Vol. V. APRIL, 1929 No. 7

UNIVERSITY OF BRITISH COLUMBIA
The
APR 2 - 1929
Library

The Bulletin

of the

Vancouver Medical Association

Osler Lecture

Undulant Fever

Hospital Beds

Published monthly at Vancouver, B.C., by
McBEATH-CAMPBELL LIMITED
Price $1.50 per year

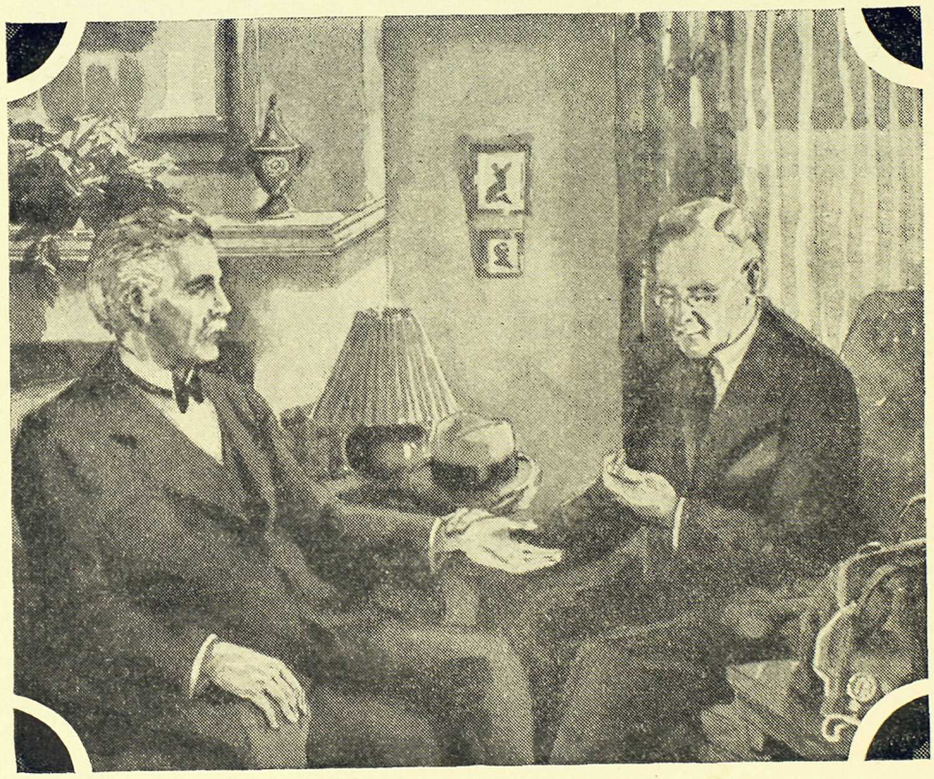
Patient Types:

THE ELDERLY PATIENT

It is often a task to keep an elderly patient in active service. Constipation may be the borderline between invalidism and good health. Cathartics are particularly harmful in such a case but Petrolagar and "Habit Time" will help the senile bowel to normal function.

Petrolagar is composed of 65% (by volume) mineral oil with the indigestible emulsifying agent, agar-agar.

Petrolagar



Deshell Laboratories of Canada
Limited

245 Carlaw Ave. Dept. V.M.
TORONTO, ONTARIO

DESHELL LABORATORIES OF CANADA, LTD., DEPT. V.M.,
245 Carlaw Ave.,
Toronto, Ontario.

Gentlemen: Please send me copy of the new brochure "Habit Time" (of bowel movement) and specimens of Petrolagar.

Dr. .....

Address .....

.....

THE VANCOUVER MEDICAL ASSOCIATION

BULLETIN

Published Monthly under the Auspices of the Vancouver Medical Association in the Interests of the Medical Profession.

Offices:

529-30-31 Birks Building, 718 Granville St., Vancouver, B.C.

Editorial Board:

DR. J. M. PEARSON

DR. J. H. MACDERMOT DR. D. E. H. CLEVELAND

All communications to be addressed to the Editor at the above address.

Vol. V. APRIL, 1929 No. 7

OFFICERS, 1928 - 29

DR. T. H. LENNIE
Vice-President

DR. W. S. TURNBULL
President

DR. A. B. SCHINBEIN
Past President

DR. G. F. STRONG
Secretary

DR. J. W. ARBUCKLE
Treasurer

Additional members of Executive:—DR. A. C. FROST AND DR. F. N. ROBERTSON

TRUSTEES

DR. W. F. COY DR. W. B. BURNETT DR. J. M. PEARSON

Auditors: MESSRS. PRICE, WATERHOUSE & CO.

