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Fifty Years of General Practice

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Liverpool, N. S.

I HAVE been solicited on many occasions to write an account of my experiences during a practice extending over a period of more than fifty years. I naturally hesitated feeling that my experiences would largely coincide with those of my contemporaries and there would be nothing of particular interest about it, and that those who had read the *Horse and Buggy Doctor* would anticipate a great deal of which I would relate. However, I rather reluctantly accede to a recent request and shall endeavor to write a short sketch.

Like a great many young men of my time, I taught school for a few years and saved a little money out of the meagre salary of that date and, by borrowing some more, I succeeded in graduating from the College of Physicians and Surgeons at Baltimore. Shortly after graduating, being what I considered heavily in debt, I gladly accepted an offer from a Narcotic Cure Institute at Providence, Rhode Island, at a very attractive salary. After serving there for one year I decided to get into general practice somewhere, but before doing so I would go back to Baltimore and get some more clinical experience. I was there only a few days when I was offered the position of substitute for the Resident Physician at the Hebrew Hospital as the Resident was called home because of sickness in his family. About six weeks later, the annual meeting of the Hospital Association was held and the Resident Physician was re-appointed and I was appointed Assistant Resident Physician for the ensuing year.

The Hebrew Hospital was just across the street from the Johns Hopkins Hospital which had recently been built—and was giving a Post-Graduate Course. The Johns Hopkins Hospital at that time had one of the ablest, if not the ablest, staff in America: William Osler, Chief of Medicine; Halstead, Chief of Surgery; Kelley, Chief of Gynaecology and William H. Welsh, Chief of Pathology and Bacteriology.

Our Resident Physician, being a very genial and accommodating fellow, we arranged our work so that I could take the courses given by Professor Osler and Professor Welsh.

I had the great privilege of accompanying Doctor Osler through the wards on Monday, Wednesday and Friday mornings for seven months attending his bedside clinics—a great opportunity to learn something about physical diagnosis. On one occasion Doctor Osler examined a man and discussed his symptoms and finally said, "Gentlemen, what this man's trouble is I don't know. We shall have to keep him under observation." That statement impressed me with the greatness of the man. In my practice, especially in the early days, I have had cases I could not diagnose on my first visit, but I did not have the courage to make a frank admission that I did not know, for fear I would be dismissed and another doctor called.

When I completed my services at the Hebrew Hospital I took the advice of a doctor friend and opened an office in East Baltimore. I selected a location on a very respectable looking street, furnished it modestly and hung out my "shingle." I waited two or three weeks for patients but very few seemed to notice my sign. My finances being limited, expenses going on and very little cash coming in, I decided to close up, so I returned my furniture to

the firm from which I had bought it on the installment plan, and accepted an invitation to locate at Port LaTour, Shelburne County, in May, 1895. I was not greatly enamoured of the place but for financial reasons I was obliged to stick until something better turned up. During that summer I did a fairly good practice and when I enucleated an eye for a man and got him an artificial eye I became quite famous.

The latter part of October I received word of the death of the late Doctor G. A. Smith of Liverpool, and invitations from a few of my friends to locate there. Without debating the question very long I decided to move. I was able to pack all my worldly goods in my buggy and I drove through, over horrible roads made worse by a heavy rainstorm.

The "big fire" at Liverpool which destroyed the entire business centre of the Town had occurred about six weeks previously and accommodations of any kind were hard to get. For an office I succeeded in securing the front shop of a one time shoe store with two cobblers working in the back room and there I hung out my "shingle." A few months later I secured a more desirable office where I remained until I moved into my present residence.

My predecessor was a popular man and enjoyed a large practice and I, being of the same name, dropped into a busy practice from the start.

Transportation in those days was a serious matter. The worst by-road to-day is far superior to main highways of that day. I had a buggy built to order, with the seat higher than the ordinary carriage so that in going over very rough roads I could throw my weight on my feet and relieve the jar. That buggy had a leather boot fastened down in front with a flap on each side to turn the water out. Under this boot in cold weather I used a thick lap robe or a buffalo robe. In addition to all this, on a rainy day I wore a cape which I pulled over my head and it came down over the seat and turned all the water out of the buggy. With all this paraphernalia and a "SouWester" to keep the water from going down my neck I could drive a long distance and keep dry. In the back of my buggy and under the seat I put my medical and surgical bags also, in case of emergency, a bunch of wire, some rope and a hatchet. More than once I broke a spring and cut a sapling to replace it and made it fast with rope or wire. On one occasion, eighteen miles from home, I broke my axle off at the hub. I cut a birch and made one end fast on the front axle and secured the hind axle on it, lashed the wheel on behind and dragged the whole thing home. Quite a difference to-day when you can step into a closed car, press the button and turn on the light.

During the first ten years of my practice there was no railroad on the South Shore of Nova Scotia, and the nearest hospital to me was at Halifax. The only regular means for transporting a patient to hospital was by steamer that ran once or twice a week between Yarmouth and Halifax. On one occasion I had a patient at Port Mouton with a large ovarian cyst. She looked like a full term pregnancy. I shipped her by a packet that ran between Port Mouton and Halifax. The results were just as good as if she had travelled by parlor car.

Absence of Hospital facilities forced me to do things that I otherwise would have shrunk from. When I came face to face with a case of strangulated hernia with stercoraceous vomiting I could not stand by and see the man die. He would be dead before I could get him to hospital. I was compelled to undertake the operation. My first success gave me confidence and during

that early period I was called upon to deal with seven cases all successful, except one man who waited two or three days before calling for aid, and was found so gangrenous that all I could do was sew him up and give plenty of sedative.

To show the conditions under which we had to work those days I shall relate one case. One afternoon in the late summer I was called twenty-four miles out in the country. I found a man over sixty years of age with a strangulated hernia for the past two days, with stercoraceous vomiting and in an exhausted condition. I had to drive back four miles to telephone to Liverpool for a doctor to come out and bring some things I needed. I went back to the house and commenced to set up a table and sterilize some things in preparation for the operation. By the time we were ready for the operation it was dark and I had to depend upon two men holding oil lamps for light. Just as I got down to the sac where it required very careful dissection one of my lamp bearers crashed down in the corner, lamp and all. I was compelled to finish the job with one man holding a lamp.

I was also obliged to operate on a number of cases of empyema. Three of those cases served afterwards in the Army overseas during the first world war. It fell to my lot to do a few amputations but I never regarded them as difficult as certain so called minor operations.

At the expiration of eleven years of practice I conceived the idea that I might become a surgeon. I went to the New York Post-Graduate Medical School for seven weeks. After witnessing a few cases of abdominal surgery I concluded that with a busy country practice and no hospital facilities I was wasting my time, so I devoted my time to Tonsils and Adenoids, Rectal Surgery, Fractures and Dislocations—things I was meeting in my every day work.

