebral circulation may be of more than theoretical importance, as in the cases of coronary and renal blood flow. Schmidt states that many drugs may give rise to cerebral vascular dilatation in the experimental animal, so long as the concentration is not sufficiently high to depress the vasomotor centre and thereby cause a redistribution of blood. There appear to be no drugs which are uniform cerebral vasoconstrictors.

Concerning cardiac arrest in man, it has been pointed out that this can occur either following ventricular fibrillation or in the absence of it. Ventricular fibrillation can also occur following cardiac massage of a heart not previously fibrillating. It is evident that there are certain factors which predispose to cardiac arrest, in general cases, as well as in intrathoracic surgery. There are: (1) An overdose of anaesthetic drugs; (2) Coronary disease; (3) Myocardial insufficiency; (4) Hypoxia, this especially in the presence of the former two conditions; (5) Shock due to operation or to blood loss; (6) Vago-vagal reflexes during operation and at the time of intubation or extubation; (7) Electrolyte imbalance. These may all be considered as predisposing to cardiac arrest.

Often difficulty is experienced in diagnosis either clinically or with electrocardiographic aid. It is advised (1) that all possible prophylactic measures

should be taken to avoid the risk of cardiac arrest by noting the causes which predispose and (2) that, if cardiac arrest can definitely be diagnosed, immediate effective massage must be undertaken, and, if the heart is in a state of ventricular fibrillation, it must be shocked out of that state. Emergency equipment ought to be available for this purpose.

There are so many reports of continuing studies on other cardiac abnormalities, on arterial pressure and on sympathetic blocking agents, that it is not feasible to deal with them at this time. Those of you who are interested may find much detail in the Annual Review of Medicine, 3, 1952.

With regard to relaxing agents, their use in anaesthesia is reminiscent of the names, Claude Bernard, Laewens and Griffith. Several new drugs have been produced. Meanwhile much has been done to elucidate the physiology of the myoneural junction. Harold Griffith recently said: "The addition of curare and other muscle relaxing drugs has greatly widened the practical application of the anaesthetic gases. Our experience with curare, which extends not over twelve years, tends to confirm our first impressions that its use eliminates the need for toxic deep anaesthesia. I am aware that in certain circles there has been criticism of the use of relaxant drugs, but I am sure that any evidence there may be for increased operating room mortality is based on misinterpretation of all the factors involved. Wherever curare has been used by careful anaesthesiologists, within the recommended clinical dosage, in combination with proper anaesthesia, and with maintenance of good oxygenation it has been a blessing to patient and surgeon alike. The new muscle relaxant drug, succinylcholine ("Anectine") will probably largely supplant d-tubocurarine, because of its short action and its controllability. When succinylcholine is given as an intravenous drip in dilute solution its rate of flow may be so regulated that abdominal muscle relaxation may be turned on or off as the exigencies of the operation require, and as the drug is so rapidly broken down and metabolized there is very little side-effect to worry about."

Now about the respiratory system, the essential physiological factors calling for the necessity of assisting respiration under some circumstances, and the pros and cons of controlling it, with the subsequent physiological embarrassment, have been ably set forth by Watrous, Davis and Anderson of Oakland, California. The methods by which these are achieved and possible sequelae, if incorrectly performed, are described in detail. Awareness of the possible deleterious effects upon the circulation is stated, and methods are advanced to minimize them. It would seem that there is agreement concerning the effects upon the circulation of positive endopulmonary pressure or negative external pressure, as compared to electrophrenic respiration.

Physiological respiratory assessment is being wisely applied to assay risk before surgery, especially of the thoracic type—so well carried out in some of the clinics of France. Such an assessment must be carefully studied and coordinated with clinical judgment.

From the clinical point of view, stress is being laid upon individual attention to premedication, that is, one should consider each patient separately and keep in mind the great differences in operative risks, age limits and the use of drugs which depress respiration minimumly. Complementary combina-



tions of drugs are being used in the belief that, as toxicity is really the interference with enzyme systems, it is impossible to obtain effect without inhibiting one or more of these systems. Yet, the toxic properties of drugs depend, in large extent, on the dosage; that is to say, on the capacity of the body to handle and eliminate the drug. The practice has evolved, therefore, of using small amounts of several drugs, each having its peculiar effect with little derangement.

In the light of improved procedure in assay, trend is that old agents and old methods are being re-evaluated. Such a re-evaluation took place at the University of Wisconsin, where Waters with several collaborators made laboratory and clinical studies on chloroform. They have published a book, called, *CHLOROFORM: A study after 100 Years* (The Univ. Wisc. Press, 1951). The descriptions are delightfully and easily intelligible. The authors deserve the highest commendation for excellent sets of work. Throughout the book emphasis is laid upon the avoidance of hypoxia in all forms of anaesthesia, bringing to light, stressing and proving the suggestion made by Thompson (W.H.:B.M.J., i: 608, 1906) 48 years ago, and verifying the work of Loevenhart and his co-workers (A.S., Koehler, A.E., & Brunquist, E.H., J. Biol Chem. 64: 313, 1925) 29 years ago. These latter observers had shown that anoxia per se causes a more marked acidosis than is found in any other condition. The lesson for us to learn is that: We *must* maintain a clear, unobstructed free airway, *must* do all in our power to assist the anaesthetized individual to get rid of carbon dioxide and *must* supply and adequacy of oxygen—nay more! even a superabundance! In these connections, Waters wisely reminds us that the vapour of any volatile agent in the respired atmosphere occupies space in the alveoli and is bound to take some of the place that oxygen ordinarily takes at the alveolar wall, tending to diminish the fullness of oxygen absorption and leaving less room for the excretion of carbon dioxide.

If these precautions are taken, chloroform anaesthesia may be made relatively safe. But there still remains the serious consideration of the effects of chloroform on the circulation of the blood. Sudden and severe changes may take place even with, what might be spoken of as, the slightest innocence or ignorance, or, even with, what might be called, the slightest carelessness or negligence, concerning the dangerous depression which the Wisconsin workers have elucidated so well. This dangerous depression of the circulation is all the more momentous when we realize that, as yet we have not got the means of making very small and accurate changes in the concentration of chloroform vapour. A means of *vapourizing chloroform with accuracy* is particularly needed, and Waters has ended his conclusions with a plea for the discovery.

It is not known yet exactly where chloroform acts on the enzyme systems, but according to Quastel, this drug has two types of action; one reversible and the other irreversible. This latter action becomes more pronounced with increasing concentration and with increasing duration of anaesthesia. All that can be said at the present time is that chloroform interferes with the processes which have to do with the oxidation of glucose. It is altogether likely that the irreversible effects of chloroform are closely bound up with the failure of the mechanisms responsible for the regeneration of adenosinetriphosphate (ATP).

Coming now to intravenous anaesthesia, I shall say only that evipal, pentothal, surital, kemithal and such like other "-als", while they are pleasant for the patient and are a boon which we should not want to be without, yet these drugs are to be used cautiously. They are deceptively easy to administer, but not always easy to control. They should be used only for induction of anaesthesia prior to the giving of inhalation agents and by themselves only for very short operations. They should not be used in the presence of respiratory obstruction, in cases of shock, haemorrhage, marked obesity, or in the very old.

Since the world wide publicity which was given the incidence of complications following spinal anaesthesia by Foster Kennedy and Perry, 1950, the eyes of the medical profession have been focussed upon this factor. This was good in a way as it prompted analysis of the situation. Several large series of spinal anaesthesia cases have been reported. In spite of the crippling conditions which are inevitably seen at the big neurological centres, the general impression remains that such conditions are in reality rare and that there is no need to abandon a sound form of anaesthesia when indications arise for its use. And so, steps have been taken, and are being taken, to modify techniques in order to lessen the complications of spinal anaesthesia.

For the poor risk patient, recommendations continue, and there is an unanimous expression given to the importance of individual treatment before, during and after operation. This applies to drugs used, techniques employed, postures adopted, electrolyte balance and the like. Emphasis is laid upon the effects of all these on a patient who has already suffered physiological trauma.

In thoracic surgery, it is well to bear in mind that the observations made with the chest open reflect upon the circulatory system, the respiratory system and the chemistry of the blood. There is still no unanimity on the type of anaesthesia to be employed in major chest surgery. This is well, for each type appears to be selected with the foregoing considerations in view. Surgery is only undertaken after thorough preoperative studies; and, diligent post-operative care follows. In reality it matters little the drugs used, or the methods, so long as the anaesthetist knows what he is doing. A good anaesthetist chooses well.

Reports concerning anaesthesia in obstetrics, show that it is still an old problem of considerable controversy. Since the publication of Granty Dick Read's book, the psychological approach has been applied more and more. And sedative and analgesic drugs are being used more carefully. Of all that we may do in the relief of pain in obstetrics, the whole matter centres itself around two thoughts, namely, of oxygenation and freedom from immoderate drug depression. Of the many drugs, almost any may be allowed from dependable hands for the early part of labour. Then, from competent hands, nitrous oxide and oxygen for intermittent analgesia towards the beginning of the second stage of labour, and continuous anaesthesia for the final stages, produced by the same nitrous oxide with oxygen, along with just enough of some other more potent agent. In lieu of this procedure, but from equally dependable hands, one of the forms of regional anaesthesia may be adopted, that is, such as spinal anaesthesia of the "saddle back" variety with nuper-

caine. For those who are less experienced and for the general practitioner, vinyl ether or trichlorethylene, followed by ethyl ether, is highly recommended after the beginning of the second stage of labour.

