The Relationship Between The Department of Health and the General Practitioner *

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Mr. President and Gentlemen:

It is a privilege to have been requested to address your meeting to-day. The subjects already discussed have been concerned chiefly with clinical medicine and you will find it stimulating at this juncture to change your point of view to that of the Health Official who must, of necessity, regard his problem from a different angle. The perspective of the Health Official is to view the community as a whole, in which the individual is a unit. To put it as simply as possible, the health officer views the community as an individual seeking medical advice. Thus he must seek out the analogy of a family history, a personal history, the present illness; he must do a physical examination, as it were, of this community, perform what special examinations are required and finally, having the community's chart complete, arrive at a diagnosis and then advise as to cure of present ailments and prevention of future illness.

Into this picture are drawn all fundamental facts concerning the community:—general death rate, leading causes of death, infant mortality, maternal mortality, mortality from communicable disease, morbidity rates, methods of protection of essential supplies of food, water and milk, and that all inclusive word environment, which has been described as including "every mundane experience which, directly or indirectly, may exert an effect on the constitution and function of tissue." This requires organization, a co-operative and sympathetic medical profession and a public which has some appreciation of the value of health procedures.

Now, if the viewpoint of the health officer is understood, immediately it becomes apparent that certain facts about a community must be collected and analyzed if there is to be an appreciation of the health status. Such information leads to compilation of statistics and is the reason for weekly reporting of communicable diseases, the notification of births and the proper completion of death certificates. Here the practitioner has a most important role to play and unless he lives up to his responsibilities, an accurate picture of health of communities cannot be drawn.

Undoubtedly the ground on which a public health officer and the practitioner most frequently face a problem with a common objective is in the control of communicable diseases. This problem may be, in its scope, international, national, provincial or local. The present discussion is confined to provincial and local aspects. Communicable diseases carry a high morbidity in different age groups. They cause unnecessary invalidism through complications and all too frequently result in premature and preventable death, not to mention such social aspects as loss of working time and possible financial embarrassment. The physician's responsibility is to diagnose, treat and report the disease; the health officer's to control its spread and work toward its eradication. In the one instance prime consideration is the individual, in the other, the protection of the community. To-day a new science, epidemiology, is well advanced and its practical application produces results, as has been evidenced in the past, and will be in the future. Epidemiology may be described as the science of aetiology of epidemics, and the same science may be applied in connection with endemic diseases.

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*Address given before the Annual Meeting of the Medical Society of Nova Scotia, July 1942.

The control of communicable diseases implies much more than this, however. A united effort of physician, public and public health official is required. The Department of Health provides the physician with the necessary facilities for assistance in diagnosis free of charge; antitoxin for treatment at cost, and biologicals such as toxoid, vaccine, etc., for prevention. In the matter of assistance to diagnosis, the provincial laboratories under the capable direction of Dr. D. J. MacKenzie, examined slightly less than 200,000 specimens last year, this being an increase of some 93,000 over the previous year. This figure reduced to daily work, means between 500 and 600 specimens a day—all to do directly or indirectly with control or prevention of communicable diseases. The Department also provides containers for certain of the specimens in connection with communicable disease. These are, a container for blood culture and Widal in connection with typhoid fever; the outfit for dark field illumination of discharges for spirochetes pallidum; specimen containers for stools, specimen containers for sputum, test tubes with swabs for throat and tubes for blood for serology or agglutination tests. These are available to practitioners on request. In addition, a pathologist's opinion is available on malignancy. In the past year, some 3,000 specimens were examined in this connection.

Other branches of the Department which work hand in hand with the practitioner and health officer, day in and day out, are the Divisional Medical Health Officers and the public health nursing service. Of the former, there are now five in the province, with headquarters at Halifax, Yarmouth, Windsor, Pictou and Sydney. The opinion, advice and team work of any of these trained men is immediately available to any practitioner or Board of Health in their respective districts. Each Divisional Health Officer has under his direction a staff of trained public health nurses who do their work in the homes with the consent of the family physician.

To digress for a moment from communicable disease, the nursing service which, while under the direction of the Department, works in close association with family physician, in 1941 visited 47,000 individuals and spent 10,348 hours in some 26,000 homes in connection with illness of a preventable nature or in the interests of prevention of disease—35,400 pupils in 1986 classrooms were inspected for apparent defects and these drawn to the attention of parents or physicians or both, and endeavors initiated for correction, when necessary. This service is indeed a boon to the individual and the physician, especially in the rural districts.

To return to communicable disease control, there are many examples of the close relationship existing between the public health official and the physician. Probably the best is in the efforts directed toward tuberculosis control. This disease remains a major public health problem. In the decade of 1931 to 1940, 4,680 deaths were recorded due to tuberculosis in its various forms in Nova Scotia. In the same decade the death rate fell from 102.3 to 73.8 per 100,000, which indicates that 415 individuals died of this preventable disease in 1940. The general practitioner has proved himself to be a most potent factor in the programme for control of tuberculosis since he finds the greatest number of new cases. If accurate records of source of diagnosis are kept, it will be found that this is invariably true, and yet it is also a fact that up to 40% or more of such cases are far advanced at the time of such diagnosis, which is regrettable, but can be explained. The fact is that a patient complaining of definite symptoms, almost always has moderately or far advanced disease. The one lesson that has come from intimate experience with the disease is that early or minimal tuberculosis rarely causes symptoms and that

the only dependable method of diagnosis is a good X-ray film of the chest. A modern programme for the control of tuberculosis demands that tuberculosis be found before the patient knows from subjective symptoms that he is ill. By making such a diagnosis invalidism is avoided, the patient is not permitted to become a spreader of the disease and hundreds of dollars are saved in treatment. Control of tuberculosis depends on finding tuberculosis, which in turn depends on tuberculin testing and X-raying of positive reactors or an examination by X-ray plate alone. To facilitate early diagnosis the Department of Health has supplied each Divisional Medical Health Officer with a portable X-ray unit by which X-ray plates are taken at clinics on patients referred by doctors, old cases of tuberculosis and "contact" cases. This has lead to an appreciable increase in diagnosis of early tuberculosis and has placed the preventive programme on a modern, dependable basis. The travelling clinic service covering the rural districts, together with the X-ray service available in urban hospitals, provides universal X-ray service whereby any person can have an X-ray of the chest.

In 1940, in Cape Breton Island, records were kept to ascertain the findings from the chief sources of diagnosis. In all, 392 cases of adult tuberculosis were diagnosed during the year. Of these, 101 or 25% were credited to practitioners. In this group, 39% were in the minimal stage, 23% in the moderately advanced and 38% in the far advanced stage. The clinic service, that is travelling diagnostic clinics, accounted for 196 or 50% of the new cases. Of this group, 53% were in the minimal stage, 31% in the moderately advanced and 16% in the far advanced stage. A fair number were referred to the clinic by the practitioner but the majority of cases were discovered by reason of procedures for examination of contacts carried out by Public Health Nurses in the field. In addition to the previously named sources of diagnosis of tuberculosis, the so-called "tuberculin surveys" are employed. Such surveys deal directly with apparently healthy people. They are tuberculin tested and the positive reactors are X-rayed. During the year referred to, 5,000 individuals were tuberculin tested. The groups were made up chiefly of teachers and high school students. 1930 had positive tuberculin reactions and of these 95 were found to have tuberculosis. Of all cases diagnosed, (392), this 95 is 24%—56 or 59% were in the minimal stage, 30 or 32% moderately advanced and 9 or 9% far advanced.