The country doctor in my early days was often confronted by some difficult problems, as for instance, when he got a call in the country and finds a fracture of the thigh and all the equipment he had with him was a spool of adhesive plaster. It taxed his skill and ingenuity to arrange the bed, apply weight and pulley and adjust splints. All the equipment had to be improvised by the aid of a saw, hatchet and jack knife. In these modern times the tendency is to "pass the buck," apply a temporary splint and send the case to the hospital. Probably I would have done the same if there had been a nearby hospital to which to send them.

In my early days we did not have the armament that we have to-day for fighting disease. Diphtheria Antitoxin was just in its infancy. Most doctors were afraid of it and administered it in too small doses. Immunization was not practised. Sulfa Drugs, Penicillin and Streptomycin were not known. I can recall cases that could have been saved with Sulfa Drugs and Penicillin.

The country doctor has a pretty hard life, but if he possesses a little sense of humour he frequently sees or hears something that will give him a laugh to relieve the monotony. I regret that I did not keep notes on the many amusing things I have seen and heard.

Perhaps I may relate a few amusing incidents that come to my mind.

One day a man came into my office and told me that Janie (his daughter) was going to be married. I said: "Who is the fortunate young man?" "Well," he said, "you know Willie Crowdis? Well, he came up there and he says, says he, 'Mother is getting old now and she can't do all the work.' He would

have to get some one to help do the work, and he had been thinking the thing all over and he thought the cheapest thing he could do was to get married." "Yes," I said, "and what did Janie say to all this?" "Oh well, Janie said she supposed she would have to get married some day to get a home of her own and she might as well marry him as any one else."

I was attending an old man well up in his eighties who was suffering from cardiorenal trouble. In his latter weeks he became somewhat demented and very careless about his personal wants—hence a good deal of trouble to take care of him properly. The poor old wife became very tired, impatient and discouraged. At my visits she would exclaim, "He's so much trouble! He's so much trouble! I only wish the Good Lord would take him!" Eventually the old man passed away and soon after that I had occasion to call at the house. Meeting the old lady I shook hands and said "Uncle John has left us." She burst out crying "I miss him so. I miss him so. He was so patient. He was so patient."

One day I met a man with a pair of oxen and a load of wood. As I approached he stepped into the road and held out his whip as a signal for me to stop. When I brought my horse to a stop he said "I have a crow to pick with you." I could not think what I had done or what could be wrong but decided to put on a bold front. So I said "Trot out your crow." He said, "Do you know where I can get a good milk cow?" I said, "I believe I do. You know Mr.—in Milton. He has two good cows, kind, gentle, not breechy. They give excellent milk and are good butter makers. One of these cows he will sell. She is good in every way except she only gives milk out of three teats." He said, "That's the hell of it, the cow they want to sell always has something the matter with her. Last week I was all over the place looking for a cow. I saw lots of cows. The one I wanted to buy they wouldn't sell, but the one they wanted to sell always had something the matter with her. My Gott, I'd rather go out any day looking for an ox or a wife."

After more than fifty years of active practice which I must say I greatly enjoyed, on the 1st of January, 1947, I was obliged to restrict my practice to office work and the enjoyment of kind words from many friends. To sum up I may say that although my life has been hard and strenuous, it has been a happy and enjoyable one.

Some Notes on the History of Pain Alleviation

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THE following observations are in no manner the product of effort along research avenues, nor can it be suggested that this compilation is original in any sense of the word.

These facts, herewith set forth, can be found in many current volumes. The paragraphs have been selected and set down, not because most of our readers are not fully acquainted with them, but because they make an interesting review.

With these qualifications, and in view of the plea for more contributions from the profession at large to the BULLETIN we make so bold as to submit these notes.

The use of anaesthetics to alleviate the pain of surgical operations or childbirth was entirely unknown before the middle of the 19th century. Prior to that time operations were performed only from direct necessity. The fully conscious victim was restrained by physical means to prevent his escape under the surgeon's efforts, and he was compelled to meet the situation with as much fortitude as he could command.

This barbarous state of affairs, once accepted as inevitable, can now be happily compared with the present humane oblivion so easily produced by any one of a fairly large number of agents.

The discovery of anaesthesia for surgery and obstetrics took place in 1846. It depended not so much upon the employment of a new drug, as upon a new administration—i.e. inhalation.

It is purely academic to observe that with the employment of agents of anaesthesia, the provinces of surgical and obstetrical procedures became without boundaries or ceiling.

The deadening of pain by soporific potions was known even to some primitive people. Helen of Troy, we are told, cast "nepenthe" into the wine of Ulysses. The Talmud of the Jews speaks of a narcotic "Samme de shinta." There are also the "drousy syrups" of the Arabian Knights. Opium and Indian Hemp were known to the Egyptians and Greeks,—and mandrake, to the Hebrews and Babylonians. Biblically, "Rachel sought mandrake of Leah" (Gen. xxx 14-16). It is uncertain for what purposes she used them. Mandrake wine was used by Dioscordies, surgeon in the army of Nero. Mandrake was popular essentially during the middle ages until the 16th century. Paré, the noted French surgeon found it inefficient as an anaesthetic and it is wryly recorded in 1525 A.D., that he preferred not to so torture "poor wounded mer." He simply lashed his patients to the table so that their writhing would not interfere with his work.

The surgeons of the 18th and 19th centuries sometimes intoxicated their patients with opium or alcohol when the procedures necessitated freedom from struggling. But the surgeons of pre-anaesthetic days depended largely upon speed. Thus we read of the sleight-of-hand affairs of a surgeon-general in the Hanoverian army at the time of Napoleon "amputating an arm while one might take a pinch of snuff."

In all of this no mention is made of the child-bearing woman. Soporific potions may have been used in ancient times, true enough, but no one ever troubled themselves about the pains of the parturient. Indeed the efforts to avoid the parturient pains sometimes called forth punishment. The Greek Goddess, Actemia, it is noted, terrified by her mother's suffering at her own birth, sought from Zeus, the favour of eternal virginity. Subsequently she seduced Endymion and was punished for her early prudery by a truly god-like superfecundation; she became the mother of fifty daughters at one time.

There are a few recorded instances of painless childbirth during profound intoxication induced for reasons other than those of analgesia. One such case occurred in a woman brought into the Hotel Dieu of Paris, 1818. Another was the celebrated case of Countess de St. Geran, who was rendered insensible by a draught given to her by the midwife; she was then delivered and her child abducted before she regained consciousness. We find, however, no definite record of effort to alleviate the pains of parturition as such.

There is a prescription for relieving painful childbirth which is set forth in a manuscript of Zerobabel Endicott of Salem, in 1660. Endicott's prescription is here given in full. "For sharp and difficult travail in woman with child, take a lock of Virgin's hair of any part of ye head, of half ye age of ye woman in travail. Cut it very small to fine powder and take 12 ant's eggs, dried in oven after ye bread is drawne or otherwise make them dry, and make them to powder with the haire, give this in 1/4 pint of Red Cow's milk or for want of it, give it in strong ale wort." There, we agree, is an attractive potion for the gastronomic mechanism of a fatigued primipara.