SECTIONS

Clinical Section

DR. L. H. APPLEBY ..... Chairman
DR. J. R. DAVIES ..... Secretary

Physiological and Pathological Section

DR. C. E. BROWN ..... Chairman
DR. R. E. COLEMAN ..... Secretary

Eye, Ear, Nose and Throat

DR. W. E. AINLEY ..... Chairman
DR. F. W. BRYDONE-JACK ..... Secretary

Physiotherapy Section

DR. H. R. ROSS ..... Chairman
DR. J. W. WELCH ..... Secretary

Pediatric Section

DR. E. D. CARDER ..... Chairman
DR. G. A. LAMONT ..... Secretary

STANDING COMMITTEES

Library

DR. D. F. BUSTEED
DR. C. H. BASTIN
DR. W. A. BAGNALL
DR. LYALL HODGINS
DR. S. PAULIN
DR. W. A. WILSON

Dinner

DR. E. M. BLAIR
DR. L. LEESON
DR. H. H. PITTS

Rep. to B. C. Med. Assn.

DR. STANLEY PAULIN

Orchestra

DR. A. M. WARNER
DR. W. L. PEDLOW
DR. J. A. SMITH
DR. L. MACMILLAN

Publications

DR. J. M. PEARSON
DR. J. H. MCDERMOT
DR. D. E. H. CLEVELAND

Credentials

DR. J. T. WALL
DR. D. D. FREEZE
DR. W. A. DOBSON

Summer School

DR. B. D. GILLIES
DR. L. H. APPLEBY
DR. W. T. EWING
DR. J. CHRISTIE
DR. W. L. GRAHAM
DR. R. P. KINSMAN

Hospitals

DR. F. BRODIE
DR. A. S. MONRO
DR. F. P. PATTERSON
DR. H. A. SPOHN

Sickness and Benevolent Fund — The President — The Trustees

VANCOUVER MEDICAL ASSOCIATION

Founded 1898 Incorporated 1906

PROGRAMME OF THE 31ST ANNUAL SESSION

GENERAL MEETINGS will be held on the first Tuesday and CLINICAL MEETINGS on the third Tuesday of the month at 8 p.m. from October to April inclusive. Place of meeting will appear on the Agenda.

April 2nd—General Meeting.
Paper—Dr. F. P. Patterson: Subject to be announced.

April 16th—Clinical Meeting.

April 23rd—Annual Meeting.

VANCOUVER HEALTH DEPARTMENT

STATISTICS, FEBRUARY, 1929

Total Population (Estimated)	228,193
Asiatic Population (Estimated)	12,300

		Rate per 1,000 of Population
Total Deaths	177	10.11
Asiatic Deaths	24	25.36
Deaths—Residents only	150	8.57
TOTAL BIRTHS	391	22.34
Male 194		
Female 197		
INFANTILE MORTALITY—		
Deaths under one year of age	7	
Death rate per 1,000 Births	17.90	

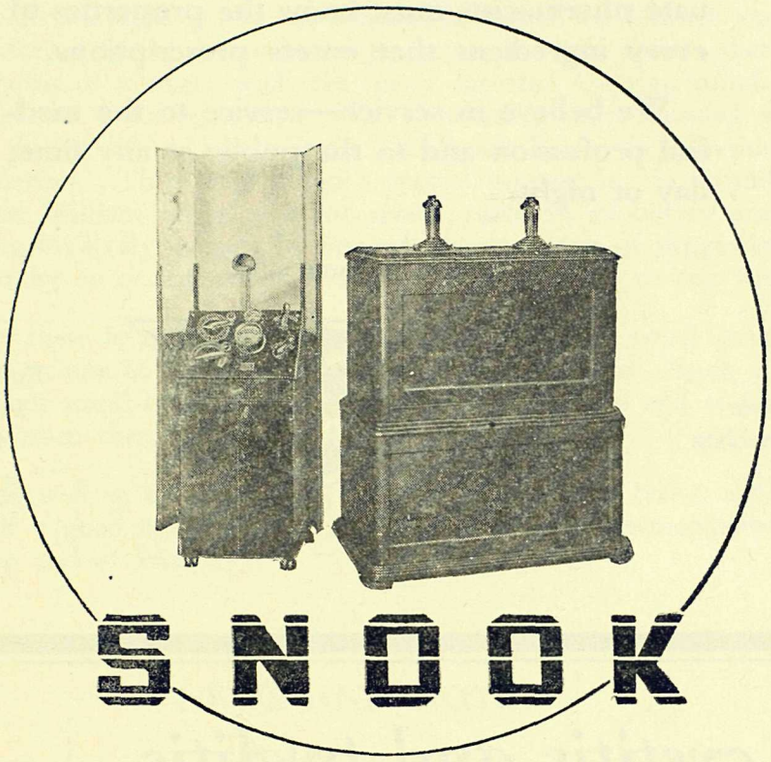
CASES OF INFECTIOUS DISEASES REPORTED IN CITY

Smallpox	79	0	55	0	37	0
Scarlet Fever	19	0	22	0	15	0
Diphtheria	80	4	62	0	15	2
Chicken-pox	94	0	45	0	45	0
Measles	6	0	19	0	51	0
Mumps	116	0	138	0	239	0
Whooping-cough	3	0	1	0	4	0
Tuberculosis	15	16	11	16	7	—
Erysipelas	11	1	9	0	9	1
Poliomyelitis	0	0	0	0	0	0
Typhoid Fever	0	0	0	0	2	1
Cerebral-Spinal Meningitis	1	1	2	1	0	0

N.B.—Typhoid cases from outside City.