Organization, education and availability of X-ray service are all essential to a satisfactory program of tuberculosis control, but in the final analysis it is the general practitioner who has the most intimate association with the patient and it is he who advises the patient as to what should be done. Consequently a report of every examination is forwarded to the family physician with what comment is required. That this very necessary service is appreciated by the practitioners is evidenced by the fact that in 1942, in the Province of Nova Scotia, 18,354 examinations pursuant to tuberculosis clinic work were carried out.

It is apparent that this subject of the relationship of a public health worker and practitioner cannot be treated exhaustively within the scope of this paper. Not all the responsibilities of the Department have been mentioned, nor indeed, all the available services. However these few more intimate examples illustrate to some degree the subject under discussion. In the final analysis, health official and practitioner have a common objective in the alleviation of human suffering and the improvement in the health status of each of our communities—and search as you will, in no other sphere is team work and cordial relationship more necessary than between the physician and a Department of Health.

*The Physician and the Workmen's Compensation Act

Frank Rowe
Chairman, Workmen's Compensation Board

TWENTY-FIVE years or so ago when one of the live political questions was whether or not we should have compensation in this Province, its purpose and its extent were being discussed on every platform and were pretty thoroughly understood, but with the passing of the years the tendency has been to lose sight of a lot of this and to demand of compensation many things that as yet it does not grant, with the inevitable disappointment when they are not received and often times with no little bad feeling against those who are supposed to be withholding the good the gods have provided.

Modern compensation started on the continent of Europe some fifty years ago. Up to that time, and for some few years after, English law had proceeded on the theory that for every wrong there was a remedy but no remedy unless there was a wrong. Under this theory a workman who voluntarily undertook employment was held to have assumed the risks of such employment, that he also assumed the risks of anything that might happen to him through the negligence of a fellow servant, and that of course he was entirely responsible for any negligence on his own part. These theories were perhaps not so bad so long as industry was decentralized and carried on in small groups, but with the coming of the machine age and the centralization of industry in large plants, where machinery played a prominent part, these old legal theories soon showed their inadequacy. The frequency of accidents leaving an increasing number of industrial workers to become a charge on charity created a public demand for redress and in 1897 the Parliament of England passed its first compensation law.

In 1910 the Province of Ontario undertook the first step towards setting up a system of compensation in this country. Sir William Meredith, Chief Justice of the Province, was appointed to make a thorough survey of various compensation laws in force in different countries and to determine how far such laws were giving satisfaction. He took considerable time to make his survey, travelled widely and investigated many jurisdictions. He handed down his final report in 1914 and that same year the Workmen's Compensation Act of Ontario was passed and this was followed the following year by the Act of this Province, which was modelled on that of Ontario.

A startling innovation which the Ontario system of compensation provided was the complete elimination of the courts. Sir William Meredith, although an eminent jurist himself, reached the conclusion that it was a very necessary adjunt of a system of this kind to be able to provide workingmen with a swift and speedy settlement of their claims and his greatest hope was, as he expressed it himself, to build up a system not so much to insure absolute legal justice in every individual case, but rather to provide a system under which the great average of injured workman would receive substantial justice administered by men who would approach the task untrammelled by legal decision and technicalities. The Ontario Act therefore abandoned the courts completely.

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*An address delivered to the 89th annual meeting of The Medidal Society of Nova Scotia, Sydney July 8, 1942.

Most of the other Provincial acts are the same. In Nova Scotia and New Brunswick an appeal to the courts is still provided for on questions of law, but on all questions of fact the decision of the Board is final and probably less than a dozen appeals have been taken in the last twenty-five years from the decisions of both Boards on matters of law.

By 1931 all provinces had passed similar legislation, with the exception of Prince Edward Island, which is still without a law of this nature.

Now as to our own particular Act, and as to how it affects the medical profession, I would like to draw your attention to one or two main facts.

1. In the first place it must be remembered that the Act does not apply to all industries, or even to all workmen engaged in connection with industries which are covered. The industries to which the Act automatically applies are listed in the Act. Others may be admitted on application to the Board on such terms and for such time as the Board may decide. All industries not under in one or other of these ways are out and workmen engaged in them have no right to compensation. Similarly casual employees, outworkers and certain specific employees of corporations are specifically excluded. I shall not delay in dwelling on the why or the wherefore of this and I mention it in passing simply because even after twenty-five years of compensation it still leads to some misunderstanding and remonstrances against the Board for refusing compensation under circumstances which obviously give no right to payment, and that introduces my second main point, viz:

2. That the injured workman's right is still a legal one provided by statute. The Workmen's Compensation Board is appointed to administer that statute; it does not make the law nor can it change it. It can, and sometimes does, make recommendations to the Legislature as to ways and means, in the opinion of the Board at least, of improving the law, either in an administrative way or sometimes to the greater benefit of workmen, but except insofar as changes may be made in that way, the Board cannot initiate them. It is true, of course, that the Act must be construed liberally, so far as workmen are concerned. I believe it is a fair proposition to say that despite the many mistakes which we admittedly make, and which will always be made so long as you have human beings administering human affairs, although of course some make more than others, the Act is by and large administered favorably to the workman, and I am firmly convinced that for every mistake we make against the workman we make a good many—if you can call them mistakes—in his favor. I make no apology for that statement to those who are presumed to be paying the shot, because, as I have already said, it is definitely what the law provides.

I think everyone will agree that before any claim is paid we should at least have a report from the claimant himself, from the employer and from his doctor. Sometimes one or other of these reports is late in reaching us, as often as not the workman's own. This, of course, causes delay, but subject to delays of this nature although I have no exact statistics on the matter, I think I am perfectly safe in saying from observation that fully 90% of our cases are paid and a cheque is in the mail for the first payment within forty-eight hours after we have received the last of these documents. In other words, the large proportion of our claims are paid with reasonable promptitude and without any controversy whatever.

I would like to draw your especial attention to Section 6 of our Act which is almost the whole Act as far as handling claims and dealing with your profession is concerned. That section provides that compensation shall be paid for injuries

caused "by accident" "arising out of" and "in the course of" the workman's employment, provided the workman is thereby disabled for seven days and with some exceptions which I need not touch on here.