Trend in paediatric anaesthesia has been made clear through the efforts of Leigh and Belton, of Stephen and Slater, and of Bourgeois-Gavardin. Particularly have they stressed the anatomical, physiological and biochemical differences obtaining between the young and the adult. And they have elaborated the non-rebreathing: non-resisting valve. This valve provides a foolproof method of casting out from the respiratory passages the gaseous products of metabolism, reduces the dead space to a minimum of resistance against which the patient must breathe. They all state that "of least importance is the agent selected, be it cyclopropane, ether, pentothal, or nitrous oxide and curare. Any one or combination of these may be feasible, provided the technique and manner of administration does not work against the physiological requirements of the patient. In infants under two years of age, employment of a non-rebreathing valve with 'compensated' respirations appears to work best towards the desired principles." "But no matter what the agent or technique, a satisfactory *outcome will depend on the acumen, diligence and application of knowledge* on the part of the doctor 'at the head of the table.'"

Without going into detail, it is certain that far more attention is being paid to the post-operative care of patients. To this fact, the increase in the number of post-operative recovery rooms bears witness. Many leading surgeons and anaesthetists have described such facilities as being life-saving and economical. Trend is to extend this splendid principle.

Here arises discussion on blood transfusion and oxygen therapy. Little is new, except that it appears that more care is being taken in the elimination of reactions and in control of the amounts of blood administered. Rapid blood transfusion by the intra-arterial route is now more than an attempt at saving life; it is the treatment for profound circulatory collapse with loss of arterial pressure. If blood or plasma is not readily available, the knowledge that some substitutes are of value may be of help. Hudson and Jacques have reported favourably on the use of polyvinylprolid and gelatine.

One would do well to read the monograph of Comroe and Dripps, "The Physiological Basis for Oxygen Therapy" (Charles Thomas, Publisher, Springfield, Ill., 1950). They give some very useful advice even to the point of showing how oxygen administration may not only be wasteful but may be harmful. Beecher and Heymans, separately, have made similar observations.

Finally, it is felt that this consideration of the trends in anaesthesia may suffice to stimulate within us an abhorrence for complacency, an ardour for higher perfection, and a living urge toward inquiry. Let us remind ourselves "that no static maintenance of perfection is possible. This axiom is rooted in the nature of things. Advance or decadence are the only choices offered to mankind." (Alfred North Whitehead).

Let us say, with Voltaire, "Il faut cultiver notre jardin." (Candide ou L'Optimisme, 1759).

# Doctor Isaac Webster, 1766-1851

Kenneth A. MacKenzie, M.D.

THE geneological records of the Websters have been well preserved. The first to come to New England was John Webster, a native of Warwickshire, England, who settled in Cambridge in 1633. He had a legal education and played an important part in the administration of his adopted country, having served in turn, as Magistrate, 1639 to 1655, Deputy-Governor in 1655 and Governor in 1656. His son Thomas married a Miss Alexander from a distinguished Scottish family and this union gave to the Nova Scotian Websters a good English and Scottish ancestry. Our Isaac Webster was a great-great-grandson of John.

Isaac Webster was born at Mansfield, Connecticut. He studied with a Dr. David Adams and as far as is known, had no college degree. The apprenticeship system was the usual method of medical training at this period. Abraham Webster, an uncle of Isaac was probably the first Webster to come to Nova Scotia (1760) and it was this man who persuaded Isaac to come to the province where it was claimed that medical men were urgently needed. So Isaac came in 1791 and after a brief stay in Yarmouth and Newport settled at Horton's Corner (Kentville) where he lived and practised his profession for more than fifty years. This was before the days of anaesthesia and anti-sepsis. Calls were made on foot or on horseback, and it is quite certain that Dr. Webster shared the hardships of the country doctor in carrying out his professional work.

Dr. Webster was the first, and for many years the only doctor in the district of Horton's Corner but several doctors were known to be in Kings County before him—Samuel Willoughby 1776, William Baxter 1782, Gurden Denison and R. Walton. From 1821 to 1825 Webster had a worthy colleague in the person of Dr. Robert Bayard, Edin. 1809 who later moved to Saint John and practised there for many years. His son Dr. William Bayard was considered the Dean of Medicine in Saint John for many years and was the first President of the Maritime Medical Association. Other physicians in Kings County during the Webster period were Drs. C. C. Hamilton, Lewis Johnstone, J. R. Fitch, J. R. DeWolfe, E. L. Brown, and E. N. Harding. In 1882, Dr. W. B. Webster, having completed his medical training at Edinburgh settled in Kentville with his father.

The records of the early physicians have not been well kept and interesting details are not available. Webster built a house called the "Chestnuts" where several of his descendants lived for many years. This house was torn down only a few years ago to provide a site for the C.P.R. Hotel, the Cornwallis Inn. Webster took an active part in community affairs. When the Duke of Kent visited the district in 1794 and was entertained by Judge DeWolfe it is likely that Webster was one of the party. A few years later it is recorded that a meeting was held in Webster's office at which it was decided to change the name of Horton's Corner to Kentville in honor of the Duke. One may surmise that Webster would often be seen, especially on Sundays and on special occasions, wearing his silk hat and frock coat, at that time a recognized form of dress even in the small villages.

If the records of Dr. Isaac Webster's professional career are scanty he has left one enduring record which is worth preserving in the medical archives of the province. Sixteen of his descendendants became members of the medical profession and many of them remained in the province. For one hundred and sixty-two years Nova Scotia has had a Dr. Webster in active practice. Sometimes there were two and for a few years three. The following is a list of the medical men who are descendants of Dr. Isaac Webster.

#### Sons

William Bennett Webster, M.P.P.	1789-1861.	Edin.	1820.
Frederick Augustus Webster	1807-1879.	Edin.	1832.
		Glas.	1832.

#### Grandsons

Henry Bentley Webster.	1852-1930.	UNY.	1872.
Arthur Douglas Webster.	1856-1941.	McGill	1878.
John L. R. Webster.	1835-1885.	UNY.	1858.

#### Grand-grandsons.

Charles Ashton Webster.	1864-1942.	UNY.	1886.
William Henry Chase, B.A. Acadia	1894-1938.	Dal.	1922.
Lalia Barclay Chase, B.A. Acadia	1893-	Dal.	1924.
Douglas Webster.	1884-	Edin.	
William Webster.	1888-1942.	Edin.	
Barclay Webster.		Edin.	

#### Great-great-grandsons.

Donald Robertson Webster, B.A., Ph.D.	1902-	Dal.	1925.
John Alexander Webster.	1914-	Dal.	1938.
Robert MacNaught Webster.	1920-	Dal.	1952.
John Francis Lydiard Woodbury, B.Sc. Dal.	1918-	Dal.	1942.
William Henry Chase.	1928-	McGill	1952.

William Bennett Webster, the son of Isaac, after graduating from Edinburgh University visited several clinics on the continent. In Kentville he soon took a leading place in the community both as a physician and as a citizen. Most of his professional life was before the days of anaesthesia and long before antiseptics had been established as a principle in surgery. He was recognised as a competent surgeon and a most interesting record states that in 1836 he successfully removed a cataract, the first operation of this nature to be done in the province. He was a faithful attendant at medical meetings and was a Charter member of The Medical Society of Nova Scotia in 1854. In 1858, he helped to draft a Bill to legalize dissection and later he brought it before the Legislature. The result was the Anatomy Act without which the organization of the Medical School in 1868 would not have been possible. Dr. Webster represented the county of Kings in the Legislature for many years. One of his hobbies was geology and his collection of specimens was presented to the Provincial Museum at Halifax.

Frederick Augustus Webster, a younger son of Isaac, spent four years in Scotland and took degrees from Edinburgh and Glasgow. He came to Yarmouth in 1833, at which time the practice was in the hands of two Bonds

and one Farish who married a Bond. This group was known as the "Family Combine" and Webster was an intruder. However, he succeeded in getting established in practice and eventually established friendly relations with the "Combine". Webster was acknowledged to be a good surgeon and one historian states that "he was the ablest man in Western Nova Scotia." His first years of practice were in preanaesthetic days and only in later years did he know anything about antiseptics. In his early days he made calls on foot or on the saddle and in later years he had a carriage which he built himself. His office was considered to be the biggest curiosity shop in the province, crowded with stuffed birds, reptiles, small animals and all the curios which he was able to collect. At one time he operated a wood-working factory which was not a financial success. He operated a large farm and was interested in horses, raising a special breed, some of which refused to be harnessed by anyone but the doctor himself. In later years he was disabled by rheumatoid arthritis and had to be taken on his calls in a specially constructed carriage devised by himself.

John L. R. Webster, son of Frederick A, joined his father in practice in 1858. He has been described as a large fine looking man weighing about two hundred and ten pounds and bearing a striking resemblance to "The Doctor" in Luke Fildes' famous painting. He is reported to have been the first doctor in Yarmouth to keep a full time office boy. This boy, James Hilton, had multiple duties;—preparing medicines, making pills, dressing wounds, pulling teeth, vaccinating children, keeping books and collecting accounts, duties which were usually carried out by the doctor's wife. Dr. Webster had a group of apprenticeship students several of whose names have been handed down;—James Hilton, the office boy who did not proceed to a university; George Butler who later practised in England; Joseph Messenger who settled in New York and three who practised in Nova Scotia, Edward Kelley, Simpson Lathern and Charles A. Webster. These students lived with their preceptor and had a special room where they studied human bones, plates and books; they were also taught elementary microscopy. An office fee in those days was twenty-five cents and a house call fifty cents which often included medicines. Many bills were paid with farm produce and while little cash was seen the needs of the family were bountifully provided for.

Henry Bentley Webster was the son of H. B. Webster, Barrister, and a grandson of Isaac. He settled in Kentville some years after the death of his uncle, Hon. W. B. Webster. He studied at Dalhousie, McGill and at the College of Physicians of New York where he received his medical degree. Later he took post-graduate training in Edinburgh. During his fifty years of active practice he was prominent in community affairs, being twice Mayor of Kentville. He was interested in medical societies. In 1888 he was Secretary for Nova Scotia for the Canadian Medical Association and at the end of his fifty years was made an honorary member of The Medical Society of Nova Scotia. He had a number of student apprentices whose names have not been recorded. His colleagues in Kings Co. were Henry Shaw, Henry Chipman, Barss, Brown, J. S. Miller, Holmes C. Masters, Field and Bowles.