40% *More Snooks Installed in* 1928

THE increasing requirements in an X-ray machine due to the newer technics in more recent years, have served to bring about a greater appreciation of the Snook. While the number installed during 1927 far exceeded the records of previous years, the year 1928 saw the 1927 Snook record exceeded by 40%.



Was this because of low price? No, for there are any number of machines offered in competition at considerably lower prices, and claiming to do the same class of work. Proof thru actual performance and the visualization of end results, plus the enthusiastic endorsement of an army of satisfied Snook users the world over, are the concrete reasons for this increasing popularity.

There is only one Snook—it is distinguished from others by the double cross arm type of rectification, as originally designed by Mr. Snook in 1906. While the present-day Snook machine offers certain definite refinements over the original, such as added convenience of operation, improved control system, greater capacity and more artistic design of cabinet, the original principles remain unchanged. Thus it has adapted itself to the advances in X-ray technic through the years and is equal to the most critical requirements of the present.

All of which is eloquent proof that the fundamental principles are right.

Victor X-Ray Corporation of Canada, Ltd.

Manufacturers of the Coolidge Tube and complete line of X-Ray Apparatus VICTOR *Physical Therapy Apparatus, Electrocardiographs, and other Specialties*

524 Medical Arts Building, Montreal
Motor Transportation Bldg., Vancouver

2 College Street, Toronto
Medical Arts Bldg., Winnipeg

A GENERAL ELECTRIC ORGANIZATION

Credo

We believe in quality—all pharmaceutical preparations must be chemically pure.

We believe in knowledge—our nine graduate pharmacists must know the properties of every ingredient that enters prescriptions.

We believe in service—service to the medical profession and to the public at any time, day or night.

Phone Seymour 1050

Nine Graduate Pharmacists

Georgia Pharmacy Ltd.

Granville at Georgia

For 21 Years Prescription Specialists

in cystitis and pyelitis

TRADE **PYRIDIUM** MARK

Phenyl-azo-alpha-alpha-diamino-pyridine hydrochloride

(*Manufactured by The Pyridium Corp.*)

For oral administration in the specific treatment of genito-urinary and gynecological affections.

Sole distributors in Canada

MERCK & CO. Limited Montreal

412 St. Sulpice St.

EDITOR'S PAGE

We publish in this issue of the Bulletin the annual Osler Lecture of the Vancouver Medical Association. The lecturer this year was Dr. H. M. Cunningham and the subject the peculiarly appropriate one of "Ourselves"—not "as ithers see us" but as we hope we are.

The title is one which would have been dear to the heart of Osler and in the matter and method of Dr. Cunningham, he would have delighted as an example of the dissertation in which he himself excelled. If the choice of future lecturers ranges never so wide, always there will be some point of contact with the many facetted Oslerian mind, so it touch Medicine even remotely. The Lectureship was founded several years ago shortly after Osler's death, Dr. Brodie being then President of the Association. This Society had a special interest in the foundation, in that Sir William Osler was for many years an Honorary member, manifesting his lively interest by not infrequent letters of suggestion and advice and by an occasional more material contribution to our funds.

What these letter and contributions meant to the small struggling Society only those of our older members can fully realize. Such a broad catholicity of mind had this busy professor at Baltimore and at Oxford. No Chauvinism there.

We do well in these annual events to ponder such traits, such best portions of a good man's life. His little, nameless, unremembered acts of kindness and of love.

* * *

NEWS AND NOTES

We are glad to learn that Dr. F. C. Bell is convalescing from his recent operation.

* * *

Dr. G. E. and Mrs. Gillies have left for a trip to Europe. They expect to be away for about six months.

* * *

Dr. J. C. Farish has returned from a holiday in Honolulu.

* * *

The "School of Seven"—not to be confused with another group of artists of the same title in Eastern Canada—spent a profitable week end in Victoria recently. The Western group are not pre-eminently colourists, their best work being rather manifestly confined to the greens.

* * *

Lt.-Col. A. S. Monro has recently been honoured in his election to the presidency of the Medical Officers Association.

* * *

It is understood that the new Maternity wing of the Vancouver General Hospital is at last open for the reception of patients. We wish we could report the same of the Private Ward wing.