You will notice, if you give that section even cursory attention that there are three very important conditions to be met before compensation can be paid. In the first place, injury must be "by accident", secondly, it must arise "out of" the employment, and it must occur "in the course of" the employment. The latter phrase as a rule doesn't give us much trouble. There has been very little difference of opinion in judicial decisions on this particular point, and with some very few exceptions it is generally accepted that for a workman to be hurt in the course of his employment he must be at his actual place of work, and the accident must happen during the actual hours of employment, but the question of "accident" and the question of "arising out of" the employment are two very different matters. Reams of legal argument and judicial decision have been written around these two points. Certain general principles have been laid down but I think they can be summed up in one word, viz., that each particular case must be decided on its own facts, that all the facts must be considered and a decision rendered along the lines of what the reasonable average man would say if he were asked to say whether or not the workman had had an accident and whether or not the employment had contributed to the condition of which he complained. If a man is hit by a falling object, jams his fingers in a machine which he is using and has a right to use, and if this happens while he is going about work that he is properly employed to do, obviously there is no question about the matter; the two conditions are fulfilled. If, on the other hand, he is going about his work in the usual way, performing tasks that he has performed day after day for some time and suddenly complains of a pain somewhere or other, he may quite properly attribute it to his work, but the question is here not so clear. In the first place, it is not so clear that he has had any accident, and in the second place the question as to whether his employment has contributed to what he complains of, is also in point. If he has undertaken some prohibited act, in some place where he has absolutely no right to be, the situation is also somewhat clearer, because then it is not so hard to decide that he is without the scope of his employment.

But in between these two extreme illustrations there are all shades and degrees which call for considerable thought and which are very difficult to decide. I can assure you there are some times we wish that we could dispose of them as far as these points are concerned, with the ease which some of you find possible. Last year we had some 17,000 accidents reported to us for payment of compensation or medical aid. In perhaps less than twenty-five of these was there any suggestion by the doctor concerned that there might be some question as to the origin of the trouble complained of. These cases ranged all the way from cancer to T.B., and from a small scratch to serious amputations. Then there is also the case where the question is whether the workman is suffering from disease or from injury. Latent conditions are bound to manifest themselves for the first time while men are at work or at least while they are still active, and the most natural thing in the world is for such men, quite honestly, to link their condition with some bump or lift or similar incident in their employment which would otherwise have passed unnoticed. There is also the case of industrial disease or accident—those conditions which instead of being accidental are brought on by continued exposure to some element or other, some of which are compensable and some not. The best the Board can

do in all these cases, as I have already intimated, is to endeavor to get all the facts and to apply reasonable judgment following the principles laid down by the courts, particularly in the English jurisdictions, where appeals to the courts on all matters are still the order of the day.

3. Medical aid is defined by the Workmen's Compensation Act as meaning medical, surgical and dental aid, as well as hospitalization and skilled nursing services. It also includes the supplying of artificial limbs and certain other appliances which I need not refer to further. The Board is authorized to pay such medical aid as may be necessary provided the same—and I quote the exact words of the Act—"shall not be supplied for a longer period than thirty days". This period is taken by the Board to begin from the day the workmen first saw the doctor following his injury, thus giving him the benefit of the longest time possible to get in his thirty days' treatment.

So far as this thirty day period is concerned we experience very little trouble Occasionally the necessity of some item of expenditure is questioned, but in the great majority of cases accounts are paid as rendered and without deductions. There are, however, still some of whom this cannot be said, and I must frankly state my own humble opinion to the effect that deductions in such accounts have not been severe enough. We could in some instances I believe, save the trouble of asking for bills at all, because from experience we know before our forms are sent out that if the workman has a thirty days' lay-off we are going to be charged for thirty attendances. If ten days, we will be charged for ten attendances. There are still certain others who possess a conscience and they reduce the number of attendances to say 25 in the 30 day period and probably 8 in the 10 day period, and so on.

We have set a scale of fees which may or may not be the best one. My own personal opinion is that for some items it is not high enough; in some others it is quite adequate. We would welcome any suggestions you might have to make to us on this score, because I think in the near future we plan to revise this scale and we will certainly not do it without consulting you. One thing is certain, our scale is not intended to authorize the piling up of unnecessary daily attendances merely to justify a $1.50 charge, and I hasten to say that in the great majority of cases your profession abides honorably by this view. As to whether or not attendances are necessary, we sometimes are asked pretty angrily what we know about such matters. My answer is that our knowledge is based on the information you give us, so if at times we appear to deal unfairly with any of you, perhaps that may be the source of your trouble. As in dealing with workmen's claims, we can only use the best judgment we are capable of in such cases, and after all some of these cases are not as mysterious, even to a layman, as is sometimes suggested. Some of you, I know, keep rather poor records, because I have frequently seen cases where charges have been made for attendances on dates preceding the workman's injury, for attendances made when the workman was clearly miles away from the place where the services were supposed to be rendered, and indeed I have on my desk right now a case where we are being charged for several attendances on dates definitely after the workman's death. The treatment so far as I can make out the writing which, like my own, is not too legible, consised of hot saline soaks and some treatment with cocaine. I am not familiar enough with the kind of life the deceased lived to know whether cocaine, which I understand deadens the feelings, would be of any benefit to him in the hereafter, or not, but I have a sneaking suspicion that the hot soaking was being administered to us.

Seriously though, we do want to pay you a reasonable fee. We want workmen to get prompt and proper medical attention, and we think that if for that we pay you what you could reasonably charge that workman in your locality if compensation did not enter into the picture, and if he was reasonably well able to pay, we have done everything that should be required of us. We are the sole remaining province where complete medical aid is not paid. I venture to suggest that the quickest and surest way of bringing full medical aid in this province is to rid ourselves of the abuses attendant on part time medical aid and I feel sure that any steps we may reasonably take to that end would be welcomed by your profession.

Just one other word re medical aid. Some of you have been a bit perturbed over the limitation to three months of the period for rendering your accounts, and have regarded this as another evidence of the Board's desire to assert authority. It is nothing of the sort. The provision is contained in the statute and is absolutely binding on the Board, being clearly mandatory in its terms, so that no auditor would pass an account rendered after three months ifwe did pay it. The change was made in the Act after repeated representations made to some members of the Government by employers who complained about accounts paid and charged to their class. They protested against the size of many of these accounts and their protest was principally on the ground that receiving notice of payment one year after payment was made, as was almost invariably the case in the accounts complained of, they were seldom if ever in a position to check the correctness of such bills properly. I must confess that after listening to two of such delegations place their complaints before the then Premier of the Province, I was convinced there was considerable in what they had to say and while the Board did not initiate this change, I must be frank enough to say that we saw no reason whatever why we should advise the Government against it. You may disagree but I still think it is a fair provision, particularly when those who let a whole year pass before rendering their bills are still the ones who wait until the end of the three month period. All a good many would have to do would be to make one field day and get caught up in rendering their accounts and then carry on as before and it would matter little what limitation was set.

I may add that when the change was made in the legislation ample notice was given all doctors by circular letter from the Board. In spite of this quite a few lagged and as a further concession at the last session of the Legislature a special amendment to the Act was passed enabling us to clean up such of these accounts as were in our hands by February 28th. Previous to this we had again circularized the profession, stating that this would be done and urging them to get in their accounts, although in that circular we set the date line to the end of the year because at that time we did not know what exact date the Legislature might decide, but felt that it would not be earlier than that. From that date on, therefore, the three month limit must stand until changed by the Legislature.

I notice a good many doctors from mining centres and I know what I have said about accounts will be of slight interest to them as they carry on under contract practice, a practice under which employers deduct from employees' wages a fixed weekly or monthly sum which is paid over to the doctors of the workman's choice. This system has been fiercely attacked by some and just as stoutly defended by others. No doubt much could be said on both sides. Within recent months I have read in two reliable publications,

or what I would regard as reliable, the statement that the Workmen's Compensation Board looked with considerable suspicion on reports of all doctors working under this practice. One publication went so far as to say that we would accept reports only from one doctor in a certain area where there is a large number of doctors. I am happy to say such is not the case and I wrote to that publication saying so and asking them to correct the statement.