Arthur Douglas Webster, brother of Henry Bentley received his degree at McGill and then proceeded to Edinburgh where he practised for sixty years.

He took the conjoint examinations in 1886 and also became a Fellow of the Royal College of Physicians of Edinburgh. In 1888 he took the degree of Bachelor of Science in Public Health. He was interested in military medicine and belonged to several units one of which was the 4th battalion of Royal Scots. He was in Kitchener's Army, wrote some interesting military reports and was awarded the Order of the British Empire.

Charles Ashton Webster, son of John L. R., studied at Dalhousie and finished his medical training at the College of Physicians and Surgeons of New York. After an internship at Randall's Island and post-graduate work in New York and London he settled in Yarmouth where he carried on the Webster tradition for fifty years. In 1917 he was elected a Fellow of the American College of Surgeons, one of the first in Nova Scotia. He took a keen interest in community affairs and was a member of the Board of Trade, the Public Library, three agricultural societies, two historical societies and the Yarmouth Hospital. Like his father and grandfather he ran a farm as a hobby and was especially interested in fine horses. In 1936, after fifty active years he was made an honorary member of the Medical Society of Nova Scotia and a senior member of the Canadian Medical Association. He was well known to the older members of the profession of today.

William Henry Chase, son of W. H. Chase and Fanny Webster, took his early education at Horton Academy, St. Andrew's College and Acadia University where he received a B.A. Degree in 1916. In World War I he was a member of No. 7 Stationary Hospital and later transferred to a field ambulance. On his return to Nova Scotia, he completed his medical course at Dalhousie and while a student was a valuable laboratory assistant at Camp Hill Hospital. Later he did post-graduate work in Pathology. In 1925 he was Lecturer and Douglas Fellow in Pathology and Curator of the Medical Museum at McGill. Later, he joined the Pathological Department of the Royal Victoria Hospital and Women's General Hospital in Montreal. His career was cut short at the age of forty-four by a serious illness—tumor of the brain.

This concludes a brief story of the members of the family who have passed on. Those who are living and still active are not entitled to much historical comment and only a brief reference will be made here.

Donald Robertson Webster, B.A., M.D., C.M. (Dal.), M.Sc., Ph.D. (McGill.) son of C. O. H. Webster, D.D.S. and grandson of John L. R. Webster of Yarmouth spent several years in post-graduate work in general surgery and in the Experimental Surgical Laboratories of McGill University. During the War he was a valuable member of the Naval Medical Service for five years. Soon after the war ended he was appointed to the surgical staff of the Royal Victoria Hospital and in 1953 was appointed Surgeon-in-Chief to the Royal Victoria Hospital and Professor of Surgery at McGill University.

John Alexander Webster, M.D., C.M. (Dalhousie,) spent two years in post-graduate work in surgery at Cleveland. He is a Fellow of the American College of Surgeons and is now upholding the traditions of the Yarmouth Websters, the fourth generation.

John Francis Lydiard Woodbury, B.Sc., M.D., C.M. (Dalhousie,) served in the R.C.A.M.C. in World War II and later took two years of post-graduate

training with special attention to Arthritis. He is now the Medical Director of the Nova Scotia Division of the Canadian Arthritis and Rheumatism Society.

Dr. Lalia Barclay Chase, does not practise, but devotes all her activities to business.

Dr. William H. Chase, Jr., son of the late Dr. William H. Chase, is still doing post-graduate work.

Three sons of Dr. Arthur Webster received their medical degrees from Edinburgh University. J. Douglas was for years Director of Radiology and Radiotherapy at Middlesex and is now retired. William practised for a time at Winchester and later joined the Indian Medical Service. He was in France during World War II. Barclay is practising in Australia.

The Webster story would not be complete without a brief reference to three medical men who were related by marriage.

Abraham Gesner married Henrietta, daughter of Isaac, and had a large family who settled in the U.S.A. He practised for twelve years at Parrsboro and gave up medicine for geology. He was distinguished as the discoverer of Kerosene.

Dr. Thomas O. Geddes, whose daughter married J. R. L. Webster, was the ancestor of three generations of Yarmouth Websters. He was born in Scotland and came to Nova Scotia at the age of ten. He studied medicine under Dr. Stirling and Dr. Adamson at Halifax. He practised at Barrington for thirty-six years and moved to Yarmouth in 1857. It was said that he resembled Sir John A. MacDonald. Geddes was a well educated man, reading Latin fluently and much interested in theology. He was one of the few doctors who kept a diary which is still in the hands of his descendants. His diary records his income. 1876, \$1,123.00; 1878, \$1,210.00. Consultations, with medicine, were often as low as twelve and one half cents.

James A. Coleman, 1839-1896, Harvard 1868. Practised at Granville Ferry for twenty years. He had a number of student apprentices, including Drs. J. A. Sponagle, C. S. Marshall and C. J. Fox. He was President of The Medical Society of Nova Scotia in 1891.

The Websters followed the general trend of medical training in Nova Scotia. Isaac, the first one, had no degree. His two sons trained at Edinburgh and Glasgow regarded as the best medical schools in the world at that time. Returning to their native province one settled in Yarmouth and became the ancestor of three generations. The other settled at Kentville and his descendants with the exception of Dr. H. B. Webster have lived outside the province. The next age group trained on this side of the Atlantic, New York and McGill. The younger members except those who were born abroad were graduates of Dalhousie. The Websters at all times aimed at a high grade of training, visited clinics frequently and took full advantage of post-graduate facilities.

The runners-up for familial medical records were the Almons and the Bond Farishes. Both of these families have ceased to be represented in the province. There are several young physicians still active in the province to carry on the Webster tradition.



# Cardiac Arrest With A Report Of Two Cases

D. S. Nathanson, M.D., Halifax

CARDIAC arrest, or the sudden cessation of cardiac activity, during surgery and anaesthesia is an emergency which must be immediately dealt with in order to prevent the effects of prolonged cerebral anoxia. Experiments with animals have shown that one has approximately  $3\frac{1}{2}$  minutes in which to restore cardiac function. Complete recovery may be expected up to that time. After that, however, one can expect irreparable brain damage manifested in alterations in behaviour, loss of normal intelligence, blindness, spasticity, dementia or death.

Fortunately, cardiac arrest during surgery does not happen very often. From the extensive experience of Bailey in England, Lahey in the United States, and others, one may expect to see about 2 cases each year in any busy operating room.

The specific etiological factor in individual cases of cardiac arrest is difficult to determine, and it is likely that more than one factor is responsible for any given case. Most important among these are: (a) Oxygen deficiency, resulting from an obstructed airway or low blood pressure. (b) Anaesthetics, which if maintained too long or pushed too far will cause cardiac arrest. (c) The reflexes affecting the heart are more sensitive under light anaesthesia, and manipulation or surgery under these circumstances will result in arrest. (d) Sensivity to drugs, myocardial damage, and chemical imbalance are also factors.

Promptness in diagnosis and in instituting effective therapy are essential. The anaesthetist is usually the first to notice that something is amiss. He finds that without warning he is unable to detect a pulse or obtain a blood pressure reading. The surgeon is notified, and the findings are either confirmed or denied by feeling for the pulsations of a large vessel in the vicinity of the area in which he is working. In the abdomen the aorta or some other large vessel is easily palpated, or if the chest is open the heart and great vessels are readily visualized, and finally, to the surgeon carrying out manipulations, the femoral or brachial vessels are within easy reach. With the pulse and blood pressure unobtainable, and the pulsations in a large peripheral vessel absent, one must assume that effective cardiac action has ceased. There are three possibilities: weak contractions with a normal rhythm, cardiac arrest or ventricular fibrillation.

Other aids to diagnosis at this time are unreliable, and are mentioned here only to emphasize that precious time may be lost looking for the instruments if they are not readily available. These include: the stethoscope, the ophthalmoscope, the electrocardiograph.

A conclusive diagnosis can be made only by opening the chest and visualizing or feeling the heart. Therefore, with a minimum of delay, the chest wall is painted with an antiseptic solution and a transverse incision is made in the 4th left intercostal space, beginning 1" lateral to the sternum and extending it to the midaxillary line. In cardiac arrest there will be no bleeding. The hand is inserted into the chest through the incision and the lung is pushed aside. The heart is felt and the diagnosis confirmed. It will either be in

arrest, contracting weakly, or in fibrillation. The latter is an arrhythmia which has been described by one author as consisting of, "Weak, irregular, futile, squirming contractions, that seem to be going in all directions at the same time." The opening of the chest affords an excellent route for the institution of therapy once the diagnosis is confirmed. If the abdomen had already been opened during the course of the operative procedure, or if the sub-diaphragmatic approach had been chosen, the upper abdomen is quickly opened and the diagnosis confirmed and therapy instituted by feeling the heart through the diaphragm.

Effective treatment depends upon the combined co-operative efforts of the surgeon and the anesthetist. Once the diagnosis has been confirmed, adequate oxygenation and circulation of the blood must be restored and maintained. The former by artificial respiration and the latter by cardiac massage.

Artificial respiration, using 100% oxygen, is immediately begun by the anaesthetist by manually compressing the rebreathing bag of the anaesthetic machine. The most efficient means of ventilating the lungs is provided by the use of an endotracheal tube, but if one had not already been inserted, a close fitting face mask and a pharyngeal tube is all that is required. When the patient is well oxygenated, one may take the time to insert an endotracheal tube. It has been shown that artificial respiration alone can cause some circulation of the blood to the brain and other organs, but this alone is inadequate. It is therefore necessary to resuscitate the heart in order to restore an adequate circulation.