UNDULANT FEVER IN BRITISH COLUMBIA.

By

H. W. Hill, M.B., D.P.H., L.M.C.C.; Director and Bacteriologist, Vancouver General Hospital Laboratories; Professor of Bacteriology; and of Nursing and Health, The University of British Columbia.

Synonyms—Undulant fever—Malta fever—Mediterranean fever—Cyprus fever—Gibraltar fever, (all in human). (Allied diseases—Malta fever infection of goats; contagious abortion in cattle and hogs; tularemia in the human; tularemia in rabbits; perhaps deer fly fever, in animals and man).

Cause—Undulant fever in the human in North America is caused by a bacterium (*B. abortus*) which appears to be identical with that which produces contagious abortion in hogs, (*B. abortus,* Bang, porcine); closely similar to that which produces contagious abortion in cattle (*B. abortus,* Bang, bovine); and at times indistinguishable from that (*Mic. melitensis*) which produces Malta fever in the human (itself derived from an infection of goats). A closely allied but probably not identical form of bacterium (*B. tularense*) produces tularemia in rabbits which is transmissible as a serious infection to man.

Sources of Infection—Undulant fever in the human in Europe, and sometimes in North America, would apear to be derived from goats infected with *Mic. melitensis;* but, in North America, more often from hogs infected with *B. abortus,* (Bang, porcine); sometimes from cattle infected with *B. abortus* (Bang, bovine); cattle may be infected at times with the porcine strain, and so transmit the porcine strain to man. (Clinical or epidemiological relationships between undulant fever in the human, and tularemia in the human, have not yet been worked out).

Vehicles of Infection—Undulant fever in the human would appear to be carried from animals in—the raw milk of goats affected by *Mic. melitensis;* discharges of the genito-urinary tract of affected cattle and hogs; the raw milk of affected cattle at times; and the feces of infected animals. Infection from human to human appears to be not as yet established, but is probable. "Typhoid precautions" are indicated.

Routes of Infection—Undulant fever in North America appears to be contracted by the human rarely through the use of raw infected milk of goats; sometimes through the use of raw infected milk of cattle; usually, through the handling of infected animals alive or dead, and especially of their genito-urinary discharges. (In tularemia, through the handling of infected rabbits, especially skinning same).

Portals of Entry—Undulant fever in the human would appear to be contracted (like most other infections) by way of the mouth, nose and eyes; the former certainly in the cases of infection from raw goats' milk or cows' milk; and probably, through the hands going to the mouth, in the cases of infection from handling discharges of animals. In human tularemia the initial infection has usually been from the carcases of rabbits, through cuts, etc., in the hands of persons skinning or other-

wise handling the carcases. It is possible that undulant fever may be contracted through cuts, etc., in the hands of those handling infected animals.

INCIDENCE—Undulant fever in the human in North America has been found so far, chiefly in adults, and more in men than in women. Children, although drinking more milk, have relatively escaped. The higher incidence in men over women would appear to be occupational and related to more intimate contact with the infected animals on the part of the former.

MORBIDITY—While found in numbers approximately that of typhoid fever in Iowa, Ontario has reported to date only 14 cases; British Columbia 2.

MORTALITY—Deaths are rare, perhaps 1 or 2% of cases. These studies are so incomplete, and the cases and deaths found bear so little proportion to the (probable) numbers of each existing, that none of these figures can be considered final. Undulant fever may easily exist in considerable amount in the human without identification, in the absence of agglutination tests.

INFECTED WELL PERSONS—Judging from the results of our agglutination tests in the human, British Columbia has so far yielded more well persons showing agglutination than sick. We have two positive sick persons on our records, and five positive well persons. Of the latter, three were intimately associated with infected cattle over long periods, one with (infected?) goats; of one, nothing definite was learned. On the other hand, over 40 tests on various persons sick and well, were negative. The positive reactions were obtained in dilutions of the general order of 1 in 160.

IMMUNITY—While well worked out in cattle, immunity following infection in the human is as yet nebulous, but probably at least as good as immunity following typhoid.

COURSE OF THE DISEASE—Undulant fever in the human is held to show in incubation period of about two weeks, i.e. from infection to first symptoms. The evidence is not extensive however. In *mild* cases, two weeks of fever ranging 101°—104° F. may terminate in recovery; such cases may be ambulatory; and difficult to distinguish clinically from "flu." In *typical* cases, two weeks of fever is followed by an interval of two days up to two weeks of intermission and the attack recurs. This may continue for four months. In *severe* cases, fortunately rare, a stormy attack with high fever, delirium, stupor, may terminate rapidly in death.

ONSET AND PRODROMES—Ordinarily like those of typhoid, but rising to the fastigial range of temperatures more rapidly (in 3 or 4 days rather than a week). There is constipation, and no rose spots, but otherwise typhoid is suggested, and in the early stages, undulant fever may, like typhoid, be mistaken for influenza.