The pain of childbearing has always been woman's heritage. The pain and fortitude with which she has met it, are not new with modern civilization. Biblically—it said of the parturient, (Jer. IV: 31) "For I have heard a voice as of a woman in travail—the anguish as of her that bringeth forth her first child, the voice of a daughter of Zion, that gaspeth for breath, that spreadeth her hands, saying 'Woe is me now, for my soul fainteth before the murderers.'" As for the fortitude of women, it can be quoted (Jer. XLVIII; 41) "And the heart of the mighty men of Moab, at that day shall be as the heart of a woman in her pangs."

Apparently the introduction of anaesthesia to alleviate the pangs of labour, aroused a violent storm of controversy. It was science versus didactic teaching of the then known clergy,—and would seem amusing were it not for the suffering involved.

Scotland has a legend regarding anaesthesia. Thenu, mother of St. Kentigern, of Glasgow, was impregnated under a soporific potion and without her knowledge or consent. In consequence, as a punishment, she was cast down from the top of a high hill, but wonderful to state, she was not hurt. Her tormentors were not satisfied with this evidence of divine intervention and she was then set adrift on the Firth of Forth, whereupon she floated safely across to Fife and was rescued by St. Servanus. In due time she was safely delivered of a son—later to become the famous St. Kentigern. Having a saint whose history was so closely associated with childbirth, may have given the clergy some sensitiveness on the subject. At any rate, it is a historical fact that in 1591 a lady of rank, Eufame MacAlyane, sought the assistance of Agnes Sampson for the relief of pain at the time of her son's birth. Agnes, tried before King James for her heresy, was condemned as a witch and buried

alive on the Castle Hill of Edinburgh. Again in the 19th century, the Scottish clergy arose,—this time to consume by fiery condemnation the practice of a physician, one Dr. James Y. Simpson. This man, however, less submissive than the lady of history, turned and with their own weapon of religious interpretation, silenced the clergy and cleared the way for the progress which was to change the way of life for womanhood in the vital function of parturition. More of Simpson anon.

Reference to the events leading up to the general use of agents of anaesthesia are in order at this point.

Sir Humphry Davy really fired the opening gun in the controversy over anaesthetics. In 1800, he observed, following some experiments with nitrous oxide on himself, "As nitrous oxide in its extensive operation appears capable of destroying physical pain, it may probably be used with advantage in surgical operations in which no great effusion of blood takes place."

Forty-four years later, in 1844, Horace Wells, of Hartford, Conn., began to use this gas in dentistry. He was thus the first man to make practical application of anaesthesia. His observations were based on the fact that students, taking the gas in lecture room demonstrations, did not appear to mind the fall or slight injuries received in falling or staggering against the furniture.

Some years later a death occurred while he was giving nitrous oxide. This unfortunate incident caused Wells to withdraw from practice; he became melancholy and eventually took his own life.

Wells had reported the progress of his work and as cocaine was not in use until 1879, one can imagine the extensive fields which were suddenly opened up to dental surgery. Wells' friend and former partner, William Morton, of Charlton, Mass., was on the lookout for a suitable agent of anaesthesia. His colleague, Dr. Chas. Jackson, Harvard Medical School, had observed the above noted circumstances as applied to the mild "Ether Frolics" in which students oft times indulged. Morton, aware of its possibilities, tried it on the family dog and finally anaesthetized himself. The following description of his first patient is in detail Sept., 1846. "At this moment the door bell rang and Morton admitted a man named Eben Frost, whose bandaged face with mingled hope and consternation is familiar to all dentists. He asked if it were possible to mesmerize him and readily consented to inhale ether, when assured that it superseded mesmerism. To the joy of the operator and the astonishment of the patient, the attempt was perfectly successful." As I say, this was in 1846.

Morton was a medical student as well as a dentist and after the unqualified success of the first professional venture with ether, his mind quite naturally turned to its possibilities in surgery.

Now the event with which we are all familiar. Morton prepared for two weeks and then invited Dr. Warren, senior surgeon at the Massachusetts General Hospital, Boston, to permit him the opportunity to give a demonstration of the properties of ether on a patient undergoing a surgical operation. To this request, Dr. Warren acquiesced and the date was set for Oct. 16, 1846.

It is history that the demonstration was abundantly successful in every respect. The very newness and originality of the phenomenon left those concerned without a name for the agent or the state. An appeal to Oliver

Wendell Holmes was rewarded with the words, "anaesthetic," the agent to produce insensibility; "anaesthesia," the state of insensibility.

Forthwith, be it sadly noted, Morton and Jackson attempted to capitalize on their efforts by trying for a monopoly on the "ether rights" to a given community by issuing permits to the physicians for a fee ranging from \$37.00 to \$200.00, according to the size of the locality. This highly questionable state of affairs was vigorously resented by the rank and file of practitioners who still recognized the odors of sulphuric ether in spite of the patent name of "letheon," which decorated the product.

Jackson and Morton soon parted company, and each selfishly sought acclaim as the discoverer of anaesthesia.

The friends of Wells, now deceased, who had used nitrous oxide in practice, completed the vigorous three cornered controversy.

The battle raged for some years and a wag eventually suggested that a monument be raised to Jackson and Morton with the word "e(i)ther" inscribed on the pedestal.

In 1854, a bill proposing an appropriation of \$100,000 to the real discoverer of anaesthesia was actually up for its final reading before the Senate. At this stage, a senator Dawson arose and stated that it had been brought to his attention that ether had been used by Dr. Long in Athens, Georgia, at least four years previous to Morton's demonstration at the Massachusetts General Hospital.

In consequence of this declaration, the hectic period of altercation over anaesthesia quietly ended.

Dr. Long was a country practitioner known only to the few in the locality in which he practiced. The bill for the first operation under anaesthesia is still preserved, made out to one James Venable; it is a charge, including anaesthesia, of \$2.00.

The prime motive in his communication to Senator Dawson was to still the ferment aroused by the then nation wide controversy.

Now to return to Dr. James Y. Simpson, Professor of Obstetrics at Glasgow University. Here, apparently, was a reformer with both feet set solidly on the ground and also blessed with a healthy disposition toward argument. He was among the first in Europe to employ ether in obstetrics, but he looked further afield in the hope of obtaining a less irritating agent and one that would be less offensive to the patient. He and his colleagues finally chose chloroform as the most promising possibility.

He published his first paper on its particularly beneficial action in childbirth in the year 1847. Immediately he was engulfed by a violent controversy as to the propriety of abolishing labour pains. He was denounced from pulpit and by pamphlet.