The fact is that there are many doctors, both under and not under contract practice, whose reports we accept readily as honest statements of facts in their possession and as honest expressions of opinion based on these facts. With these we may have some difference of opinion, but never any question as to bona fides, and right here I would like to interject the statement that perhaps one of the best set of records in this province is kept by a doctor whose practice is largely contract and who can produce these records to show just what he did for every compensation case that he has treated in his twenty years of practice.

It is equally true that there are some, both under and not under contract practice, whose reports do not bear the same weight. I am glad to say they are in the minority, but I think sober truth would compel me to say that the proportion is larger in the contract areas.

I am going to venture a suggestion to all doctors in this connection, and that is, that the very best service any doctor can render the workman is to state as facts carefully and fully only what he knows to be such and to refrain from becoming an active advocate for all cases whether good or bad. In this connection a little time at the start in carefully filling out a medical report, may be of inestimable benefit later on. I respectfully submit that if any doctor makes a report as to such matters as period of disability, nature and extent of injuries, etc., under circumstances which clearly suggest that the claimant is merely obtaining the type of report he asks for, that doctor may get something for that particular case, but ultimately he must come to have all his reports viewed with suspicion and that is an undesirable state of affairs from any angle.

Now, Mr. President and gentlemen, in concluding I wish to express my appreciation and that of the Board for the privilege of addressing you to-day. I hope I have said nothing to hurt anyone's feelings. I believe our relations with the medical fraternity as a whole are pleasant. We would like to feel that we are joining with you in performing a piece of social service in this Province of extreme importance. An indication of its extent can be found in the fact that last year $1,347,018.00 was paid by way of compensation, $143,340.00 was paid to doctors for medical services, and another $44,870.00 to hospitals.

No one can encounter the disabilities which industry has left in its wake in this province without feeling that this, good as it is, is all too small. The surest way of increasing the benefits of any service is to eliminate its abuses and no one shares a greater responsibility in that regard than the medical profession. My plea, therefore, is for an increased co-operation between the Board and yourselves for a more sympathetic understanding of the other fellow's problems. May I ask that when we make our mistakes, you endeavor to set us right with facts rather than abuse and we will do our best to reciprocate.

Bringing Europe Back to Life*

ALLIES NOW AT WORK ON COMPREHENSIVE PLAN

By A Reconstruction Specialist

TO-DAY almost the whole of continental Europe is subject to a blockade which will not be lifted till the Nazi power in Germany has been completely broken. This blockade is not only, or even mainly, directed to the denial of foodstuffs to the enemy. Europe is not, even in normal times, wholly self-supporting in food and, since production in war-time is more incalculable than in peace, there remains the probability of grave—if only local—shortages arising at or before the end of the war.

The blockaded area now includes the whole of Europe with the exception of Switzerland and the Iberian peninsula. Spain is in a precarious food position. The Scandinavian countries and Holland have become potential candidates for relief instead of sources of supplies. Greece, Norway and Belgium, three countries which in peace-time are importers of bulk foodstuffs and in the last war received at least minimum supplies from overseas, are now entirely dependent on German-controlled economy.

Estimates of the post-war needs of food and raw materials of Europe are now being prepared by the Allies. The technical problems of agricultural relief, medical relief, nutrition, inland transport and of supplies and shipping are under consideration. The aim is that, by the time Europe or any part of it is free, a comprehensive plan of dealing with the emergencies that will arise shall be agreed by all the Allied Governments. There is no suggestion of taking arbitrary action on statistics prepared beforehand, but of developing plans of a flexible character to meet the situation which is likely to arise. The supply of foodstuffs will depend, perhaps, more on the course of the war outside Europe and the possibility of placing stocks in positions where they can be drawn on at short notice.

Britain Will Go Shares With Europe

Reconstruction must synchronize with relief. It is important that, so far as possible, relief should be initiated on sound dietary lines so as to make this foundation the basis for an all-round improvement in European nutrition in the years to come. A well fed Europe will be a peaceful Europe. This result will not depend merely on a realization of the need for improvement or in dietary education. It depends, not only for the industrial workers but to some extent also for the rural population, on such an increase in spending power as will permit the purchase of something more than the cheapest types of bulk foodstuffs.

Relief is both a political and an economic concern since adequate feeding, the prevention of epidemics, the return of people to their homes, the re-stocking of farms and the provision of productive employment are indispensable foundations for a stable political regime in Europe.

* Received from Robert Williamson, Mowbray House, Norfolk Street, London, W C. 2.

The state of Europe after this war may be so critical as to prompt the people of the better-off countries willingly to forego for some months the freedom of purchase which they enjoyed before the war and to demand a continuance of rationing of at least some of the vital food supplies. The contribution of the United Kingdom can be as effective in refraining from consumption as by donating supplies. We have been told that stocks of food will be in Britain at the end of the war and quantities of food will be on their way there, as they have been, thanks to the Allied Navies, so regularly throughout this war. May we not expect to find repeated the generous action which, on the day the last Armistice was signed, prompted the Governments to divert cargoes of food to northern and southern Europe to meet acute feeding difficulties and to transfer immediately consumable war stocks to black areas on the Continent?

Europe's Harvest Will Depend on America's New Ships

Europe will need raw materials as well as food at a very early point after the end of the war: cotton and wool for clothing, hides and leather for boots, copper for electrical power and light and timber for rebuilding the houses in the devastated areas. Shipping therefore cannot at the end of the war be devoted solely to the carriage of foodstuffs but must also bring essential raw materials so that men can get back to work once more and make good the deficiencies of food, wearing apparel and dwellings. The construction of refrigerated tonnage will become an urgent problem to enable imports of meat, butter and fruit to be resumed as rapidly as possible. Europe will be expecting supplies of coffee, cocoa, rice and tropical fruits. Coffee has become a necessity on the Continent. The Germans' effort to find a satisfactory brown, wet and hot substitute from acorns and barley, or anything else which when roasted will give the right degree of colour, is proof of this. We in Great Britain consume as much cocoa as the whole of the rest of Europe. A surplus of cocoa is piling up in West Africa and after the war, when shipping is available, Britain and the Continent will have cocoa in plenty. Rice is a Far Eastern staple article of diet and the provision of European needs will be affected if the Far Eastern war finishes after the European war. Oilseeds and copra which go into the making of margarine will also not be easy to import from the Far East while the Japanese war continues. We may therefore expect to see an increased production of African palm products. The Continent will need these vegetable fats.

Feeding stuffs are necessary to build up the livestock population and maize is one of the most important of them. There are large supplies but maize is bulky to ship and ships may be scarce. The hope of increasing European supplies of maize and of oil cake, so important to the dairy industry in countries such as Denmark and Holland, rests on the development of the vast shipping programme which the United States has in hand. Fertilizers are of course essential to increased production of food in Europe. There will be a large demand in Europe after the war for potash and phosphates provided before the war by France. Nitrogenous manures will not, with the change over of European industry from war to peace, be a problem.