FASTIGIUM—"Coated tongue, tender palpable spleen, anemia with normal total white, but low polymorphonuclears may be the only signs."

(Headache, sleeplessness, sweats, nose bleed, palpable spleen, leucopenia, may be present). Later neuritis, arthritis, orchitis, joint pains, emaciation, palpitation, prostration, premature ageing may be found in prolonged cases.

DIAGNOSIS—Agglutination tests and blood cultures should be made in clinically erratic cases of "influenza" or "typhoid" or "paratyphoid," or of "undiagnosed continued fever." These agglutination and blood tests should include those for typhoid, the paratyphoids, and Shiga, as well as for *B. abortus* and its congeners. Fortunately one withdrawal of serum for the varied agglutination tests and one blood culture is sufficient for making all the above. One set taken as soon as the need for diagnosis arises, should, if negative, be followed by a second set within a few days. Blood cultures should be observed for nine days, as the bacterium grows very slowly. A proper clinical picture, elimination of other causes, and a positive *abortus* result from agglutination and (or) blood culture gives an acceptable diagnosis.

I am indebted to many recent articles for the above accumulation of data—particularly to Blumer—New England Medical and Surgical Journal, January 28, 1929.

PREVENTION—Avoidance of infected animals; aseptic precautions in handling such; pasteurization of milk. Physicians encountering obscure typhoid-like cases, or otherwise undiagnosed erratic fevers, are urged to send in blood for the agglutination tests above outlined, and for culture. This work is done free for the human under the Provincial grants at any of the Provincial Board of Health Laboratories—at the Vancouver General Hospital; Royal Inland Hospital, Kamloops; Royal Jubilee Hospital, Victoria; or Kelowna General Hospital.

* * *

HOSPITAL BED SHORTAGE

A Special meeting of the Vancouver Medical Association was held in the Outdoor Department of the Vancouver General Hospital on March 14th to hear a report by the Hospitals Committee on the meeting with the Hospital Board on March 8th re the acute bed shortage which had arisen in the General Hospital. Mr. McVety and Alderman McInnis attended the meeting on behalf of the Board.

Dr. Monro, said the shortage had become so acute that during a short period recently the order was given for no admissions to the wards of the Vancouver General Hospital. This was followed by an order limiting admissions to emergencies and accident cases only. At the meeting on March 8th between the House Committee of the Board of Directors and the Hospitals Committee of the Association, methods of relieving this situation were considered, with the fact always before them that there could be no increase in the number of beds for a long period of time. It was agreed that if certain measures could be adopted an increase of 15-25% in admissions could be secured. The House Committee of the Board suggested the appointment of a Registrar to scrutinize admissions and discharges. In the event of a difference be-

tween this Registrar and the attending physician a Referee would be necessary and the appointment of this Referee or Committee should be made by the Association.

Mr. McVety, called on by the Chairman, considered the present situation to be due to a lack of foresight on the part of the City Council and the public. The shortage was anticipated by the Board many years ago. He explained that all bed patients must be removed from the Annex within the next few weeks by order of the Fire Warden, and further, when the new wards were opened and other wards rearranged the present number of beds would be increased by only sixty. He estimated the bed shortage at the present time at 325.

The causes leading to the need for more beds were given by Mr. McVety as (1) increase in the number of families living in flats, (2) the difficulty of caring for patients in the home, (3) the tendency of medical men to get their patients into hospital to save time in visits to outlying districts, (4) the admission of large numbers of patients who could be treated in their homes, and (5) patients remaining longer than necessary. In his opinion the hospital should be kept for acute cases. Conditions with regard to Ward X were gone into and the speaker complained that cases were dumped into hospital by medical men and the police and the hospital authorities were left with the problem of getting in touch with the relatives and obtaining the completion of the necessary forms before the patients could be removed to Essondale. Mr. McVety added that the suggested methods for improvement could only be carried through with the whole-hearted co-operation of the medical men.

Alderman McInnis considered community service should be given first to those unable to supply the service for themselves. Someone should be appointed by the Hospital to supervise the cases in regard to admission and discharge. The question was one of co-operation between the Hospital Board and the medical profession.

Dr. F. P. Patterson referred to the necessity for a campaign for the provision and equipment of hospitals. If there was no immediate possibility of this then the best use must be made of the accommodation already at their disposal. He considered the present congestion due to a difference in opinion among medical men as to the cases which should be admitted and the length of hospitalization necessary. He thought if the Association passed a resolution approving the procedure outlined by Dr. Monro the Hospital Board was prepared to put the scheme into operation and in his opinion once the arrangements were in working order there would be a very small percentage of cases in which any difference of opinion would arise between the Registrar and the attending doctor. Nothing in the nature of discipline was intended—it was a question of trying to arrive at an average hospital stay in any particular type of case. He thought the Association should support the scheme which worked well in other hospitals. Dr. Patterson went on to say that the hospital had neither sufficient equipment nor sufficient nurses to take care of more patients so that the situation could only be met by reducing the length of hospital stay.