Many otherwise sensible folk were led by their religious scruples to doubt the propriety of inhaling chloroform. The clergy insisted that the pains of mankind was the ordained lot of man—to prevent it was sacrilege. One clergyman said, "Chloroform is a decoy of Satan, apparently offering itself to bless women; in the end it will harden society and rob God of the deep, earnest cries which arise for help in the time of trouble." He submitted that mother instinct would suffer. He drew a picture of a drowsy debauch during which a child was brought into the world. He insisted that there was something imbued into the child during the agony of labour, which was good. This was to be lost, said he, if anaesthesia was employed.

Simpson's rebuttal is a masterpiece of its kind. It was written in 1847—listed under the heading "Answers to the Religious Objection Against the Employment of Anaesthetic Agents in Midwifery and Surgery." His keen and sound judgment, as is evidenced by the arguments he sets forth in defence of his beliefs, are as inimitable as they were original for his time. His best argument was that there had always been objection to innovation. He cites the turmoil over vaccination as one of the high points. "Pestilence," said he, "was supposed by the clergy to be a visitation from God and originates in man. Vaccine was produced by man and was therefore a daring and profane violation of the holy religion." Another opponent of vaccination added that "since her daughter had been vaccinated with cow-pox that she coughed like a cow and grew hair over her whole body." Another said vaccination was discontinued in a certain part of the country as all vaccinated men bellowed like bulls. Simpson reasoned that the objectors to chloroform were analogous to the vaccination opponents.

Simpson completed his paper with a piece of almost irrefutable logic, and certainly one of his most amazing. Said he, "Those who urge, on a kind of religious ground, that an artificial or anaesthetic state of unconsciousness should not be induced merely to save frail humanity from misery and tortures of bodily pain, these individuals forget that we have the greatest of all examples set before us outlining this very principle of practice. I allude to that most singular description of the preliminaries and details of the first surgical operation ever performed on man which is contained in Gen. 11:21, 'and the Lord God caused a deep sleep to fall upon Adam, and he slept: and he took one of his ribs and closed up the flesh instead thereof!' In this remarkable verse the whole process of a surgical operation is briefly detailed. But the passage is principally striking as affording evidence of our Creator himself using means to save poor human nature from unnecessary endurance of physical pain."

Simpson carried the weight in his arguments and silenced the religious objectors and he then turned to lay low his medical opponents with equally masterful rhetoric. The tone of derision, which he had carefully excluded from his papers on religious objections, he let loose with fury on his medical objectors.

Simpson felt that their main resentment was due to the fact he was attempting to change the order of the things established. His principal opponent was Dr. Meigs of Philadelphia. Dr. Meigs insisted that the pain was physiological and therefore essentially to be endured. "The pain of childbirth," said he, "was a desirable, salutary and conservative manifestation of the force of life."

Simpson submitted that the same argument would certainly be applicable to the first use of the carriage as a means of locomotion; if the traveller's feet blistered as he walked, it would have to be endured as the will or wish of the Diety. He must, therefore, forego the practical impulse to seek a ride as a means of alleviating the dolorous pedal extremities. He stated that most of such travellers would not endure the logic of such a medical advisor, but would seek vehicular locomotion in good time. He argued that the parturient, having travelled along the way a great distance, was entitled to the extra artificial lift at the end of the fatiguing journey.

Simpson published a paper two years after his first notes on chloroform in childbirth. In it he was able to report its use on 50,000 cases in labour

and upon those undergoing surgery. Simpson had established this advance toward the alleviation of pain and suffering. The greatest influence on all opposition, and there was plenty of opposition, was in 1853, when the world was astounded to hear that Queen Victoria accepted chloroform in the birth of her seventh son, Prince Leopold. Thereafter most formal opposition ceased.

Simpson was eventually knighted. Sir Walter Scott proposed a coat of arms for Simpson consisting of a "wee naked bairn" and the motto (chloroform in mind), "Does your mother know you are out?"

It is with pride that we may state that all the fortitude and vision did not stay in the British Isles with the exodus of tens of thousands of its people to the new world—in this reference—Nova Scotia.

Mark you, Simpson's first rebuttal to his opposition was in 1847. Queen Victoria took chloroform in 1853. In 1848, in the small town of Pictou, Nova Scotia, the gentleman J. D. B. Fraser, apothecary, pioneered the production and the use of chloroform in Canada. In his old family bible there is this entry, "Robert Peter Fraser, born March 22, 1848. At the birth of this, my 7th child, chloroform was first used in Canada during childbirth."

Thus it is recorded that only a few months after the first known instance in the world of chloroform being used at childbirth, the little known gentleman in that small pioneer town was making and using a substance which was to quickly become a boon to mankind, unparalleled up to that time.

NOTICE

The annual meeting of The Medical Society of Nova Scotia will be held at Keltic Lodge on September 13th, 14th, 15th and 16th. On the 13th there will be a meeting of the executive at 2.30 in the afternoon. The general meeting including the scientific programme will be held on the 14th, 15th and the morning of the 16th. As accommodation is limited, members are advised to secure accommodation early through the president, Dr. Eric W. Macdonald of Reserve. Kindly note that these dates are different from those published in the March issue.

H. G. GRANT, Secretary

Spina Bifida with Meningocele and Associated Pilonidal Sinus

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Case Report

SPINA bifida is a congenital defect in the neural arches of certain vertebrae. It is caused by failure of the neural groove to close, and the mesoblast to grow in to form the neural arch. Both the laminae and spinous processes are usually absent, and several adjoining vertebrae affected. The meninges and cord protrude through the defect. In some instances the protrusion is covered with skin, but in one variety, spina bifida with myelocele, the raw cord is exposed to the surface without any covering at all.

Spina bifida is relatively common, about 1 in 1,000 births, and four varieties are usually described:

- (1) Spina bifida with meningocele. A protrusion of the meninges containing spinal fluid.
- (2) Spina bifida with meningo myelocele. Here the protrusion contains meninges, spinal fluid and spinal cord or nerves of the cauda equina.
- (3) Spina bifida with syringomyelocele. The protrusion contains meninges, spinal cord, and most of the cerebrospinal fluid.
- (4) Spina bifida with myelocele. Here the cord is exposed to the surface without any covering at all.

Trophic and paralytic phenomena such as ulcers, paralysis of the legs, and of the bladder and anal sphincters and other congenital defects such as hair lip, talipes, displaced hips, pilonidal sinus, etc., are frequently associated with spina bifida. The following case is presented:

Baby C, aged one week, was admitted to hospital, December 27, 1947, with a preliminary diagnosis of spina bifida with meningocele. The child was well nourished. Weight, 8 pounds 4 ozs. Temperature, pulse, respiration, and urine analysis normal. There was a pedunculated swelling, about 6 cm. in diam. in the midline of the back in the lumbosacral region. The swelling was covered with healthy skin, was translucent, and when gently compressed caused slight bulging of the anterior fontanelle. X-ray examination showed the absence of neural arches and spinous processes in vertebrae L2, L3, L4. There were no sensory or trophic disturbances. The reflexes were normal; bladder, and rectal control normal. There was an associated, but unrelated, pilonidal sinus over the lower end of the sacrum.