The heart, having been found to be in arrest by the hand inserted into either the chest or abdomen, is immediately massaged. This should be carried out by either compressing it between the thumb in front and the fingers behind, or by compressing it against the sternum. The former method has been found to be the most effective. It has been shown that the more rapidly the ventricles are compressed the greater is the blood flow. Therefore, the rate at which the heart should be massaged is as rapidly as possible without causing the hand to become tired too quickly. Sometimes one contraction is felt but the heart does not continue to beat, and all that is required is that the heart be massaged until it springs into spontaneous activity. This usually occurs within the first two minutes, but cases have occurred where cardiac massage was continued up to 45 minutes. If the abdominal approach had been selected, the left lobe of the liver is turned down and the heart massaged by either of the above methods. In order that the heart be more easily compressed between the thumb and fingers through the diaphragm, a button-hole incision is made between the two attachments of the diaphragm immediately behind the xiphisternum, and the thumb of the right hand is inserted into the opening.

The use of drugs in the treatment of cardiac arrest is controversial and it is generally agreed that drugs alone will not initiate the resumption of spontaneous cardiac activity. Epinephrin, however, is particularly useful following resuscitation of the heart as it increases the tone of the heart muscle. 0.5 to 1.0 cc of 1:1000 solution of epinephrin may be injected into the heart directly or through the chest wall. It does increase the tendency to fibrillation. If fibrillation was found on examination of the heart or if it was pro-

duced by the cardiac massage, then epinephrin is contra-indicated, and the use of procaine either intravenously or by local injection into the heart muscle is beneficial. Five cubic centimeters of a 2% solution is used. Beck and Wiggers advocate the use of electroshock to defibrillate the heart, and they place two electrodes, one on each side of the heart, and administer a shock of 110 volts and 1.5 amperes for from 0.1 to 0.5 seconds. This may have to be repeated, but once the fibrillations have ceased normal rhythm may be restored by cardiac massage and epinephrin.

After restoring cardiac action, one may expect either complete recovery of the patient, or that the heart may suddenly stop after the lapse of a varying period of time, or the patient remains comatose and dies. However, once the heart has been resuscitated, the patient will require constant attention. He is placed in an oxygen tent to insure a high oxygen saturation level of the blood. The patient is usually unconscious and will require frequent suctioning to remove the secretion from the back of the throat and the trachea. Antibiotics are given to prevent pulmonary complications as well as to combat any infection that may have occurred as a result of the haste in opening the chest or abdomen to institute cardiac massage. Respiratory stimulants may be used, as may various drugs to help maintain the blood pressure. Intravenous fluids are important in maintaining urinary output and the blood volume.

The following cases occurred in the operating room at Camp Hill Hospital during the past year. Both cases were successfully resuscitated but with markedly different results.

#### *Case No. 1*

A.M.P., a 40 year old Indian Male, was admitted to the Surgical service complaining of a large lump in the left groin and swelling of the left leg. He had injured his left groin with an axe handle in 1951, which was followed by the appearance of a plum-sized, non-tender lump in that area. It slowly disappeared, but periodically recurred during the following year. One year ago, he again injured the same area. The lump recurred, gradually subsided, and after periodic recurrences it disappeared until six weeks prior to this admission when the lump reappeared and continued to increase in size. His left leg began to swell and there were minimal complaints of pain.

Physical examination showed the left leg to be markedly swollen, and there was a large, firm, elliptical, grapefruit sized swelling in the left groin, just inferior to the inguinal ligament. The mass was hard, nodular, non-tender and fixed to the deeper tissues. X-rays of the groin showed a circumscribed cystic area in the left acetabular region, and evidence of a large soft tissue swelling over the upper end of the left femur. There was slight periosteal reaction noted in the region of lesser trochanter, the appearance of which was suggestive of a possible periosteal fibro-sarcoma.

Seven days after admission he was taken to the operating room for a biopsy of the mass. He had been given pre-medication with Nembutal gr. 1½ at 8:00, Morphine gr. ¼ and Hyoscin gr. 1/100 at 9:00, and spinal anaesthesia was administered, using Pontocaine and glucose, at 10:00.

Twenty minutes after the administration of the anaesthetic, the surgeon and his assistant were scrubbed and waiting for the go ahead from the anaesthetist, when the patient was suddenly noted to be cyanotic. Examination showed that he was not breathing, pulseless, the pupils were dilated and he was without reflexes. He was apparently dead. The anaesthetist immediately began artificial respiration with 100% oxygen, using the anaesthetic

machine and an endotracheal tube. 1.0 cc of 1:1000 adrenalin was injected into the heart muscle through the chest wall. The surgeon made an incision through the linea alba and began to massage the heart through the diaphragm. The heart began to beat almost immediately, so the abdominal incision was closed and the operation on the leg completed. It was estimated that the heart had been in arrest for 5 minutes.

Post-operatively, he was treated with continuous oxygen, intravenous fluids, antibiotics, stimulants, nicotinic acid, and vitamin B 12 Conc. (1000Ugm/cc). He was comatose and exhibited signs of decerebrate rigidity. Consciousness gradually returned but he continued to be drowsy. Neurological examination showed signs of Central Nervous System damage. He gradually became less spastic and by the fourth post-operative day responded to the spoken word. He was unable to remember even simple things and could repeat only simple words and phrases after the examiner. However, his phonation was aimless, and he would utter a moan without apparent reason. His blood pressure rose slowly to its normal level, his cardiac rate was rapid and irregular. The electrocardiogram showed a pattern of myocardial ischemia. Initially, his bowels and bladder were incontinent, but their voluntary functioning gradually improved. He remained restless, and at times would tear at his pyjamas or gesticulate aimlessly with his arms. He would answer questions, but continued to be forgetful. He often mumbled or talked to himself, and this at times became incessant. The swelling in his leg gradually subsided and he became ambulant.

His speech became more rational, and he would smile when a question was directed to him or when a member of the staff approached his bed. He began to walk with some help and could be taken out of the hospital for short jaunts in his wheel chair. Psychological testing was attempted but the results were very poor and all that could be said was that he had severe brain damage. On the 34th day an occupational therapy project was begun, but his attention was easily diverted and could not be maintained for more than half an hour at a time. He lacked social controls and unexpectedly would curse and spit without restraint.

The biopsy was reported as being a rare and unusual variant of Lichtenstein's chondroblastoma, a low-grade sarcoma of periosteal origin. After 46 days, x-rays of the chest showed the presence of cannon ball type metastases in both lung fields which gradually increased until the lungs were reported to be loaded with them. His dyspnoea gradually increased until his death, from metastases, 90 days after the operation.

#### Case No. 2

T.I.M., a 37 year old white male was admitted to the Urological service, for dilatation of a urethral stricture. Three years prior to admission the patient had fractured his pelvis, which resulted in a urethral stricture. Subsequently he developed acute retention of urine and was taken to his local hospital where after unsuccessful attempts to dilate the stricture, a suprapubic cystotomy was done. He was then admitted to this hospital for dilatation of the urethra and closure of the cystotomy. Physical examination was not remarkable except for a catheter inserted into a suprapubic cystostomy.

An initial attempt to dilate the stricture under local anaesthesia was unsuccessful. So, two days later, the patient was taken to the operating room where the dilatation was to be done under spinal anaesthesia. He had been pre-medicated with Demerol 100 mgm. and Atropine gr. 1/150. One hour later spinal anaesthesia in the form of 150 mgm of Novocaine crystals was administered. Some force was required to dilate the stricture, and at about 9:30 it was noted that the patient was becoming restless, so 50% Nitrous Oxide and oxygen were administered. This was followed at 9:35 by 5 cc of 5% Pentothal in 500 cc of 5% Glucose and Saline which was allowed to drip slowly intravenously.

At 9:45 with the operation completed, the patient's breathing suddenly stopped. He was pulseless and appeared grey in colour. The surgeon was notified and the peripheral pulses were checked and found to be absent. The patient was apparently dead. The

anaesthetist immediately began artificial respiration with the anaesthetic machine using 100% oxygen; 1.5 cc of 1/1000 adrenalin were injected into the heart muscle through the chest wall. The surgeon made a left subcostal incision through which the heart was massaged through the diaphragm. It was immediately felt to beat vigorously and after controlling the bleeding, the incision was closed. Breathing began spontaneously in less than 2 minutes, and the estimated time that the heart had been in arrest was 3 minutes.

Post-operatively the patient was given continuous oxygen. He was still unconscious but did not show any sign of rigidity. He was treated with antibiotics, intravenous fluids, A.C.E., nicotinic acid, vitamins C, B-plex, and B12 concentrate (1000 Ugm/cc). He became conscious two hours and twenty minutes later, and immediately responded when spoken to. By evening he was answering questions intelligently. There was no memory loss or rigidity, and his neurological examination did not elicit any abnormal responses. The electrocardiogram showed a pattern of an anterior myocardial infarction. Subsequent daily electrocardiograms showed a marked improvement in the pattern, which led to the speculation that the abnormal tracing had probably been caused by the No. 16 needle, which had been used to inject the adrenalin, puncturing the coronary artery causing a localized hematoma in the heart muscle. In view of the electrocardiographic changes, he was placed on a myocardial infarction regime of bed rest. He subsequently interested himself in an occupational therapy project. He gradually became ambulant with no residual effects and was discharged 1½ months after admission.

Six weeks later he returned to this hospital for a further dilatation of the urethra and electrocardiographic studies. The latter showed that the cardiac pattern had returned to normal.

## DISCUSSION

The cause of the arrest in each of the above cases is obscure. In case No. 1, the arrest was probably due to either a sensitivity to the spinal anaesthetic agent or to the hypoxia resulting from a sudden drop in blood pressure as a result of the spinal anaesthesia. In case No. 2, the forcible manipulation of the urethra and bladder neck in an effort to dilate the urethral stricture, combined with the fact that the anaesthetic was wearing off, probably cause the sudden cessation of cardiac activity on a reflex basis. Time is the most important factor in determining the results, and the above two cases clearly show the slim time margin that separates a successful outcome from irreversible brain damage due to anoxia. The first case had been resuscitated after an estimated lapse of 5 minutes and resulted in severe brain damage with loss of intelligence, marked behaviour changes, and with emotional instability. The second case had been resuscitated after an estimated lapse of 3 minutes, with no demonstrable character, behaviour or emotional changes, and without signs of damage to the Central Nervous System. The estimated times as given, were agreed upon by all who were present in each case.