Each Country to be Rationed for First Year of Peace

One of the subsidiary aims of relief in 1919 was the firm establishment of a number of new or reconstructed national States. It seems unlikely that this motive will play an important part in the future. The movement in Central and South Eastern Europe is towards regional agreements, of which the first have been the Polish-Czech and the Greek-Yugoslav agreements. The possibility of wider understanding is being discussed to-day by Allied statesmen. The exact form which such agreements may take or the areas which they will ultimately cover is unknown, but the mere existence of larger economic units will considerably simplify the problems of relief. Many difficulties bearing on questions of transport, currency and the balancing of surplus and deficiency areas will be greatly relieved, as will certain minority and potential refugee problems.

There can probably be no immediate reversion at the end of the war to a free economy, and the Allied nations will need to plan a policy to take the place of the Nazi New Order in Europe. If this seems to be far from the sphere of post-war feeding in Europe, and of relief, it must be remembered that, for the first year after the war, or perhaps longer, it will be for the Inter-Allied relief authorities to decide the quantities not only of foodstuffs but of raw materials, agricultural requirements and capital goods entering each country.

Political planning on a regional scale should be accompanied by economic planning. Industrially it should be possible to aim at preserving and extending those branches of manufacture which are adapted to each region's natural resources, including labour resources, its home consumption or payment for its necessary imports. Agriculturally a similar plan might be followed with the special aim of raising the nutritional standards in Europe.

The object of a relief organization, when it has completed the work it has been set up to do, is to give fuller opportunities for reconstructive effort. If the Allied relief organization whose planning has now begun can, in its fuller international development, not only prevent the immediate suffering of the after-war years but leave a foundation on which the constructive agents can build, its main purpose will have been fulfilled.

PHYSICIAN WANTED

Wanted, a physician to take over at once a country practice. Gross value 1941, $15,000.00. Further information from the Secretary.

Book Review

Vaginal Hysterectomy. J. W. Kennedy and A. D. Campbell, 495 p. Illus. F. A. Davis & Company, Philadelphia, 1942.

THE editors of the Bulletin have given me *Vaginal Hysterectomy* by J. W. Kennedy and A. D. Campbell (F. A. Davis & Co., Philadelphia) to review. As I have been deeply interested in this subject for some years I thought I might take the occasion to say something on my own about it.

First, the book, which divides itself into two quite definite parts—a Kennedy and a Campbell part. One might say, more truly, that the Campbell part is an appendage to the Kennedy part, since it deals only with one aspect of the operation. In the Kennedy part the history of the operation is recounted, and it makes interesting, if ghastly reading—as does the history of all operations that were first performed before the age of anesthetics and antisepsis. As might be expected, the part played in the development of the procedure by the late Joseph Price is considerably stressed.

It was my privilege to see Kennedy perform several operations one morning in Philadelphia, and the evidence of his hero-worship was even stronger then than it is in this book. So deeply has he come under the spell of his dead master, that he operates in exactly the same way, with the same sort of instruments and sutures, on the same operating table, in the same hospital. Make no mistake about it: he is one of the ablest operators on this continent, but to watch him perform with his archaic instruments is like hearing Nearer My God to Thee sung in Sanskrit. Some of this archaicism has unfortunately crept into the Kennedy (but not the Campbell) part of the book.

Two operations are described, the clamp operation and the suture operation. The essential difference between the two is that special clamps with removable handles are put on the broad ligaments and left there for three or four days in one operation, while in the other the ligaments are sutured. The operation described by Campbell is not a straight vaginal hysterectomy, but a vaginal hysterectomy plus a repair of cystocele and rectocele, and one that I have always known as the Mayo operation. Unfortunately neither author describes what might be called the straight vaginal hysterectomy with sutures, which I prefer to the clamp operation when I merely want to remove the uterus.

A considerable number of gynecologists do a routine removal of the prolapsed uterus along with repair of the cystocele and rectocele as described by Campbell. This is not my practice. I remove the uterus only when there is a *uterine* indication for its removal: otherwise I believe you get a stronger pelvic support by leaving it behind and doing some modification of the Fothergill operation. In my hands, at any rate, recurrence of prolapse has been more frequent when I did the operation described by Campbell, than when I did the Fothergill. Of course if there is definite uterine pathology present, the uterus should be removed; if prolapse is present, it should be repaired at the same time, and for that purpose no operation is better than the one described by Campbell.

The clamp method of vaginal hysterectomy as described by Kennedy has one advantage over the ordinary suture method. It is an easier operation to perform. Its disadvantages are that you have to put packing up into the

Pouch of Douglas, which causes considerable vaginal discharge after it is removed. I do not use the operation, preferring the suture method which brings all the structures into apposition, leaving no raw areas exposed either above or below. That, of course, is a personal preference. In taking my stand on it I don't forget what Kipling said about there being fifty-seven ways of writing ancient lays—every single one of which is right.

One welcomes this interesting book primarily as a stimulus to all surgeons to undertake vaginal hysterectomy more frequently. It has advantages over the abdominal approach as serious as the removal of tha gall bladder has over drainage of that organ. Let me discuss these briefly.

Safety:—At the end of my first 100 vaginal hysterectomies I went back over my last 100 abdominal hysterectomies. There were no deaths in the former, and three among the latter. I have now done upwards of 400 vaginal hysterectomies with only one death—pneumonia on the 17th day. It seems to be the experience of all gynecologists who have mastered this operation that it has an outstandingly low mortality. For instance, Heaney, whose operation (with some modifications) I do, has done over 900 vaginal hysterectomies with only 3 deaths. I have never heard of a series of abdominal hysterectomies with so low a mortality rate. But not only is the mortality low—shock is less and the patients feel better afterwards, having their wound in the painless vaginal vault, rather than the painful abdominal wall. Furthermore they have to remain a shorter time in bed and in hospital by several days, and their late post-operative pick-up is more rapid and satisfactory.

The Entire Uterus is Removed:—This is coming to be recognized as an important desideratum in pelvic surgery, and the day will shortly arrive when subtotal hysterectomies will only be done in the most exceptional cases. The reasons for this are several. There is first the very real danger of stump cancer. Besides this the remaining cervix may become a pocket of infection causing discharge, chronic ill-health, and pain. To show that these things are not so infrequent let me say that I have removed four such stumps this year already. Having been all my surgical life an advocate of routine total hysterectomies, it is some satisfaction to note that the gynecological world is moving steadily in that direction with more and more articles on the advantages of total vs. subtotal hysterectomy appearing in the journals.

It can be done as part of an extensive repair, thus making the abdominal approach unnecessary. In cases, and they are not infrequent, where hysterectomy is indicated in a woman suffering from any of the various forms of prolapse, vaginal hysterectomy can easily be done as part of the operation, adding little if any shock to the procedure. As I have stated, I do not believe that it should be done routinely for prolapse, as the book under review seems to advocate, but rather for the removal of a *diseased* organ, complicating prolapse.