The child was operated upon January 27, 1948. Preoperative medication—Morphine, gr. 1/480 with Scopolamine, gr. 1/600. Ether anesthesia was used. It was operated upon in the prone, head down position. An elliptical incision was made over the body of the protrusion, and the lower end of the incision prolonged so as to include the pilonidal sinus. The skin above the incision was dissected off the sac. The pilonidal sinus was then excised. The skin below the incision was freed from the sac, until the neck of the sac was completely exposed, and the defect in the neural arches demonstrated. The sac was emptied of spinal fluid and the inside of the sac inspected. The opening

of the sac was then closed with No. 0 plain catgut suture. A tent was prepared for the sac by dissecting and reflecting the deep fascia off the lumbar muscles. The sac was plicated, and buried under the deep fascia which was fixed over the sac with interrupted silk sutures. Reinforcing sutures were placed in the subcutaneous tissues, and the skin was closed with interrupted silk sutures.

Postoperatively the child was kept in the prone position, with the head down, to prevent loss of cerebro spinal fluid and to reduce pressure on the sac. Fluids were restricted and prophylactic injections of penicillin given. The skin sutures were removed on the 9th postoperative day. The child was discharged from the hospital February 15, 1948. The wound was healed, and there was no evidence of any protrusion, or bulging of the anterior fontanelle.

Comments

- (1) Operative treatment should be undertaken in properly selected cases of meningocele and meningomyelocele, but is useless in cases of myelocele and syringomyelocele.
- (2) Prophylactic administration of penicillin considerably reduces the danger of postoperative meningitis.
- (3) Preservation of the sac, emptied of its contents, and buried under fascia, is thought to be a distinct advantage over amputation inasmuch as the sac continues to absorb spinal fluid, and lessens the likelihood of hydrocephalus occurring later on.

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* Mesodermal Mixed Tumor of The Vagina: Report of Case

GEORGE H. MURPHY, JR., M.D.

Fellow in Pathology, Mayo Foundation,

and

JAMES W. DUSHANE, M.D.

Section on Paediatrics

THE following report is of the first case of a mesodermal mixed tumor of the vagina to be diagnosed at this Clinic.

Report of Case

A white child thirty-three months of age was admitted to the Clinic on November 6, 1946. About November, 1945, the parents had noted a little blood around the vulva and examination by their family physician had revealed a tumor of the vagina. This was excised in March, 1946, and diagnosed histologically as a "botryoid sarcoma (rhabdomyoma) of the vagina." The operative site was given radium and roentgen therapy and the child was well for several months. Then more vaginal bleeding was noted and more roentgen therapy was given. On admission to the Clinic the patient presented no apparent signs of distress but the parents said she held back urine as long as possible. Examination revealed a soft mass in the vagina. At operation on November 8, 1946, a soft polypoid tumor mass was found filling the vagina. Frozen sections showed evidence of a high-grade malignant process and, since the tumor was infiltrating the vaginal wall, a local removal only was performed. The tumor was found to originate on the right anterior vaginal wall over an area of about 5 by 2 cm. The child was discharged from the hospital in good condition, but the parents were told that the prognosis was extremely grave.

Pathological findings:—The tumor, in pieces, weighed 24 gm., forming an aggregate mass about 6 by 4 by 2.5 cm. It had the appearance of a group of fused polyps, the classical "botryoid" morphology. The surface was smooth and gray-white and the cut surface homogeneous and glistening. Histologically the tumor consisted mostly of a myxomatous-appearing network formed by star and spindle-shaped cells and their processes. More cellular areas showed plump spindle cells with prominent nuclei and nucleoli and with mitotic figures; interspersed were giant cells with bizarre, sometimes multiple nuclei, and scanty cytoplasm. Other similar areas contained irregular, round or elongated cells, many with longitudinal striations and some with well-defined cross striations—young striated muscle cells; scattered among these were embryonic myoblasts—large, often multi-nucleated cells with a relatively large amount of granular cytoplasm. No cartilage or bone was found, but some areas of the tumor contained a considerable amount of collagen. Adult type squamous epithelium covered the surface of the tumor. Staining for mucin gave a positive result in the myxomatous-appearing areas, and some extra-cellular and intracellular glycogen was noted.

*Reprint from the Proceedings of the Staff Meetings of the Mayo Clinic, January 7, 1948.

Mesodermal mixed tumors are found in the uterine body, the cervix and vagina. They are monodermic in origin, as opposed to the origin of teratomas which is tridermic, they develop from mesoderm and they consist of heterotopic and highly malignant tissues.

There are numerous confusing reports in the literature as to their nature and incidence. McFarland¹ listed 116 different names collected from the literature for mesodermal type tumors of the genital tract, among the best known being "botryoid sarcoma." Amolsch² found reports of 447 cases of mesodermal mixed tumors of the uterus, cervix and vagina, so diagnosed on the basis of the presence of embryonic myxomatous tissue. Lebowich and Ehrlich,³ and Ehrlich⁴ demanded the finding of embryonic myoblasts, and on this basis could find but fourteen mesodermal mixed tumors of the body of the uterus in the literature. With less exacting requirements, Glass and Goldsmith⁵ recorded ninety-four such tumors of the uterine body and cervix. The incidence of the vaginal group is even more uncertain. McFarland reported seventy-four, Bergström⁶ fifty-four. New cases have been reported infrequently over the last twenty years; we could find but seven in the literature,^{1,2,7-9} and none since 1939. The wide variation in all these figures is undoubtedly due to the differing criteria of diagnosis.

Most observers have favoured an origin from cell rests, that is, from pluripotent embryonal mesenchymal cells which have persisted in the genital tract and which are capable of producing the varied mesodermal tissues. Some, however, prefer a theory of metaplasia. Thus McDonald, Broders and Counsellor,¹⁰ in reporting two mesodermal mixed tumors of the uterine body in 1940, could trace the development of fibroblasts of the endometrial stroma into cartilage, and they considered these tumors to be true endometrial sarcomas.

Mesodermal mixed tumors have been found in the uterine body mostly in the menopausal and postmenopausal age groups, and in the cervix during the reproductive period. Those of the vagina have all been in very young females, the great majority of patients being less than three years of age.

The relative incidence in the three sites is rather difficult to ascertain. The ratio of those in the uterine body to those in the cervix has been variously reported as 1.6:1, 1:3 and 1:1.5. The number of vaginal tumors is uncertain, but they would seem to be the most common of the three.

The clinical picture is not at all characteristic, vaginal discharge and bleeding being the commonest signs.

Grossly, mesodermal mixed tumors of the uterus appear often as single or multiple polyps, while the cervical and vaginal tumors show the grape-cluster effect that led to the name "botryoid" sarcomas.