## Summary

1. A discussion of the etiology, diagnosis, and treatment of cardiac arrest has been presented.

2. Emphasis has been placed on the necessity for promptness in diagnosis and in instituting effective therapy, as well as on the effects of prolonged cerebral anoxia due to delay.

3. Two cases of successful resuscitation of cardiac arrest have been presented, which show clearly the slim time margin that exists between success and irreversible brain damage.

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I wish to express appreciation to Drs. T. E. Kirk, J. A. Noble and C. G. MacKinnon, for permission to publish the above cases, and for their interest and helpful suggestions.

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Modern Blood Pressure Machine for sale, \$15.00. Address Mrs. W. P. McBride, P. O. Box 177, Kensington, P. E. I.

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#### NOTICE

There is an opening in Souris, Prince Edward Island for a General Practitioner. Souris is an Incorporated Town of approximately 1400 people, and there is a large surrounding rural area to be serviced. The facilities of a well equipped Hospital are available in the Town.

The Town of Souris is expanding industrially at the present time, and the surrounding area is a farming community.

There are two Doctors now practising here, one of whom is getting along in years and at the moment is not too actively engaged in practise.

This would appear to be a good opportunity for a young Doctor.

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MELVIN J. McQUAID,  
SOURIS, P. E. I.

# Minutes Of A Special Meeting Of The Executive Of The Medical Society Of Nova Scotia, 1954

A special meeting of the Executive of The Medical Society of Nova Scotia was held in the Board Room of the Dalhousie Public Health Clinic, Halifax, N. S., on Wednesday, March 17th, 1954, at 2.30 p. m.

Doctor M. G. Tompkins presided and those attending were Doctors H. F. McKay, D. M. Cochrane, H. G. Grant, A. G. MacLeod, J. A. MacCormick, H. J. Devereux, C. G. Harries, P. R. Little, L. J. MacLeod, E. F. Ross, F. J. Barton and H. B. Ross.

Doctor Tompkins called the meeting to order.

The Secretary stated that he and Doctor R. O. Jones had been working on a badge with the help of Mr. Forbes Thrasher, Manager of the Lord Nelson Hotel of Halifax, an expert on heraldry. Mr. Thrasher who had been invited to the meeting spoke briefly telling the Executive what had been done. He showed two coloured paintings of the proposed badge which had been done by Mr. Donald Mackay, an artist of Halifax. One in shield shape to be the coat of arms of the Society, and the other, a circle surrounded by a belt to be used as a badge for membership in the Society. In each instance the design shows the blue saltire or X-cross on white for Nova Scotia in the upper third or chief. The lower two-thirds of the shield or the badge is murrey which is the colour of dried blood. On this is a golden vertical band entwined by a silver or white snake with a golden tongue.

The Secretary said he had written to some twenty doctors scattered throughout the Province, for suggestions for a motto for the Society and that he and Doctor Jones had met and chosen three suggestions—Ope et Consilio (By help and counsel); Servabo fidem (I will keep faith) and "For the health of humanity" which last they preferred. He then moved that the report of the Committee recommending the badge with the murrey colour, and also the motto, the last one, be adopted. This was seconded and carried.

Doctor E. F. Ross moved that the bill of the Lord Lyon, approximately \$135.00, and Mr. Donald Mackay's fees, \$12.50 for the shield, of which there will be two, and \$25.00 for the badge, be approved. This was seconded and carried.

It was moved by Doctor H. J. Devereux that the Secretary write Mr. Forbes Thrasher a letter of thanks for all the work he had done in connection with obtaining a badge for The Society, and also send him a badge at a later date. This was seconded by Doctor J. A. McDonald and carried.

Doctor F. J. Barton, Chairman of the Public Relations Committee, then gave the following interim report dated March 17, 1954.

"I beg to submit the following report of the Public Relations Committee covering the activities since our last annual report of two months ago.

"We are pleased to report that the long awaited newspaper articles have been published in the Halifax Herald four mornings from February 16th to 19th,

inclusive. The topics Medical Licensing, Medical Education, Medical Ethics and The Doctors Attitude toward Health Insurance and Pre-paid Medical Plans. It has been very hard to assess the value and reaction of these articles. For our part we feel that they did not receive the promotion in the newspaper that they might have, they were not well placed, being rather inconspicuous, the only one that really attracted attention was the one dealing with medical licensing where a picture set it off. All in all, I think the results were not as satisfactory as they might have been had the articles been more favourably placed in the paper. Those persons who read the articles thought that they were first class, but our impression was that the majority of people overlooked them. I might say, in this connection, that the experience with the other Provinces had been that the articles were very favourably received, were widely publicized and had a substantial list of readers. I think with a new press relations programme that we could do much better on our next series benefitting from the experiences of this first attempt.

"We would next like to report to you on the Conference on Public Relations Chairmen which was held in Toronto on February 5th and 6th, 1954.

"The Conference was made up of the Public Relations Chairmen of the ten Provinces along with the full membership of the central nucleus committee in the Toronto area which has been piloting the activities of the Public Relations Programme across the country along with our genial deputy general secretary, Doctor Arthur Kelly, and this was the first Conference of its kind ever held by The Canadian Medical Association.

"The general purpose of the conference was to discuss the work that the various individual provinces had been doing in the Public Relations field with a view to coordinating the same, and as well to describe a pattern for the future.

"I can report that the conference was very worth-while providing as it did a complete picture of what has been going on in the other provinces and with what degree of success. The reports from these provinces on their activities in the field of radio, television, newspaper and health forums, provided us with a definite forecast of the role the profession is going to play in meeting the public through these various media on topics with very definite interest to both the doctor and the public.

"Specifically the outstanding things we observed at the conference was this—as one travels from east to west in Canada one finds an increasing public relations consciousness among the profession with a proportionate increase in the scope of public relation activities. At the extreme west we find British Columbia with several *health forums* on such topics as polio, heart disease, diseases of the eye, and so on; as well as other ventures into radio, television and newspaper articles. By our standards to date here in Nova Scotia the British Columbia public relations programme could well be labelled as very radical and by some certain aspects might be considered poor taste. It is noteworthy, however, that Ontario is following suit and are currently running monthly health forums in the largest available auditorium in the Toronto area, housing some fifteen hundred people, on the subjects that the people want to hear about most—for example polio and heart disease. These open



forums so called are following a series of newspaper articles bearing the names of medical authors who are experts in the field chosen by the profession; e.g. Doctor Wallace Graham on Arthritis, Doctor H. B. Atlee on Obstetrical subjects and Doctor O. H. Warwick on Cancer and so on.

"Coming from the traditionally conservative part of Canada, I on behalf of Nova Scotia asked the British Columbia delegates how they felt about all of this? Was it worth while? What did they hope to accomplish? The British Columbia representative was very enthusiastic in his reply saying that he feels the stock of the medical profession has gone up manifold because of these forums, and allied activities. The people coming into the doctors' offices have been loud in their praise of the forums, the newspapers, and have gone out of their way to praise the profession for their promotion of these activities. The press releases have been very complimentary and all in all my British Columbia confreres assured me that the doctors' standing and general regard in the Vancouver area has definitely been improved judging by the indices mentioned above. Furthermore they feel that the best weapon that the profession can have in any differences that might arise between government and profession when the implementation of health insurance becomes a reality is a public that is on our side. They argue that by getting down and talking over with the people in health forums and in the press will do a great deal to bridge the gap between the profession and the public; a measure that will stand up if we find ourselves in the ring with the government over our health insurance legislation. This briefly is the position of the British Columbia Society. In a way they are proud of their Public Relations programme. They feel they are doing a good selling job, selling the profession to the public. A form of life insurance as they see it and a means that might help to perpetuate the kind of medical life we have been used to and would like to see embodied in any government plan.

"A bird's eye view of the Public Relations activities in the various Provinces brings out the following highlights.

*British Columbia:* Has led the field in the scope of activities and in experience. The representatives can speak authoritatively on the results with radio panels, open health forums, newspaper articles, over a period of at least two years.

*Manitoba* is currently running a series of what one may call "canned" radio programmes lasting from ten to twelve minutes. These prepared programmes are brought in from New York and cover topics of interest to every one; for instance, the Common Cold, Tonsillitis, Heart Disease, Rheumatic Fever, Appendicitis, and so on. They are purchased for Fifty-two Dollars (\$52.00) a programme, and Manitoba is apparently spending Two Thousand Dollars (\$2,000.00) on this type of programme. The programmes are apparently packaged and give the Manitoba Society the credit due it as the sponsors. Manitoba has a Press Relations man as well, and in each area someone who is authorized to speak authoritatively to the press and answer questions that may arise.

*Ontario* recently completed a series of newspaper articles by well known medical men in their chosen fields on suitable topics and carrying the name and

the appointments of the authors—to lend weight and volume to the release. Now in the midst of a series of open forums at which the public are invited on subjects the public have chosen through the newspaper columns. These, as in British Columbia, are run in co-operation with one of the major Ontario daily papers under joint sponsorship, as it were. I will circulate among you to-day newspaper clippings covering these items.

“*New Brunswick.* Last year New Brunswick launched a new experiment in press relations. At the annual convention the profession invited the press into all its activities—both scientific and business—with very gratifying results. A press-room was set up patterned after The Canadian Medical Association set up at the annual national meetings. The good effects noted were manifold.

“1. Gave an excellent front page coverage to all the convention activities with detailed reporting.

“2. At the business meetings it tended to raise the standard of argument and discussion where the spokesmen of the meeting presumed that they would be quoted in the press.