It has the advantage over X-ray and radium that the ovarian function is not destroyed. Where radiation is used in the cure of uterine bleeding, the ovaries are unlikely to escape some damage. In a great many cases they are completely put out of business, bringing on menopausal changes. While there is no objection to this in the woman of 45 or over, I believe it is much better to spare the ovarian function in younger women—and vaginal hysterectomy offers this with an astonishingly low mortality rate.

In fat women:—Every pelvic surgeon has sweated blood trying to remove a uterus from a fat woman abdominally. One encounters such cases where

even a subtotal hysterectomy, ordinarily a very easy operation to do, becomes one of great difficulty. The vaginal approach, while somewhat complicated by excessive obesity, is very much easier than the abdominal.

What size uteri can be removed vaginally? Naturally the operation is easier and simpler to do when the uterus is little if any enlarged, as is the case in the ordinary benign uterine group. But fibroids and chronic pelvic inflammatory disease can also be tackled from this direction. By means of morcellement I have been able to remove a uterus enlarged by fibroids to the size of a five months' pregnancy. In several cases I have encountered old pelvic inflammatory disease and removed the tubes. I do not advocate the operation in such cases, as the difficulties are greatly increased by size and adhesions.

The necessity for removal of the Fallopian tubes also increases the technical difficulties of the operation. In certain cases—for instance where one is operating on a diagnosis of cancer of the body in older women—it is absolutely essential to remove tubes and ovaries as well as uterus. But despite the difficulties with the use of the proper instruments it is always possible to do this.

How often does one attempt the operation and find it impossible to do? On three occasions I have had to abandon the vaginal and adopt the abdominal approach. In all these cases the vagina has been long—and I am always wary of doing the operation in very tall women (unless they have enough prolapse to bring it down). But three failures out of four or five hundred attempts is a very low rate of failure. Nevertheless, my tendency latterly has been to adopt the abdominal route when the vagina is long and the cervix high-placed, rather than make the vaginal operation too difficult a problem.

In conclusion, let me repeat that this is a timely book on a timely subject. It is the best book on the subject I have yet read—and it should be read by everyone who does pelvic surgery.

H. B. Atlee

Editor's Column

THE KENNY TREATMENT IN NOVA SCOTIA

The opening of a wing of the Nova Scotia Hospital, at Dartmouth, for the treatment of anterior poliomyelitis, brings to maturity a plan that had its beginnings no more than three months ago. Here, under the direction of Dr. Cecil Kinley, and the care of Miss Valerie Harvey, are being gathered poliomyelitis cases in the later acute, and in all convalescent stages. Here, it is hoped, under the Kenny treatment, the great number will be returned to complete normality.

A great part of Nova Scotia's profession have already had the opportunity of hearing Dr. Kinley talk of Sister Kenny and her new clinical concept of anterior poliomyelitis. When Dr. Davis, Minister of Health, asked Dr. Kinley to pass his surgical judgment on the work of Sister Kenny, at the University of Minnesota, and on the courses which two provincial nurses, Miss Maud MacLellan and Miss Nellie Wile, had already received there, Dr. Kinley was openly skeptical. After an intensive week of round table discussions with orthopedic surgeons, pathologists, internists and neurologists, of sincere, heated argument, of lectures and demonstrations by Sister Kenny at the University of Minnesota, he was won to ardent approval.

That the promising treatment should come to Nova Scotia at a time when we are suffering from perhaps the most serious epidemic of poliomyelitis ever experienced here, is most fortunate and reflects great credit on Dr. Davis and his Department whose astuteness is clinical as well as governmental. The majority of our profession, with the little that has appeared in the medical journals as their only information, have been eager to give the Kenny treatment a trial. Dr. Davis and Dr. Kinley have been buried beneath demands for hospital accommodation. The wing of the Nova Scotia Hospital provides as good a solution as could be found in such short time.

The other great need for the proper establishment of the Kenny treatment has been a trained physio-therapeutist. Hence, Miss Harvey, who comes from Australia, a disciple cf Sister Kenny, and with years of training as a technician-teacher in the Kenny methods.

With some seventy cases now under treatment throughout the province, and the greater number of these localized in the Halifax area, Dr. Kinley reports early results as most encouraging, and consistent with the findings of Australian and the few American clinics where the Kenny method has been in practice.

Thus there is good reason to believe that this first Canadian clinic for the treatment of a new disease which Sister Kenny describes as being neither *infantile*, nor a *paralysis*, will bring health and a new hope to many of our people.

A. L. M.

Abstracts from Current Literature

A Report on the Results of Electric Shock Treatment on Mental and Emotional Symptoms. F. Kennedy, M.D., and B. Wiesel, M.D., "New York Medical Journal," September 1, 1942.

This paper is an attempt to examine the value of electrically induced convulsions in 48 cases. All but two were ambulatory—coming to the hospital without breakfast and remaining two hours after treatment, then returning home. Proper posturing and assistance is necessary to avoid fractures so treatment can only be carried out where this is available. Treatments were given three times a week and the average number of treatments was twelve. In all, 556 treatments were given with 318 generalized convulsions.

Of the 48 cases, 36 were depressed, either manic depressives or involutional. Five were called "manic depressive equivalents," these cases having one or more somatic complaints—gastro-intestinal, cardiac, etc.—and there being no frank mood statement unless especially enquired for. There were 5 cases of schizophrenia and 2 of anxiety neurosis of long standing.

The results are reported as symptom free, much improved, somewhat improved and not improved.

Thirty-six cases of depression received 434 treatments. The average duration was four weeks. Twenty-four were rendered symptom free, 9 much improved, 3 somewhat improved, and 1 not improved. Of 5 cases of manic depressive equivalent 1 became symptom free, 3 much improved and 1 not improved. One of the two cases of anxiety neurosis was much improved. In the 5 cases of schizophrenia it did not appear that the course of the disease was affected.

Five illustrative cases are presented. One of these is of special interest—a man aged 55 with an agitated depression of three years' duration. There was moderately advanced generalized arteriosclerosis, blood pressure 245/130, many retinal haemorrhages, N.P.N. 56, and the X-ray finding of arteriosclerosis of the aorta. Because of the progress of the depression and the marked suicidal danger, treatment was started. He had ten treatments with nine convulsions and by the tenth treatment was symptoms free. Retinal haemorrhages disappeared and blood pressure dropped to 188/104. Three months later he was not depressed, there were a few fundal haemorrhages and blood pressure was 200/100.

The authors conclude that this method is the treatment of choice for depressions and perhaps of value in chronic neurosis and schizophrenia.

Diseases of the Nervous System. Volume III. No. 9, September, 1942. A Symposium on Neurosyphilis.

This number of "Diseases of the Nervous System" is devoted to a symposium on neurosyphilis presented by the Massachusetts Society for Research in Psychiatry. Ten papers are presented on various phases of

SURGEONS' CONGRESS SCHEDULED FOR CLEVELAND NOVEMBER 17 TO 20

The 1942 Clinical Congress of the American College of Surgeons, originally scheduled for October at the Stevens Hotel, Chicago, which was taken over August 1 by the United States Army Air Corps, will be held in Cleveland, with headquarters at the Cleveland Public Auditorium, from November 17 to 20, according to an announcement from the College headquarters in Chicago. The twenty-fifth annual Hospital Standardization Conference sponsored by the College will be held simultaneously.