Histologically there is great variation in the findings; those of the vagina differ slightly in that neither bone nor cartilage has been found in them. All have agreed on the presence of myxomatous-appearing areas, probably embryonic mesenchymal tissue, and in addition there may be cartilage, smooth and striated muscle, bone, myoblasts and so forth. Glands, and even adenocarcinoma, have been reported in the uterine examples, but these would seem to be incidental inclusions of benign or malignant endometrial glands, but we agree with Morehead and Bowman¹¹ in the belief that it is unwise to exclude all but those containing myoblasts in view of the uniform clinical course.

The prognosis in all three types is bad, the over-all mortality rate having been given as 95 per cent, and but one five year and one ten year cure having been reported. The tumors have a marked tendency to recurrence, regardless of therapy, and death from local extension or general metastasis may be expected within six to twelve months.

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We Look But See Not

ERIC W. MACDONALD, M.D.

WE are inclined to think of physicians of the past as knowing very little by present day standards. However, although their knowledge was perhaps not as scientific as ours, they were accustomed to make good use of their senses while we are prone to neglect ours. The classical description of many diseases described in times past cannot be improved by to-day's teachers, thus testifying to the powers of observation of our predecessors.

Everyone appreciates the fact that snap diagnoses are likely to be wrong, but there is much to be gained by every diagnostician if he will only use his eyes—and, there is no better place to start than to gaze carefully at his patient's eyes. It has been said that eyes are the mirror of the soul. In any case they reflect the life, present and past of the individual. From the trust of infancy, the sparkling brilliancy of healthy youth, the careworn appearance of middle age to the apathy of old age, all is revealed for him that looks. While we all pride ourselves on our ability to size up human nature, again a snap diagnosis of character is apt to be at fault largely because we are hasty and our observations lack careful scrutiny.

From the moment the patient enters our office until he or she is ready to depart, we can learn a great deal if we use our senses. The eyes, facial expression, physical build, gait, manners and dress, yes, even the speech and language of the interview reveals much about the patient. "What we see depends mainly on what we look for."

Many conditions cannot be diagnosed by X-ray, electrocardiogram or other laboratory means. A careful history based on what we see, plus what the patient is able to tell us, when his thoughts are directed by one who has read the past and present, often makes a difficult diagnosis possible. Young doctors and students should be taught and trained to use their eyes as a diagnostic aid to a careful examination and history. One has only to attempt to describe an inflammatory swelling, a swollen joint, or a limb the site of a fracture to realize that we do not make as much use of our powers of observation as we should. History taking is an art, it is said, but unless one is going to take the patient's symptoms as all that counts he must be on guard for anything that will point the road towards which investigation must be directed.

Students are taught the major surgical and medical problems to the neglect of the so-called minor conditions. Teachers, who are generally specialists, forget that the bulk of a young doctor's patients consult him for minor ills. Many every day conditions are diagnosed by the experienced on sight and rightly so. More teaching should be directed to consideration of the every day conditions which account for about 85% of all office and house calls. Physical examination as a rule is stressed and rightly so, but the use of the ophthalmoscope, the auroscope, transillumination light, the laryngeal mirror, the sigmoidoscope and anoscope as well as the use of the gloved finger for rectal examination do not receive the repeated attention they require to make the young physician use them in practice. It is surprising how often some fail to make a pelvic examination or use a vaginal speculum even when the history indicates the need.

To be a good observer demands constant practice and there is no better training than to place on paper our findings as only by so doing will we find how far short we are of perfection. Let us look, see, think and then write our observations.



Doctor Annie Maxwell Fulton, 1848-1889

The first Nova Scotian lady to receive a medical degree.

Dr. Annie Maxwell was born on Mount Thom, Pictou County, on May 4, 1848, the daughter of Duncan Maxwell and Nancy Fraser. After attending Normal School in Truro she taught school in several districts in her native province. She then entered the Women's Medical College in Philadelphia where she received her medical degree. She practised her profession in Detroit, Upsilon and Lake City, Michigan. She died at Lake City on the fourth of August, 1889, aged forty-one years. She married Samuel Fulton and had two children. Her son, Archibald Maxwell Fulton became a dentist and practised his profession in Walla Walla, Washington. Her daughter married and was living until her death in California. A brother, Dr. Archibald Maxwell practised medicine in Bear River until his death in 1882. She has many relatives living in Nova Scotia. Mrs. C. L. Moore of Pictou is a niece. Her grandmother was a sister of my great-great-grandfather and I am proud to have her name in my family tree.

K. A. MacKenzie, M.D.

Correspondence

Canadian Medical Association

Veterans' Affairs Building
Bute and Haro Streets
Vancouver, B. C.
February 21, 1948

Dr. H. G. Grant
Secretary, Nova Scotia Medical Association
Dalhousie Public Health Clinic
Morris Street
Halifax, N. S.

Dear Dr. Grant:

I am writing to you in connection with the work of the Committee on General Practitioners of the Canadian Medical Association of which I am the Chairman.

I have recently had an opportunity of discussing General Practitioner matters with medical groups throughout the west at the time I made a trip through in connection with my D.V.A. work. Everywhere I found a very considerable amount of interest. I enclose a copy of some hastily thrown together notes that I made in this connection. We are most anxious that General Practitioners of Canada should be thinking about these matters and that all those who plan to be at the Canadian Medical Association Meeting in June next in Toronto will attend the meeting of General Practitioners to be held at 5.00 p.m. on the Wednesday of the Annual Meeting.

We are also most anxious that all the General Practitioners who are not going to Toronto should sit down and let us know what their views are so that when we finish up in Toronto we shall have a very good idea as to along what lines the General Practitioners are thinking. My Committee will do nothing in the way of any recommendations to the Executive except along the lines of what the General Practitioners want, and we must find out what they do want, if anything.

I am wondering if you would be so good, if at all possible, to put a notice in your NOVA SCOTIA MEDICAL BULLETIN using the enclosed notes in whatever way you see fit, but giving notice of the meeting in Toronto, giving notice of our desire to hear from those who are not going to be present and asking that group to write to me personally, care of the Veterans' Affairs Building, 1231 Haro Street, Vancouver, B. C.

I hope you are going to Toronto and that I shall have the opportunity of seeing you there. I may say that it appears in general that the General Practitioners will want a section of General Practitioners within the Canadian Medical Association. They have already formed a group in Manitoba and I think will apply to become a section of that division, and I understand similar action is being taken at the next Annual Meeting of the Ontario Medical Association

With very best wishes,

Yours sincerely

(Sgd.) Wallace Wilson, M.D.
Chairman, Committee on General Practitioners

For the interest of all General Practitioners, herewith is a brief discussion of some of the problems which to-day confront the General Practitioner. The Canadian Medical Association has been concerned about these problems for some time and as a result of many discussions, the Executive, at its last meeting, appointed a committee to be known as the General Practitioners' Committee and charged it with the responsibility of studying and reporting back on ways and means of helping the General Practitioner in his work, and of improving his status, both within and without the Association.