“3. Brought forth many favourable comments from the public who have never been let in on such things before. The public reaction was more than favourable.

“4. The doctors were very happy about the experiment and feel that they would like to continue it at their annual meeting.

“*Nova Scotia.* We were pleased to report at the meeting in Toronto that we had just released four newspaper articles on subjects which we felt were very apropos.

“Out of all this one might ask the question—How much of all this is appropriate to our Public Relations programme in Nova Scotia? Is there a need for and are we in favour of radio panels or health forums for instance? Finally, would the Executive endorse the principle of a press-room at our next annual convention with the press represented at all events—in particular the business meetings, which might well be reported fully in certain controversial matters. In this connection I would refer you to our annual report for 1953 dealing with these matters, and containing certain recommendations. At that meeting of the Executive we asked and I quote—‘that the Executive would give consideration to the following appointments. 1. A Publicity Committee whose chief duties would be to cover the publicity of the annual conference; establish a modified press-room set up if at all possible, and carry out in a general way the recommendations the central committee has outlined. The Committee should, we feel, be located where the convention site is, for instance, in Sydney where the next meeting will be held. 2. A Press Relations Officer. One in all the larger areas to meet the press and look after controversial matters that arise in local or national interest.’

“We would ask the Executive again, Mr. Chairman, to give consideration to these recommendations.”

Doctor Barton moved the adoption of the report, which was seconded by Doctor D. M. Cochrane and adopted.

The President stated that this was a very excellent report, and Doctor Barton should be congratulated on his work.

It was moved by Doctor H. G. Grant that the Public Relations Committee be authorized by the Executive to establish health panels, or radio panels, and other radio programmes as they saw fit. This was seconded by Doctor H. J. Devereux and approved.

Doctor Barton stated that the expenses would not be very great, practically nil. Doctor E. F. Ross asked if these panels would be done by men in active practice, and the answer was yes. It was agreed that it should be stated these panels were sponsored by The Medical Society of Nova Scotia. Doctor Barton asked authority to set up a press-room at the annual meeting in September. This was given. Also Doctor Barton was authorized to write the different Branch Societies and ask them to name liaison officers for the press in their localities, and for any other matters that might come up locally. This was agreed to.

Mr. D. C. Macneill, Manager of Maritime Medical Care, who had been asked to attend the Executive meeting, was then asked to report on the recent offer of the School Board to the teachers of Halifax to provide them with sickness insurance. Mr. Macneill said that recently the School Board of the City of Halifax had made an offer to the teachers of Halifax to pay one-half the premium on a combined Life and Sickness Policy. He felt that Maritime Medical Care had not been given a chance to tender. The offer, however, was not accepted as it was afterwards voted down by a majority of the teachers.

The Secretary thought that there should be a study made of all the sickness plans available in Nova Scotia and have them compared with Maritime Medical Care. He thought the Society should know the comparative values of the different plans.

Doctor E. F. Ross thought it would be a good idea to have them printed in the Bulletin.

Mr. Macneill stated that most insurance companies are underselling Maritime Medical Care.

The question was asked if it would be possible to get a list and then have the Committee on Medical Economics study it.

The Secretary felt that the Secretary of The Medical Society of Nova Scotia should be either a member of the Board of Directors of Maritime Medical Care, or a listener-in.

Doctor E. F. Ross moved that Maritime Medical Care be asked to give the Society a monthly news letter for publication in the Bulletin. This was seconded by Doctor H. B. Ross. Motion carried.

Doctor H. J. Devereux then gave the following report of the Medical Economics Committee.

"First, as chairman of the Medical Economics Committee of Nova Scotia, I attended a meeting of the Committee on Economics of The Canadian Medical Association, held in Toronto, November 30 and December 1st, 1953, and the following were the topics discussed:

### "1. Sick Mariners' Fund

"This question seems to be more acute in British Columbia than anywhere else—and the two main points of contention are, (a) confusion as to who accepts responsibility for the sick mariner; (b) inability of Port doctors to carry out their duties. After much discussion the following recommendations were made: (1) That the Sick Mariner Service adopt the D.V.A. schedule for payment of physicians entitled to remuneration by fee for service. (2) That Doctor H. D. Reid, Medical Director, Sick Mariner Fund, be made aware of the criticisms of the present service and the assistance of the Divisions concerned were offered in the selection of additional or alternative port physicians.

### "2. D.V.A. Schedule of Fees

"An effort has been made to increase the fees, which has not been entirely successful, but it does look as though there will be an increase in house and office calls, and the Director General of Treatment Services has stated his willingness to negotiate for an upward revision of some of the procedures.

### "3. Indian Affairs

"Nothing too definite—the committee felt that the D.V.A. schedule should be followed where the Department of Indian Affairs pays fee for service.

### "4. Reports to Insurance Companies

"After considerable discussion it was decided that this matter be referred to the appropriate committee of The Canadian Medical Association for further study and advice.

### "5. Statement of Policy and Principles relating to Health Insurance

"No change at present—to be considered at the next meeting.

### "6. Medical Care to Social Group

"This matter was studied by a subcommittee, headed by Doctor J. Lloyd Brown, who brought in a proposed plan for Medical Care of the Social Assistance Group, which would be used as a guide by the Division. This was approved. It was also recommended that any Provincial Division of The Canadian Medical Association which enters into such a contract with the Government should do so under the following stipulations:

"(1) As an experiment to obtain data on costs and administration.

"(2) That the Division be not held responsible by way of precedent or prejudice in respect of any clause in the agreement which might in a subsequent plan of care require change in any respect.

"The Committee on Economics of The Medical Society of Nova Scotia met in Halifax on February 12, 1954, and the following topics were discussed.

"(A) The contract with the Nova Scotia Government concerning the medical care of the Blind Pensioners and the Mother's Allowance group and their dependents.

"The Committee suggest that our services be expanded to cover the following:

- "(a) All house calls and office calls.
- "(b) Tonsillectomies with accompanying anaesthesia.
- "(c) Confinements.
- "(d) All fractures—whether in office, out-patient department or hospital.
- "(e) Minor surgical procedures.

"It was also suggested that the dependents of Blind Pensioners be covered, but the Minister of Health suggested that this be left in abeyance for the present.

"(B) Recent Extensions of Federal Health Grants

"These grants cover Maternal and Child Welfare, Rehabilitation, Radiological and Laboratory Services.

"At present the Government appoint the committees to study these matters without any consultation with The Medical Society of Nova Scotia; your committee feels that a certain number of the doctors on these committees should be appointed by the Society. This was discussed with the Minister of Health and he agreed to this principle, and said that in the future this procedure would be followed.

"(C) Health Survey Report

"We understand that there has been a special committee set up to study the matter under the chairmanship of Doctor A. G. MacLeod; as yet we have not received any report.

"(D) Statement of Policy and Principles Relating to Health Insurance

"No change for the present.

"(E) The Controversy between the Doctors of Pictou County Medical Men and Zurich Insurance Company

"Doctor H. F. McKay and Doctor C. E. Stuart appeared before the committee to present the facts for the Pictou County doctors. The main points of contention are the old ones of 'over service,' 'over demand,' 'excessive charges'—a schedule of fees not matching The Medical Society of Nova Scotia minimum fees—the threat by the Insurance Company, that they might be forced to take 'drastic action'—the idea inferred that the Doctors should 'police' the plan.

"After considerable discussion the Medical Economics Committee felt that this problem would be best settled at the local level and refer the whole matter back to the Executive for further consideration.

"In conclusion, I would like to note that our meeting with the Minister of Health was a most pleasant one, and he was most pleased at our offer to increase services to the Welfare Group at the prevailing rate."

Doctor Devereux moved the adoption of the report which was seconded by Doctor A. W. Ormiston and passed.

The President read the following letter received from Hon. Harold Connolly, Minister of Public Health, dated February 16, 1954.

"I would be remiss if I did not extend my thanks to the Nova Scotia Medical Society and especially to the Economics Committee of that Society for its excellent presentations of Friday last.

"I congratulate your Society too for the proposals you advanced in connection with the medical care of Mothers' Allowance recipients. The proposal to continue the present care and to add fractures, tonsillectomies and minor surgery as among your services at the rate of 83c per patient per month.

"I shall see to it that the contract is executed with the least possible delay and I should like with your acquiescence to see that the medical men of this Province receive a proper measure of credit through the newspapers for what I regard as a splendid bit of co-operation."

It was moved by Doctor D. M. Cochrane that the Secretary have extra help in the office when required at an outside limit of \$150.00. This was seconded by Doctor C. G. Harries. Carried.

The Secretary read a classification of The Canadian Medical Association and The Medical Society of Nova Scotia annual fees for membership.

It was moved by Doctor A. W. Ormiston that the fee schedule for membership in The Medical Society of Nova Scotia as suggested by the Secretary be approved starting in January, 1955, to be ratified at the next annual meeting. This was seconded and carried.

The President read the provision programme for the annual meeting which has been brought up to date since the time of the meeting.