The program of panel discussions, clinical conferences, scientific sessions, hospital meetings, and medical motion picture exhibitions at headquarters, and operative clinics and demonstrations in the local hospitals and Western Reserve University School of Medicine, has been centered around the many medical and surgical problems arising out of the prosecution of an all-out effort to win the war, emphasizing the needs of the rapidly expanding medical services of the Army and the Navy, and consideration of special problems related to the increasing activities for civilian defense.

The program of both meetings will begin with a Joint General Assembly on Tuesday morning, November 17, with addresses by Surgeon General James C. Magee of the Medical Corps, United States Army; Surgeon General Ross T. McIntire of the Medical Corps, United States Navy; Surgeon General Thomas Parran of the United States Public Health Service; Lieutenant Colonel George Baehr, Chief Medical Officer of the United States Office of Civilian Defense; Dr. Frank H. Lahey, Chairman, Directing Board, Procurement and Assignment Service; Dr. Irvin Abell, Chairman of the Board of Regents of the College and Chairman of the Health and Medical Committee of the Federal Security Agency; and Dr. W. Edward Gallie of Toronto, President of the College. The Surgeons General and Colonel Baehr will also speak at the Presidential Meeting and Convocation the same evening.

The Forum on Fundamental Surgical Problems inaugurated at the 1941 Clinical Congress will be repeated to give the younger men, representing various university departments of surgery, an opportunity to present the important results of their clinical and experimental research work before a large surgical meeting. Heretofore these younger men have seldom been able to present their original work and ideas, since many of them have not yet qualified for membership in the principal surgical societies. The forum will be held on three successive mornings.

The officers-elect of the College who will be inaugurated at the Presidential Meeting and Convocation on November 17 are Dr. Irvin Abell of Louisville, President; Dr. Leland S. McKittrick of Boston, First Vice-President; and Dr. F. Phinizy Calhoun of Atlanta, Second Vice-President.

A large technical exhibition in which leading manufacturers of surgical instruments and supplies, sutures, dressings, pharmaceuticals, operating room equipment, X-ray apparatus and hospital equipment of all kinds, as well as publishers of medical books will participate, will be a feature of the Clinical Congress as usual. It will be housed in the exhibit hall of the Cleveland Public Auditorium.

The Meyers Memorial

The Canadian Medical Association receives the sum of $100.00 a year from the estate of the late Doctor Campbell D. Meyers to provide an honorarium known as The Meyers Memorial.

The award is made in accordance with the instructions of the donor, which are:

(1) That the award shall be made ". . . to such member or guest of the Canadian or of one of the Provincial Medical Associations as shall write and read at the annual meeting of any of the said Associations the best thesis or dissertation . . ."

(2) That the subject shall be ". . . the study and treatment of those functional neuroses which, if untreated, or not treated sufficiently early might probably terminate in insanity . . ."

". . . it is impossible to classify definitely the type of diseases referred to above. I desire however to refer to those Functional Neuroses in which the psychological symptoms form the essential part of the syndrome, and to that type of neurosis which develops in late adolescent or in adult life in a patient of previous good mental and nervous history, especially such neurosis as has its etiology in emotional overstrain caused by excessive grief, worry and allied conditions . . ."

"I desire to exclude from this thesis the study of Mental Defectives, Paranoia and similar conditions of mental disease due to hereditary or organic states . . ."

(3) That the award shall be made ". . . by a Committee consisting of the President, a physician and a neurologist . . ."

Those who wish to submit a thesis are advised to confer, in advance with the Chairman of the Meyers Memorial Committee in order to make sure that their thesis will come within the terms of the award.

The thesis must be in the hands of the Chairman of the Meyers Memorial Committee on or before May 31st if it is to be considered for the award of that year and should be forwarded to him at 184 College Street, Toronto. Any thesis received after May 31st will be considered as being submitted for the following year.

Society Meetings

The Cape Breton Medical Society at its monthly meeting held September 4th., 1942, in the General Hospital, Glace Bay, had as its guests, members of the Army, Navy, and Air Force, as well as Superintendents of Hospitals, Nurses representing our Hospitals and Nursing Services. It was by far the largest attendance at any meeting of the Society, and taxed the capacity of the large lecture room of the Hospital.

Dr. Davis the Minister of Health, spoke on the policy of his department regarding "Infantile Paralysis."

Dr. Cecil Kinley gave a very learned and clear cut discourse on the Kenny Treatment, explaining Miss Kenny's Terminology and Teaching, as well as reviewing the results he had observed while at the University of Minnesota. One outstanding feature of this lecture was his demonstration of symptoms, which was a revelation to all.

Following Dr. Kinley's lecture, Miss Wile of the Department of Health, demonstrated the application of stupes, giving directions and comments as she went along.

At the end of this demonstration, members of the medical profession adjourned to the drawing room, where refreshments, cigarettes and cigars were served.

Correspondence

The following letters have been received from Major C. M. Bethune, R.C.A.M.C., Registrar, No. 7, Canadian General Hospital, Canadian Army Overseas, dated August 10, 1942.

"We are now receiving three more magazines—Life, Newsweek and Time—the gift of the Gerald Burns Memorial Fund.

These are of great interest to us all. When read by the Officers' Mess, they are passed on to the Men's Mess, and from there to the patients, so that they provide a great deal of entertainment for as wide a circle as possible.

We are having a fairly quiet time, in spite of numerous air-raids in the vicinity. Baseball and tennis are in full swing now, and our unit is acquitting itself nobly. We miss the salt water swimming very much, but the weather is so cool that we wouldn't do much swimming anyway.

We have just received issues of the BULLETIN for the months March, April, May and June.

We were all very glad to receive these and they will be read with great interest. The personal items are of special interest to us all, as it keeps us posted about our friends throughout the province.

Please convey the best wishes of all our officers to your Society."

THE WAR-TIME PRICES AND TRADE BOARD

Ration Section,
69 Rideau Street,
Ottawa, Aug. 11, 1942

To the General Secretary
Canadian Medical Association

Dear Sir:

We are having some difficulty with regard to the rationing of sugar in connection with requests by members of the medical profession for extra sugar supplies for patients.

Before dealing with the subject at all, we wrote to the Department of Pensions and National Health as to the validity of such certificates and we were informed that laboratory tests would be necessary to determine the need for extra sugar and that, in any case, there are many substitutes which could be prescribed in place of sugar.

We have adopted the attitude that, if a medical practitioner will write a certificate giving the name of the patient, the complaint from which he or she is suffering, the number in the family and the amount of sugar required in excess of the normal ration of ½ pound per week, we would grant a special permit to enable the patient to purchase this extra supply, but we asked that they should make a new application at the end of each month. Unfortunately, we are finding that an extra fee is being charged by the medical practitioner each month at the time of issuing a medical certificate and we are very anxious

to see that extra sugar supplies are not made available unless absolutely necessary.

Would it be possible to secure your cooperation by bringing before your members the possibility of substituting some unrationed commodity which would take the place of sugar in medical prescriptions so that we could avoid both the necessity of depleting our sugar supplies and the necessity of these patients making a monthly visit to their medical advisors in order to obtain a certificate.

We would greatly appreciate any cooperation you can give us in connection with the above.