What does this Committee propose to study, and what sort of a report does it intend to take back to the Executive? Let us make a short list.

1. *The Establishment of a General Practitioners' Section Within the Canadian Medical Association.*

As you all know very well, the Scientific Programme of the Annual Meetings of our Association is divided into sections—medicine, surgery, obstetrics, et cetera, and while it is true that the programme is designed primarily for General Practitioners, nevertheless, the papers are nearly all given by specialists. Should there be, specifically, a General Practitioners' Section? A section of which the Chairman and Secretary are General Practitioners? A section where the Scientific Programme is drawn up by General Practitioners and given largely by General Practitioners with specialists appearing on the programme only by invitation of that Section? Should the Section also hold a business session at the time of the Annual Meeting at which would be discussed problems peculiar to present day general practice and from which meeting might come resolutions to be sent forward for consideration to the Executive and Council of the Association?

The Committee asks all General Practitioners to think over this question of this Section because it proposes to call a meeting of General Practitioners on the Wednesday of the 1948 Annual Meeting of the Association in Toronto in June next, and there get your views.

The Committee, in its recommendations to the Executive, will be guided entirely by the wishes of the General Practitioner members of the Association, so, if you are planning to go to the Toronto Convention, be sure to be present at the meeting to be held at 5.00 p.m. on the Wednesday and there let us hear what you think. If you are not going to be there, please write to me here in Vancouver and let me have your views. The Committee is anxious to obtain a strong body of opinion, either for or against the Section, from all parts of Canada, and to that end will send a notice of the meeting to the Journal and also invite correspondence.

Personally, I think General Practitioners would be well advised to have such a section. They should not only be taking a much larger part in the Scientific Programme, but they should also be more active in the administrative and business affairs of the Association. More of you should be on the Executive, in Council and have greater representation on the various committees. After all, General Practitioners constitute the majority of the Canadian Medical Association membership and the Canadian Medical Association is the only organized scientific body that really does represent you across Canada. In a special way, it is your own Association, and you should be taking a far larger part in all its affairs than you are.

2. *The Certification of General Practitioners.*

These days much is being done for the specialist. Most of our medical schools and teaching hospitals are carrying out very special programmes that make it possible and comparatively easy for picked students to engage in planned post-graduate training leading towards specialization. When this training is completed and these students have successfully passed certain examinations, the Royal College stands ready, either to admit to fellowship or certify and the specialist is launched.

Out in practice, the specialist may, in addition to membership in the Canadian Medical Association, join the national body representing his own specialty. And so, whether we like it or not, specialists are becoming more and more organized within their own groups and more and more their hall mark in Canada will be fellowship in or certification by our Royal College. Further, I look to the time in the not-too-distant future when certification qualifications and examinations will be done away with and then when a man successfully meets one standard of education and one set of examinations, he will be both admitted to fellowship and certified.

And that all brings us to another of the problems confronting the man in general practice to-day. Gone are the days when, after some years in practice, he can go away, concentrate his studies for a year or two on a particular branch of medicine and then return home or moving to a city, set up as a specialist. From now on, as a general rule, it will be, once a General Practitioner, always a General Practitioner; only rarely will it happen that after some years in practice a man will be able to take the time and money to qualify and prepare to sit for fellowship or certification examinations.

Now if General Practitioners are going to remain General Practitioners, is there any way of recognizing the good ones—those who are doing first-rate work and keeping abreast of modern medicine? This question has been raised by some of you yourselves, and the answer would possibly appear to be also in certification. Certification of a first-class or Grade A General Practitioner would require the setting up of certain standards such as (a) five or ten years in practice; (b) during that time the publishing of the results of at least two or more pieces of clinical research work carried out while in practice; (c) the attendance of a certain number of refresher courses such as the ones you are attending now, and finally (d) the passing of an examination which might be oral and written, and might or might not be conducted entirely by General Practitioners. Which would be the responsible body to undertake the setting up and the maintenance of the standards, the condition of the examinations and the certification? It would appear on first consideration that the Canadian Medical Association would be the logical body. It does represent the General Practitioners, and there is somewhat of a precedent in that it already certifies hospitals for junior rotating internships.

This whole question of certification is again something in which no action will be taken except at your own express wish. So again, think it over; if you are going to Toronto, be prepared to speak to it and if not, write me your views.

3. *Clinical Research by General Practitioners.*

In general practice, there are limitless opportunities for doing first-rate clinical research. Studies in environmental influence on disease, the earliest

beginnings of many of the chronic diseases, the course and end results of others, nutrition, the results of preventive measures, et cetera—the list is endless. The undertaking of a bit of clinical research in your practice means carrying it on as a rule for a matter of years. The work is done and the records are kept as the cases come along, and with each case it means just a little more work and just a little more care.

Do General Practitioners want to engage in clinical research? Again, it is for you to tell us. We do not expect the older men to be interested; we do hope the younger men will be keen.

What the Committee hopes will develop is something along the following lines:

- (a) That there will be available for the Committee sufficient annual sums of money from sources outside the Association.
- (b) That with this money, they will be able to set up awards to be given annually for the best piece or pieces of clinical research carried out by general men in their practices.
- (c) The Committee, with expert advice, to be prepared to advise on request as to:
 - I. Suitable types of clinical research to be undertaken.
 - II. Methods of carrying on the work, e.g., records, questionnaires, et cetera.
 - III. Literature to be consulted and where it can be obtained on loan from libraries.
 - IV. The Committee to make all arrangements for the annual judging of the papers sent in to make all awards.

If you approve of a programme along some such lines, and we obtain the funds, it is hoped that as part of the overall programme, the medical schools will co-operate and in the final year give to undergraduates some instruction in principles and methods of conducting clinical research in General Practice.

Once again, this is a proposal that I hope you would approve in principle. I am convinced that a man who starts practice imbued with the idea of carrying out clinical research and who sticks with that line, will find his professional life much richer; he will practise better medicine and he will make definite contributions to medical knowledge.

POSITIONS VACANT

The Dartmouth Medical Centre, 180 Portland Street, Dartmouth, Nova Scotia, invite applications for the following positions: (1) Eye, Ear, Nose and Throat Specialist. (2) General Practitioner. To work in association with established group.

Personal Interest Notes

DOCTOR E. L. EAGLES, Divisional Health Officer, Western Division Nova Scotia Department of Public Health, spoke before the Kiwanis Club of Yarmouth at their weekly luncheon early in March. His chief topic was the control of communicable diseases, and he referred particularly to the high incidence of tuberculosis in the western section of Nova Scotia. In the matter of case finding he spoke of the free diagnostic service provided by the Provincial Health Department through his office and especially the new portable X-ray machine which will be able to take small films at the rate of three hundred an hour. He told the Club that this mobile unit would be available for the district. Doctor Eagles also mentioned briefly the control of the venereal diseases, diphtheria, small-pox, and whooping cough, and he emphasized the need for improved sanitation throughout the district.