Dr. Brodie said they only had equipment and nurses to care for 800 patients and they continually had an excess of 200 over that number. Only one solution was possible—to speed up egress. The average

hospital stay per patient was now 19-4 days; it should be 12-14 days. He thought many cases could do with a hospital stay of seven days and convalesce at home for another week. He then moved the following resolution:

> "That this Association goes on record as sympathizing with the Board of Directors in the difficulty they are having in supplying hospital accommodation for the public of this City and is willing and anxious to co-operate with the hospital authorities in relieving this condition, and this Association recommends to the Board of Directors the appointment of a Registrar to supervise the admission and discharge of patients, and that the Association appoint a Committee to confer with this Registrar in cases of dispute which may arise."

The motion was seconded by Dr. F. P. Patterson.

Dr. McLellan deprecated the present system of sending patients for physiotherapy treatment and laboratory tests to the Hospital when there were doctors competent to treat such cases either in their offices or in the patients' homes. He advocated more instruction in Home Nursing by the St. Johns Ambulance. He thought the appointment of the proposed Registrar should be made by the Superintendent of the Hospital.

Dr. Hunter said they must not lose sight of the fact that the present suggestions were an emergency measure only. Someone outside the profession was wanted to survey the whole hospital situation of the City.

Dr. Sutherland referred to the large number of staff cases which had no homes to go to. What was to be done with these?

Mr. McVety thought it might be possible to utilize the Annex for cases which could be efficiently cared for by Ward Maids thus relieving the Nursing Staff. The Board had a Committee at work surveying the hospital situation and had under consideration a proposal to bring in some outside authority to advise what is actually required. He thought it probable in view of the recent amalgamation that the scheme for extension originally contemplated by the General Hospital would be amended and hospitals erected in other parts of the larger city. The Council had in mind a hospital in South Vancouver of 300 beds and another in Point Grey of 300 beds.

The question was then put and the Resolution carried.

The following resolution was then moved by Dr. F. P. Patterson:

> "That the appointment of the Referee Committee be considered by the Executive and the appointment left in their hands."

In moving the resolution Dr. Patterson said that even when the Registrar and the Committee got working and cases were moving rapidly there would still be a large number of cases remaining longer than necessary as there was no place to which they could be sent.

Alderman McInnis promised to bring this matter immediately before the City Council.

Dr. Patterson's resolution was seconded by Dr. Sutherland and carried and the meeting adjourned at 10 o'clock.

OURSELVES

Being THE OSLER LECTURE *delivered before a meeting of the Vancouver Medical Association, on March 5th, 1929*

By DR. HENRY M. CUNNINGHAM

Our avocation has been variously described as a Profession, a Science, and an Art. We have been told, "one must always remember that the Practice of Medicine is not a Science, but an Art." However true this may have been in the past, it is fast becoming less so. This may be inevitable but should we not strive to retain whatever we can of the *Art* of Medicine?

Nothing is further from my thoughts than to disparage the debt we owe to those who have given and are still giving us more scientific aids to diagnosis. They are of inestimable value; but are they entirely an unmixed blessing? Is there not a growing tendency to depend too much on the laboratory and too little upon our own skill in matters of diagnosis and prognosis? If this be true, must it not necessarily follow that our powers of observation, tactile sense and diagnostic acumen will either atrophy from disuse or fail to develop, as the case may be? To thoroughly appreciate this danger one must, I think, have started his medical career before most of these aids were available and have watched them gradually usurp the field. When I graduated 34 years ago, the only diagnostic implements we had were our five senses, the thermometer, stethoscope, forehead mirror, nasal, aural and vaginal specula, tongue depressor, laryngeal mirror, ophthalmoscope and microscope. Our laboratory aids were urinalysis and microscopy. Looking back I am struck by the comparatively high degree of attainment reached by the microscopist of those days. His diagnosis of the various new growths was not far short of the present. The recognition of most of the pathogenic micro-organisms and the significance of their presence, was as well understood as now. Examination of the blood included percentage of hemoglobin and red and white cell count. The morphology of the erythrocyte was studied and the plasmodium of malaria searched for. We could recognize anaemia, chlorosis, pernicious anaemia, leukaemia, pseudoleukaemia and leukocytosis. Recognition of the importance of the differential count as we have it today, came later.

In our education considerable stress was laid on our ability to use the microscope. With the exception of the diagnosis of new growths and the making of cultures, the work was done by the internes. Complete qualitative and quantitative urinalysis was, of course, done in the laboratory and the laboratory expert called upon when deemed necessary.