Yours very truly

(Signed) Geo. Shortt
Director, Industrial and Institutional
Rationing.

In connection with the recent provincial order regarding restaurant employees, Dr. E. L. Eagles, district medical health officer for Hants, Colchester and Kings Counties, gave medical examinations to a number of restaurant employees in Truro the latter part of August. This examination is compulsory, and every waitress, waiter and all kitchen help must be examined and hold an official health certificate before obtaining employment in restaurants. In this examination, the first of its kind in Nova Scotia, there is no charge to those being examined; also no charges for X-rays taken.

Dr. John J. MacNeil arrived at his home in New Waterford, on September 8th after an extended stay in England where he was graduated in medicine from London University last November. Since then he has done post-graduate work in London, Epsom and other places. Dr. MacNeil, who is a son of James R. MacNeil, manager of No. 18 colliery, New Waterford, is a graduate of St. Francis Xavier. After taking up the study of medicine at Dalhousie, he went to England in 1938, and completed his course in London.

Dr. and Mrs. J. J. Carroll of Antigonish, left September 16th, for Montreal and Toronto, where the doctor will spend a month visiting hospitals and clinics.

First School Diphtheria Clinic Opens.

The first of the clinics which are to be held in Halifax public schools until every child has been immunized against diphtheria, opened September 21st at the Hon. W. S. Fielding School under the direction of Dr. E. M. Fogo, assistant commissioner of health, aided by school and public health nurses. The plans made the week previously at a special meeting of school authorities and health officials were designed to provide maximum protection to school children, of whom approximately 5,000 still have not received the toxoid. Clinics are to be held Tuesday at St. Patrick's Girls', St. Mary's Boys' and Sir John S. D. Thompson Schools and are to be continued daily until every child has had the opportunity of being immunized. The campaign is under the supervision of Dr. Allan R. Morton, Commissioner of Health, who has also announced that he plans to speed up and extend the immunization of preschool age children.

Dr. and Mrs. W. H. Robbins of New Glasgow, recently were on a motor trip to Digby, Dr. Robbins' former home. Dr. and Mrs. Robbins were forty years married this month.

Dr. S. J. Shane, Dal. '40, who practised in Port Maitland for a short time following graduation, is now associated with Dr. G. V. Burton, of Yarmouth.

Mrs. K. K. Blackadar and daughter, Mary Lee, spent a few days in Noel, Hants County, visiting her daughter, Mrs. (Dr.) R. G. Wright before joining her husband, Captain K. K. Blackadar, who has been posted as Medical Officer at No. 60 C.A.B.T.C. in Yarmouth. Dr. Blackadar, Dal. '16, was formerly with the C. N. Steamships, Halifax.

The marriage took place on September 19th, at Halifax, of Madeleine, daughter of Mr. and Mrs. G. A. Evans and Dr. Adam Brown Crosby, son of

Mr. and Mrs. A. T. E. Crosby, all of Halifax. Both Flying Officer and Mrs. Crosby are graduates of Dalhousie University, the groom receiving the degree of M.D., C.M. in May of this year. After a short wedding trip they will reside at the Lord Nelson Hotel, Halifax.

Dr. and Mrs. J. G. MacDougall have moved from Spring Garden Road to their new home, 17 Parkwood Terrace, Halifax.

Says Health Insurance Is Favourably Received.

"I have found little resistance lately to the general principles of National Health Insurance, which is a remarkable change in public opinion," said Hon. Ian Mackenzie, Minister of Pensions and National Health in the Federal Government, who arrived in Halifax on September 7th. He is making a routine inspection of military hospitals and arrived from Lunenburg after making inspection of Lunenburg hospitals, and left Halifax for Saint John. Discussion is still going on concerning actuarial features of such an insurance scheme. However, Mr. Mackenzie could not state whether or not the scheme would come into effect during this war. "Perhaps it will be a part of reconstruction after the war," he said. He was accompanied on his tour by Deputy Minister R. E. Wodehouse, Herbert George, hospital architect for the department, and Major Meikle, in charge of hospital supplies. Commenting on the shortage of nurses, the Minister said $115,000 was being spent by the Federal Government on training schools and the furtherance of scholarships. "This was not much, but apparently it will alleviate the problem. However, if the war lasts a long time it may cause embarrassment to the nursing situation in Canada." Now, he says, a shortage of doctors is being felt.

He pointed out as incidental that 2,500 pensions were now being paid by his department and men already had been discharged from the services, and these had to be looked after by his department. Medical treatment had to be given them, if needed, and then jobs found.

"Last time we blundered into peace without being ready for it," said Hon. Mr. Mackenzie, briefly checking over measures designed to check economic distress among returning soldiers after the war. Among these are included land settlements, unemployment insurance schemes, which credit full time payment of unemployment insurance to soldiers who are disabled and return to peacetime jobs, and help soldiers so they may finish uncompleted college courses. (*Halifax Mail*, September 8th).

Twenty-one nurses received their graduation diplomas and their gold badges and made the "Nightingale Pledge" from the Halifax Infirmary School of Nursing at the graduation exercises at the Nova Scotian Hotel on September 3rd. Monsignor William Burns, Vicar General of the Diocese, presided and presented the graduation diplomas. In the absence of Dr. F. S. Finlay, who was to have addressed the graduates, Dr. J. V. Graham gave the address. Dr. G. H. Murphy, Gordon Isnor, M.P., Dr. F. R. Little and Monsignor Burns, also gave brief addresses.

A proposal to establish a blood bank in Cape Breton was endorsed unanimously at a largely attended and representative meeting held in City

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Obituary

THE death occurred at St. Paul's Hospital, Saskatoon, on September 12th, after a brief illness, of Dr. Herbert D. Weaver, a former lecturer on the staff of Dalhousie Medical School and pioneer in the installation of X-ray equipment in Nova Scotia. Dr. Weaver was born at Altrincham, Cheshire, England, and came to Canada as a boy. His family took up residence at Woodstock, Ontario. In 1897 he graduated from Trinity University, Toronto. For several years Dr. Weaver lectured at Dalhousie Medical School and while in Halifax installed the first X-ray equipment in Nova Scotia. In 1905 he went to Saskatoon to take up residence and there introduced the use of X-ray. In 1906 he married Alice Thomas, a sister of Dr. Lewis Thomas of Halifax.

Dr. Weaver took an active interest in the welfare of Saskatoon and the organizational meetings for the Y. M. C. A. and the Horticultural Society were held at his home. He was a member of the Board of Governors of Emmanuel College for many years and a member of St. John's Cathedral, and physician to the Sons of England at Saskatoon. He was also a member of the Saskatoon Parks Board for many years and established one of the first nurseries in Northern Saskatchewan where he carried on experimentation for the purpose of introducing trees, shrubs and perennials suited to climatic conditions of the Prairies. To this enterprise he devoted much of his time during the last few years. He is survived by his widow, four sisters and a brother, Canon Leigh Weaver of St. Catharines.

The BULLETIN extends sympathy to Dr. Willoughby M. Phinney of Yarmouth on the death of his wife, the former Helen Robertson of Edinburgh, Scotland, which occurred after an illness of three weeks, the latter part of August.