Doctors Travel by Air as Roads Blocked by Snow

It is a comparatively new thing for the doctors of Nova Scotia to use the plane in visiting their patients. The *Morning Chronicle* of March 12th carried an item telling that Doctor Dunn of Pictou had arranged to have a patient brought from Pictou Island for treatment at the Sutherland Memorial Hospital; and that Doctor Sproull of New Glasgow had flown to Gairloch and the Garden of Eden in Pictou County to visit sick children. Also that a mother with a nine-day-old baby and two other children living near Hope-well and some distance from neighbours, isolated by snow storms, had received medicine and supplies when a plane landed without difficulty on skis.

Doctor E. Pearl Hopgood, assistant superintendent of the Nova Scotia Hospital, and a native of Malpeque, P. E. I., has been appointed Lady Provincial Superintendent of the Order of St. John in Nova Scotia. During the war years Doctor Hopgood was associated with the St. John Ambulance Brigade as a divisional surgeon in the Dartmouth area. Her new appointment places her in charge of all the Brigade's volunteer nursing personnel in Nova Scotia.

Doctor Hopgood was one of the first women doctors in North America to become an executive of an institution for the care and treatment of psychiatric cases. She graduated from the Dalhousie Medical School in 1920, and has been on the staff of the Nova Scotia Hospital ever since.

The BULLETIN extends congratulations to Doctor and Mrs. A. B. Crosby of Halifax on the birth of a son, Charles Adrian Evans Crosby on March 15th; to Doctor and Mrs. W. I. Bent of Bridgewater on the birth of a son Frank Gregory, on March 19th; and to Doctor and Mrs. H. R. Roby of Oxford (Irene Lowe) on the birth of a daughter, Helen Irene, on March 30th.

Doctor Claude M. Laughton, who graduated from the Dalhousie Medical School on September 1, 1943, and who has been practising in Shediac, N. B., since his discharge from the Army, has been appointed to the staff of the Children's Memorial Hospital in Montreal and will take up his duties this summer.

Country Doctor Honoured for Fifty Years Service

In recognition of this fifty years of active practice as a country doctor the members of the Medical Board of Soldiers' Memorial Hospital at Middleton tendered Doctor L. R. Morse of Lawrencetown a dinner at the American House just before Easter. The dinner was attended by members of the medical profession from Annapolis Royal, Bridgetown, Lawrencetown and Middleton. Doctor H. E. Kelley, President of the Board, presided over the dinner and programme. A fitting gift was presented to Doctor Morse on behalf of his fellow practitioners by Doctor L. B. W. Braine of Annapolis Royal. A large basket of roses was presented from the nursing staff of the Soldiers' Memorial Hospital. Doctor Morse has practised the entire half century at Lawrencetown with the exception of his army service during the First World War. His services to the community and district has been outstanding while his contribution to Soldiers' Memorial Hospital have been mainly directed toward the establishment of a modern X-ray department.

Will Train at Halifax Hospital

The appointment of several residents for 1948, 1949 and 1950 to do graduate training in the specialties of general surgery, general medicine, obstetrics and gynaecology at the Victoria General Hospital were announced in February by Doctor C. M. Bethune, Superintendent. These appointments have been approved by the Board of Commissioners.

Surgery

Doctor R. Gordon MacKenzie, a native of Truro, who received his B.A. from Acadia in 1939 and his M.D., C.M., from Dalhousie on September 1, 1943.

Doctor J. Sidney Wright, a native of Bedeque, P. E. I., who received his B.Sc. from Dalhousie in 1940, and his M.D., C.M., on September 1, 1943.

Dr. Walter J. O'Donnell, a native of Bathurst, N. B., who received his M.D., C.M. from Dalhousie in May, 1945.

Medicine

Dr. Gordon M. Murray, a native of Sydney, who received his M.D., C.M. from Dalhousie in May, 1944.

Doctor John B. Downing, a native of Summerside, P. E. I., who received his M.D., C.M. from Dalhousie on September 1, 1943.

Obstetrics and Gynaecology

Dr. N. Kenneth MacLennan, a native of New Glasgow, who will receive his M.D., C.M. from Dalhousie in May of this year.

Major General R. M. Luton Honoured

In recognition of "exceptionally meritorious service" as director of medical services with the Canadian Military Headquarters in the United Kingdom during the Second World War, Major General Robert Marsden Luton, C.B.E., was awarded the Legion of Merit, Degree of Commander, at an investiture

at the home of American Consul General A. W. Klieforth the evening of April second. The award was made for "extraordinary fidelity and exceptionally meritorious conduct in the performance of outstanding service."

Federal, provincial and civic officials as well as representatives of the various consulates in the city attended the ceremony, which was held at Mr. Klieforth's residence at 22 Franklyn Street in Halifax.

The citation, read by Consul General Klieforth, said that Major General Luton "effectively planned Canadian hospitalization for the Normandy invasion and supervised Canadian evacuation of casualties after V-E Day." Major General Luton was director of medical services for Canadian Military Headquarters in the United Kingdom from December 7, 1941, to February of 1946.

The citation continued: "Canadian hospitals received patients from all forces in the United Kingdom and served as evacuation hospitals for wounded flown by air direct from Normandy." Major General Luton was "responsible for the evacuation of personnel on Canadian hospital ships, which during this period transported a large number of Americans to the United States. Major General Luton's high administrative ability and his devotion to duty reflect credit upon the medical profession and the military service."

There is a doctor needed for the districts of Isaac's Harbour and Goldboro in Guysborough County. Anyone interested will kindly communicate with Doctor J. J. MacRitchie, Department of Public Health, Provincial Building, Halifax, N. S.

The Halifax Tuberculosis Hospital offers an appointment as resident physician to become effective July 1, 1948. Salary and living provided. Applications should be addressed to C. J. W. Beckwith, M.D., Medical Superintendent.

Obituary

THE death occurred at her home, Ashland, Oregon, on April 6th, of Doctor Martha Wyman Shaw. Doctor Shaw was born in Yarmouth, N. S., in 1874, the daughter of the late Mr. and Mrs. W. V. Brown. After graduating from Dalhousie Medical School in 1897, she studied in Vienna, Austria, and London, England, with her husband, Doctor Howard Shaw, who predeceased her several years ago. She took up the practice of medicine at Ashland, Oregon, following her marriage.

Doctor Shaw is survived by her son, Marvin, and his family in Oregon, and three sisters, Mrs. B. T. Smith, Hantsport, Mrs. A. B. Wells, Boston and Mrs. W. H. Curry of Windsor.

The BULLETIN extends sympathy to Doctor Francis A. Dunsworth, at present at the Meninger Institute, Topeka, Kansas, on the death of his father, Mr. Edward T. Dunsworth of Halifax, which occurred on April 12th.