We did not have that greatest of all boons the X-ray, nor did we have the Wassermann Test, Widal Test, Schick Test, metabolism estimation and biochemistry. Blood pressure and the tension of the eyeball were estimated by the sense of touch.

When studying the heart and aorta we did not have the radiogram nor the electro-cardiograph. We had to trust to our skill in observation, palpation and auscultation.

A slight consideration of what it would mean, today, to be deprived of the help of the roentgenologist and bronchoscopist in the diagnosis of

chest diseases, will bring a realization of the necessity imposed upon former diagnosticians of developing to the utmost whatever skill they could acquire.

In the diagnosis and treatment of fractures and dislocations it is almost malpractice not to avail ourselves of the help of the X-ray if obtainable; but if forced to do without, what result can be expected by one who has neglected to acquire a fair degree of skill in the older methods of observation and palpation?

As an instance of the blind faith that many have in laboratory tests, permit me to mention that of the Wassermann Test for syphilis. In this the laboratory people are in no way to blame, they can only report on what they find and have repeatedly warned us not to regard a single test of the blood as conclusive. In spite of this many consider that they have done their whole duty, so far as excluding syphilis is concerned, when they have received a single report of a negative blood Wassermann. However valuable laboratory tests for syphilis may be the time has not yet come when the physician is relieved from the responsibility of arriving at a diagnosis without them. A reasonable persistence will, however, enable him to obtain laboratory confirmation in most cases, if he cares enough about it.

In syphilitic manifestations of the nervous system nothing but a test of the spinal fluid is of any value. One may try a test of the blood first —and possibly get a positive reaction—if one clearly understands that a negative report means absolutely nothing. As an illustration let me mention two cases. One was a child that I saw in the Out-Patients Clinic; she had been through the various departments for several years and now presented a suspicious condition of her cornea. I remarked to the nurse that the first thing to do was to send her for a Wassermann test; she replied that every other department had done the same and that three negative reports were in her voluminous case history record. That being the case, I put the child on provocative treatment and got a report of 4 plus. The other was a man with optic nerve atrophy. I sent him first for a test of the blood which was negative, then for a test of the spinal fluid which was also negative; being unconvinced, I put him on provocative treatment for four days after which I received a report of 4 plus positive. The clinical evidence of syphilis still holds good regardless of repeated negative Wassermann tests and I cannot help repeating that we are in danger of losing our ability to make a diagnosis by observation alone. It is astonishing that many—who have had a supposedly first-class medical education—do not understand what is meant by "provocative treatment" in relation to the Wassermann Test.

I should like to spend a few moments in considering the use of our senses, sight, hearing, smell, taste and touch. Of those, the power of observation and the trained tactile sense are, of course, the most important. I shall never cease to be grateful to one of my teachers, Francis Delafield, for constantly directing our attention to the amount that may be learned by observation alone. In summing up a case, after giving us all the finding, temperature, pulse, respiration rate and those of physical diagnosis, he invariably wound up by one of the following

remarks; "and the patient looks sick;" "but the patient does not look sick;" or, "but the patient looks sick." In estimating the gravity of the situation the appearance of the patient had, to him, almost more significance than all the other findings put together. Is not this to a large extent still true? I know it to be so in many cases of disease of the ear and should, I think, be a large factor in deciding as to the urgency of a mastoid operation and often be a guide as to the necessity of further intervention.

Delafield taught us to always make a careful observation as to the appearance of a patient before proceeding further; does he look sick? does he look worried, anxious, or apprehensive? is he nervous, excited or apathetic? is he anaemic or plethoric? is he well nourished or emaciated? does he look toxic? notice the colour of his skin and mucous membranes. How much may be learned from the appearance of the tongue; the older practitioners paid great attention to this, a dry, brownish coated, furrowed tongue meant to them the so called "typhoid state," now usually spoken of as the "septic state." What apparatus or laboratory method will take the place of the power of observation? The older men paid more attention to the tongue because of a limitation in available modern methods. Is it not likely that with the numerous appliances and laboratory aids of today the younger men will pay less attention to what might be learned by observation than their predecessors?

I also learned a good deal from observing another man who was in many ways the direct opposite to Delafield, who, as they used to say, spent five years of his life in the "dead house" and was, as you know, an eminent pathologist before he became a clinician. This man had a very inadequate medical education and unlike many with the same handicap, he made no attempt to gain further knowledge by reading or taking post-graduate instruction. He was however, a past master when it came to knowing when it was advisable to call in a consultant and was uncanny when it came to prognosis. I often wondered how it could be possible for a man so ignorant to be so accurate in this. Largely through this faculty and his cleverness in getting out from under, he gained a great reputation and built up a large practice. I have said I learned something from this man which was, an appreciation of how much may be learned through observation when forced to depend on it. This can also be seen in the high development of the senses of touch and hearing of the blind.