#### Monday, September 6th, 1954.

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| 9.30 a.m. | Executive Meeting.  |
| 1.00 p.m. | Luncheon Isle Royale Hotel for Executive<br>The Medical Society of Nova Scotia. |
| 2.30 p.m. | Executive Meeting.  |
| 8.30 p.m. | Business Meeting of General Practitioners.                                      |

#### Tuesday, September 7th, 1954.

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| 9.00 a.m.             | Registration.  |
| 9.30 a.m.             | Welcome by the Mayor of Sydney.  |
| 9.45 a.m.             | Discussion to be opened by Doctor F. A. Dunsworth, Halifax, N. S.  |
| 10.30-11.30 a.m.      | Doctor A. L. Wilkie, Associate Professor of Surgery, McGill University, Montreal, Quebec, "Biliary Tract Surgery."<br>Discussion to be opened by Doctor Eric W. Macdonald, Glace Bay, N. S.  |
| 11.30 a.m.-12.00 noon | Time out for Exhibits.   |
| 12.00 noon-1.00 p.m.  | Doctor J. F. McCreary, Professor and Head of the Department of Paediatrics, University of British Columbia, Vancouver, B. C., "Prenatal Care and the Infant."<br>Discussion to be opened by Doctor S. A. Green, Glace Bay, N. S.             |
| 1.00 - 2.10 p.m.      | Luncheon Isle Royle Hotel.<br>Speaker, Doctor J. S. Robertson, Deputy Minister of Health, Halifax, N. S.   |
| 2.30 - 3.30 p.m.      | Doctor G. F. Strong, Clinical Professor, Department of Medicine, University of British Columbia, Vancouver, B. C., "Newer Concepts of the Treatment of Heart Failure."<br>Discussion to be opened by Doctor J. A. McDonald, Glace Bay, N. S. |

- 3.30 - 4.30 p.m. Doctor Alec M. Agnew, Clinical Professor and Chairman of the Department of Obstetrics and Gynaecology, University of British Columbia, Vancouver, B. C., "Obstetrical Shock."  
Discussion to be opened by Doctor J. C. Young, Sydney, N. S.
- 4.30 - 6.30 p.m. First Business Session.  
6.30 p.m. Reception by Doctor M. G. Tompkins, President, The Medical Society of Nova Scotia, and Mrs. Tompkins, and Doctor A. W. Ormiston, President, Cape Breton County Medical Society, and Mrs. Ormiston.
- 9.00 p.m. Dance and Bridge Party.

**Wednesday, September 8th, 1954.**

- 9.30-10.30 p.m. Doctor C. B. Stewart, Dean of the Faculty of Medicine, Dalhousie University, Halifax, N. S., "Maternal, Infant and Stillbirth Mortality in Nova Scotia."  
Discussion to be opened by Doctor D. G. McCurdy, Sydney, N. S.
- 10.30-11.15 a.m. Doctor H. D. O'Brien, Halifax, N. S., "Carcinoma of the Thyroid."  
Discussion to be opened by Doctor J. S. Munro, North Sydney, N. S.
- 11.15-11.45 a.m. Time out for Exhibits.
- 11.45 a.m.-12.30 p.m. Doctor E. F. Ross, Halifax, N. S., "Carcinoma of the Colon."  
Discussion to be opened by Doctor H. J. Martin, North Sydney, N. S.
- 2.30- 4.00 p.m. Second Business Session.  
4.00 p.m. Golf and Tea.  
6.30 p.m. Reception by Doctor M. G. Tompkins, President, The Medical Society of Nova Scotia, and Mrs. Tompkins, and Doctor A. W. Ormiston, President, Cape Breton County Medical Society, and Mrs. Ormiston.
- 7.30 p.m. Annual Dinner.  
Presidential Address, Doctor M. G. Tompkins.  
Special Speaker, Mr. D. Leo Dolan, Director, Canadian Government Travel Bureau, Ottawa, Ontario.

**Thursday, September 9th, 1954.**

- 9.30-10.30 a.m. Third Business Session.
- 10.30-11.30 a.m. Second Business Meeting of General Practitioners.

It was moved that the invitation from the Manager of Digby Pines for the annual meeting to be held there in 1955 be acknowledged. This was seconded and carried.

It was moved by Doctor A. W. Ormiston that the Society refrain from using the front page of the Nova Scotia Medical Bulletin for advertising purposes. This was seconded and carried.

Doctor H. G. Grant read the following letter from Doctor R. O. Jones, dated March 11, 1954.

"I am enclosing a letter from Mr. James C. Morrow of the Royal Securities Corporation outlining the present situation regarding the purchase of bonds.

"As you will remember at the last meeting of the Executive of The Medical Society of Nova Scotia, a motion was passed empowering me to buy five \$1,000 Nova Scotia Government Bonds with the funds currently in the savings account of The Medical Society of Nova Scotia. At this time, it was felt that we probably would receive at least 4 per cent of our money in this way, but Mr. Morrow tells me that the interest rate has fallen and it would now not be possible to secure this. He advises the purchase of the guaranteed debentures of the Eastern Canada Savings and Loan Company or the Nova Scotia Savings

Loan and Building Society, which would pay 5 per cent on a 10-year debenture. As I am somewhat of an amateur in matters of bonds and investments, I am not quite sure what we should do but I would think myself that the recommendation of Mr. Morrow is probably a wise one.

"I regret that I will probably be unable to attend the Executive Meeting since Doctor Howard Liddell is a visiting lecturer in the Department of Psychiatry on the date which the meeting has been called for.

"I would therefore appreciate it if you would bring this matter up to the Executive Committee and ask for their advice as to which bonds we should purchase."

It was moved by Doctor D. M. Cochrane that the Society continue the former policy of buying Nova Scotia Bonds. This was seconded by Doctor A. W. Ormiston. Motion carried.

The Secretary read the report of Doctor J. A. McDonald, Chairman of the Committee of the Chair on General Practice.

"Your Committee appointed to discuss the training of general practitioners with the Executive Committee of the Faculty met them in the evening, following the Executive meeting in January. At the beginning, we were informed to the effect that their plan was to listen to us, offering a minimum of comment as they saw necessary for the elaboration of any points that were made and that our expression of ideas would be studied by them later. Unfortunately, we have not had an opportunity to meet as a unit committee before meeting them. Consequently, we spoke as individuals, pointing out in turn some of our personal concepts of the apparent inability of the new medical graduate to establish himself confidently in general practice. For example, many seem to have a fear of using general anaesthesia by open method for minor surgical problems; they hesitate to handle relatively minor, but at the same time, urgent problems, such as finger-tip infections; that they did not feel competent to undertake important diagnostic procedures such as proctoscopy. A great many such points were made and there appeared to be complete agreement among the members of your committee despite the fact that as mentioned above, we did not have an opportunity to meet previously. It was conceded in general that the training in obstetrics was better fitted to the general practitioner than the training in some other fields. At the same time, we were agreed that the quality of medical education as provided by Dalhousie Medical School was unsurpassed, and we felt grateful to the members of the Faculty for the maintenance of their high standard of undergraduate teaching and for their contributions to aid in post-graduate and refresher courses. It was appreciated that the growing problems for training medical graduates for general practice were the result of the tremendous expansion of medical science which had to be fitted into the same numbers of years of study as obtained twenty or more years ago. We also pointed out that the same difficulties were found universally and had been discussed at considerable length at the First World Conference in Medical Education in London, August, 1953. Reference was made to the address by Professor Sir Henry Cohen of Liverpool on the 'Balanced Curriculum' and of Oliver Cope of Boston in the 'Teaching of Medicine and Surgery as one Discipline' at this conference. It was also noted that a very



comprehensive contribution had been made to our problem by Doctors J. S. Collings and Donald M. Clark in their study made for the United States Commission on 'Health Needs of the Nation' and published in 1953. Reference was also made to the presidential address by Doctor John P. Bowler to the New England Surgical Society, September, 1953.

"In discussing the possible aids to solving the problem, reference was made to the many plans in use across the United States as published in a recent issue of *General Practitioner*. Such plans as preceptorships, general practitioner wards in hospitals, and hospital out-patient departments to be staffed by visiting general practitioners for the supervision of internes and residents were all briefly discussed as our time had been limited by the lateness of the hour.

"We were given every consideration by the members of the Executive Faculty present who listened to us very patiently with comments, questions, and even some disagreements in which their viewpoints were very helpful. We were told that they would consider the various matters discussed and would be glad to meet us again.

"The meeting was to be recorded and the transcript made available to us and the Faculty members for compending and study. Unfortunately, the machine did not work and this report has had to be compiled from memory and a great deal has been left out. Because this transcript was not available, no attempt was made here to record the comments and the questions of the Executive Members of the Faculty present. No further meetings of our Committee have been called but it is hoped that, if it is the wish of the Executive that we continue to function, further meetings with the Executive of the Faculty may be arranged."

Doctor H. J. Devereux moved that this Committee continue to function. This was seconded by Doctor A. W. Ormiston. Motion carried.

It was moved by Doctor E. F. Ross that The Medical Society of Nova Scotia write the Pictou County Medical Society calling their attention to the schedule of minimum fees, and suggesting that they advise the employers of its existence, and ask that subscribers be informed of their responsibility for any unpaid balance for professional services. This was seconded by Doctor J. A. MacCormick. Motion carried.

It was moved that the meeting adjourn at 6.05 p.m.

# COLLEGE OF GENERAL PRACTICE OF CANADA

April 21st, 1954

This is a news-letter addressed to every doctor in Canada who has applied for membership in the College or contributed to its Foundation Fund.

The College is grateful for this early evidence of your support and you are entitled to information as to the progress being made. Below is a break-down, by provinces, of the membership applications and Foundation Fund contributors as of April 21st, 1954.

## FOUNDATION FUND DONORS (\$100 or \$70)

Yukon	B.C.	Alta.	Sask.	Man.	Ont.	Que.	N.B.	N.S.	P.E.I.	Nfld.	TOTAL
1	37	7	1	5	26	8	1	5	0	1	92

DONORS OF LESS THAN \$70—Total 7

## ACTIVE MEMBERSHIP APPLICATIONS

Yukon	B.C.	Alta.	Sask.	Man.	Ont.	Que.	N.B.	N.S.	P.E.I.	Nfld	U.S.A.	TOTAL
1	68	18	5	4	64	17	2	8	0	2	1	190

ASSOCIATE MEMBERSHIP APPLICATIONS—Total 4

(Sgd.) W. VICTOR JOHNSTON  
Executive Director

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## POLITICS

It is learned on good authority that Doctor Henry Reardon, a prominent Halifax physician and President of the Halifax Branch of the General Practitioners' Society, is interested in the Liberal party nomination for the vacant constituency of Halifax South. Many general practitioners of varying political faiths have expressed approval of his candidature, in the belief that his originality, pertinacity, vision and vigor would bring new life to the local legislature and that, in due course, the portfolio of the Ministry of Health might, once again, be held by a member of the medical profession, a change, which it is felt, would rebound to the benefit of the people and the profession of this province.

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## THE STORK

To Doctor and Mrs. A. J. "Gus" Campbell, a daughter, born May 5th, weight 7 pounds, 13 ounces; Heather Ann.

To Doctor and Mrs. H. "Curly" Still, a daughter, born May 3rd, weight 8 pounds, 11 ounces; Janet Elizabeth. "Curly" was in such a rush that it cost him \$20.00 next day in Magistrate's Court.

### HALIFAX MEDICAL SOCIETY

General Practitioners elected to the Executive of the above Society for the year 1954-55, include J. H. Slayter, Secretary-Treasurer, F. J. Barton, F. M. Fraser, L. T. Stead and H. C. Still.

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### A THOUGHT FOR GENERAL PRACTITIONERS

Is it not time that the management of such institutions as the Victoria General Hospital be returned to a small politically independent Commission, with an Advisory Board drawn from the Nursing Staff, the Medical Staff, and that great body of general practitioners who are not on the staff, who have no voice in the policy of the institution or in the conditions for rendering service therein, and yet who are responsible for the admission of a large proportion of the patients?

F. MURRAY FRASER

# Society Meetings

## WESTERN NOVA SCOTIA MEDICAL SOCIETY

The Western Nova Scotia Medical Society annual meeting was held on May 27th at the Gateway Flying Club, Yarmouth Airport, taking advantage of all time available to hear the guest speaker, Doctor H. B. Atlee, who arrived from Halifax at 3.10 p.m., and returned at 6.20 p.m. In this short period Doctor Atlee kept well occupied, speaking on "Difficult Labour" and other allied subjects in his own inimitable manner. A delicious lobster supper was served by the Ladies' Auxiliary of the Flying Club following which Doctor Atlee was given a hearty vote of thanks.

After his departure the business meeting was conducted under the chairmanship of the President, Doctor D. R. Sutherland. Officers for the coming year were elected as follows:

President—	Doctor A. M. Siddall, Pubnico
Vice-Presidents—	Doctor James L. Robbins, Lockeport Doctor Benedict J. D'Eon, Yarmouth Doctor Robert P. Belliveau, Meteghan
Secretary-Treasurer—	Doctor D. F. Macdonald, Yarmouth
Representative to The Medical Society of Nova Scotia—	Doctor D. F. Macdonald, Yarmouth, Alternate, Doctor G. V. Burton, Jr.

A motion was made and passed requesting that Dental Anaesthesia be allowed under Maritime Medical Care. Another motion, also passed unanimously, asked that The Medical Society of Nova Scotia request The Canadian Medical Association to have the Proprietary Medicine Act framed so that the important active ingredients would be listed on the package. It was pointed out that several instances have occurred where children have taken an over-dose of some medicine in which the ingredients were not known and so could not be properly treated.

D. F. MACDONALD, M.D.,  
Secretary, Western Nova Scotia Medical Society

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## ANTIGONISH-GUYSBOROUGH MEDICAL SOCIETY

The annual Meeting of the Antigonish-Guysborough Medical Society was held at Antigonish on May 30th.

Doctor J. F. L. Woodbury of Halifax gave a paper on "Arthritis", and Doctor R. M. MacDonald of Halifax a paper on "Jaundice", under the auspices of the Dalhousie Post-Graduate Course.

Following the talks a business meeting of the Society was held and the following officers for 1954 were elected.

President—	Doctor J. A. MacCormick, Antigonish
Vice-President—	Doctor T. W. Gorman, Antigonish

Secretary-Treasurer—Doctor J. J. Carroll, Antigonish  
Executive—Doctor Rolf Sers, Goldboro  
Doctor R. H. Fraser, Antigonish  
Doctor A. R. Hansen, Canso.

Representative to the Executive of The Medical Society of Nova Scotia,  
Doctor T. B. Murphy, Antigonish.

J. J. CARROLL, M.D.,  
Secretary-Treasurer,  
Antigonish-Guysborough Medical Society

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#### PICTOU COUNTY MEDICAL SOCIETY

The annual meeting of the Pictou County Medical Society was held at the Norfolk Hotel in New Glasgow in May, at which Doctor Clarence M. Miller of New Glasgow was honoured in recognition of his fifty years as a medical practitioner. Following the banquet a business meeting was held where speakers were heard on the Dalhousie Post-Graduate Course. The following officers were elected for the year—President, Doctor S. D. Dunn of Pictou; Vice-President, Doctor G. R. Douglas of New Glasgow; Secretary-Treasurer, Doctor H. A. Locke of New Glasgow, and the representative on the Executive of The Medical Society of Nova Scotia, Doctor C. G. Harries of New Glasgow.

## Personal Interest Notes

Doctor Clarence M. Miller was honoured at the annual meeting of the Pictou County Medical Society in May at a banquet held at the Norfolk Hotel, New Glasgow, in recognition of his fifty years of service in the medical profession. A complimentary address was read by Doctor C. E. Stuart, President of the Society, and mementos presented in recognition of his golden anniversary as a medical practitioner. Doctor Miller, a native of Stellarton, graduated from McGill University in 1904, and took post-graduate studies at London, England, as a Fellow of the Royal College of Surgeons.

Doctor G. A. Barss of Rose Bay, gave an interesting address on "The Development of Public Health," at a meeting of the Home and School Association held at Riverport early in May.

The marriage took place at Halifax on May 13th of Doctor Robert Anderson, Dalhousie 1954, son of Mr. and Mrs. W. W. Anderson, St. Peter's Bay, P. E. I., and Miss Marion Jean Seaman, R.N., only daughter of Mr. and Mrs. Frank Seaman of Halifax. Doctor Anderson is now practising in North Sydney.

An outstanding Nova Scotian woman doctor, Doctor Eliza Perley Brison, of Upper Rawdon, Hants County, who despite a serious physical handicap, went on to become an authority in the field of mental health, has been awarded the Coronation Medal by Queen Elizabeth II. Doctor Brison served for twenty-two years with the Department of Health and Welfare before her retirement two years ago. Since that time she has devoted much of her attention to the home for girls at Coverdale, N. B., where she is assistant superintendent.

The Bulletin extends congratulations to Doctor and Mrs. D. L. Roy of Halifax on the birth of a son on May 27th and to Doctor and Mrs. R. P. Belliveau of Meteghan on the birth of a son on June 4th.

Doctor and Mrs. S. W. Williamson of Yarmouth left the end of May by air to visit relatives in Rhode Island, Montreal and Toronto.

The following 1954 Dalhousie Medical School graduates have located in Nova Scotia. Doctor Robert N. Anderson at North Sydney; Doctor David H. Blinkhorn at Glace Bay; Doctor P. Hugh Kirkpatrick at Sydney; Doctor Eldred H. MacDonell at New Waterford, Doctor Margery U. Morris at Dartmouth and Doctor M. Grant Worthylake at Kennetcook, Hants County.



HENRY KIRKWOOD MACDONALD, M.D., C.M. (McGill), F.R.C.S. (C.)

# Henry Kirkwood MacDonald

**D**R. Henry Kirkwood MacDonald of Halifax died in that city on May 23, 1954, after a period of ill health extending over several months. In 1948 he was severely injured in a traffic accident and although in time he was able to get about again, his activities were partly impaired. He was 81 years of age.

He was born in Lyon's Brook, Pictou County, the son of Robert and Mary MacDonald. His father and grandfather operated the Logan Tanneries in that village. He attended the local school and Pictou Academy, following which he entered McGill University as a student in Medicine. He graduated in 1896.

After a period of interneship at the Montreal General Hospital he returned to Nova Scotia where he opened a general practice in Lunenburg. During those years he acquired a strong inclination to specialize in surgery and eventually went to London, England for post-graduate training. In 1911 he came to Halifax.

He was immediately appointed Assistant Surgeon at the Victoria General Hospital, and in 1913, two years later joined the teaching staff in Surgery of the Dalhousie Medical School. From that time on his life was almost completely devoted to an extremely busy surgical practice and to teaching. As a consultant he went over the entire province. No surgeon was more attentive and devoted to his patients.

In 1932 on the retirement of Dr. E. V. Hogan, he became Senior Surgeon at the Victoria General Hospital and Head of the Department of Surgery at Dalhousie University. He retired from active work in these institutions in 1945 and was thereupon appointed to the Consulting Staff of the Hospital and made Professor Emeritus of Surgery by the University. In 1946 in token of his fifty years as a physician the Halifax Medical Society presented him with an engraved gold watch.

During his long career he was successively a Fellow of the American College of Surgeons, a member of the Provincial Medical Board, and a Fellow of the Royal College of Surgeons of Canada. He represented the Provincial Medical Board on the Medical Council of Canada for many years, and was President of the Council in 1948. Thereafter he continued to represent the Board on the Council up to the time of his death.

He was President of The Medical Society of Nova Scotia on two occasions; 1920 to 1921, and 1939 to 1940.

For several years he was Surgical Consultant to the Nova Scotia Sanatorium, Kentville, and Medical Officer of the Canadian National Railways, Halifax.

To Mrs. MacDonald, his two sons and two daughters, the Bulletin extends its sincere sympathy.

(A tribute to Doctor MacDonald will appear in the next issue of the Bulletin.)



The Bulletin extends sympathy to Doctor J. P. McGrath of Kentville on the death of his mother, Mrs. T. N. McGrath following an illness of thirteen years, at Tusket on April 30th, at the age of 96; to Doctor Donald Hugh MacKenzie of Halifax on the death of his father, Mr. Colin MacKenzie, Q.C., at Sydney on May 19th, following a short illness, at the age of 72, and to Doctor A. R. Morton of Halifax on the death of mother, Mrs. A. McD. Morton at Halifax, on June 5th, following a lengthy illness, at the age of 78.