The sense of touch has, I think, suffered less from the advent of modern innovations than have the other senses. The diagnostician of today still depends a good deal upon the use of his trained fingers to supplement the X-ray plates. I doubt whether the average practitioner cultivates this talent to the same extent, as did his colleagues of the past. I may perhaps be wronging him but it seems to me that he is too apt to leave it all to the X-ray man, without trying to see how much he can find out himself. I feel sure that this is so in regard to fractures and dislocations. It is really wonderful how much can be learned by delicately trained finger tips. Being inexpensive, always at our disposal and occupying no office space, it seems a pity not to develop and retain this marvellous gift which is within the reach of all. Take the tension

Prestige . . .

¶ We are striving for prescription prestige . . .

¶ Our definite aim is to give the best possible service at all times . . .

¶ Intelligent co-operation with both doctor and patient . . .

¶ A specialized prescription service devoted in the interest of health . . .

Macdonald's SEY. 112 LIMITED Prescriptions

618 West Georgia Street, Vancouver, B. C.

SEYMOUR 118 Another phone to help serve you more quickly

OPEN ALL NIGHT MOTORCYCLE DELIVERY

PUBLIC HEALTH BIOLOGICAL PRODUCTS

Diphtheria Antitoxin
Diphtheria Toxin for Schick Test
Diphtheria Toxoid *(Anatoxine-Ramon)*
Scarlet Fever Antitoxin
Scarlet Fever Toxin for Dick Test
Scarlet Fever Toxin
Tetanus Antitoxin

Anti-Meningitis Serum
Anti-Pneumococcic Serum *(Type 1)*
Anti-Anthrax Serum
Normal Horse Serum

Smallpox Vaccine
Typhoid Vaccine
Typhoid-Paratyphoid Vaccine
Pertussis Vaccine
Rabies Vaccine *(Semple Method)*

INSULIN

Price List Upon Request

CONNAUGHT LABORATORIES
University of Toronto
TORONTO 5 - CANADA

Depot for British Columbia
MACDONALD'S PRESCRIPTIONS LIMITED
618 Georgia Street West - Vancouver

of the pulse and eye with the finger tips before appealing to the really accurate blood pressure apparatus and the tenometer; the time will not be wasted. Try to detect cripitus, friction rubs, enlarged liver, distended gall bladder and the like before resorting to the X-ray. Also try to determine the presence of pus or other fluid in a swelling and register a positive opinion with yourself before cutting into it. Notice the presence or absence of the granules of actinomycosis and the odour, if any, before sending a specimen of pus to the laboratory. Only by such means can we hope to advance.

The sense of hearing is, of course, indispensable when we come to auscultation of the chest but it is also of service in detecting the bruit of aneurysms in other regions and the friction rub of beginning peritonitis. Although the ordinary man cannot hope to attain the proficiency of the heart and lung specialist, it lies largely with himself as to how nearly, by study and practice, he can approach him.

The sense of smell, while playing a minor role, is often of great value. A number of odours are quite distinctive and may almost be said to make the diagnosis; such for instance as the acetone breath, the odour of bone necrosis, gangrene and that of lung abscess; the odour of the colon-bacillus is often most significant. When pus from the maxillary sinus has this odour one can strongly suspect that the infection came from the mouth and search the teeth for the probable tract. Other illustrations, drawn from diseases of the ear, are the odour of bone necrosis already mentioned and that of decaying skin, which is present in cholesteatoma. It is said that some of our fathers in medicine could diagnose many of the fevers and diseases, such as typhoid fever and diphtheria, by their odour; the statement may not be so fanciful as it seems since several of my colleagues assure me that they are able to do the same.

It is of the greatest importance to be able to recognize at once the symptom of acetone breath. Upon its early recognition followed by immediate steps to remove the underlying cause, the life of the patient may depend. No opportunity to teach our internes and nurses to recognize this symptom should be neglected. It is they who often have the first opportunity to detect it. That this has not always been done when it might have been I know by personal experience. One does not expect case histories in an Osler Lecture but I feel so strongly the need to emphasize this point that I hope you will bear with me while I make brief mention of three cases seen in consultation, two of which I believe owed their lives to the fact that the presence of acetone breath was recognized at the time. The first was a young woman who was to have an operation for toxic goitre—at which I was to assist. Immediately before being taken to the operating room, I visited her in company with my colleague. When near her I detected the acetone odour which he had not noticed until his attention was called to it. Needless to say the operation was postponed—as a matter of fact was never done—all her symptoms clearing up under treatment. This would certainly have been a fatality had the operation proceeded as scheduled.

Another was a case of water hunger due to functional stenosis of the oesophagus which a colleague was treating by bouginage without

result. I accidently happened to be present at one of the treatments and was astonished to hear him tell the patient to "come tomorrow." I hastily called him to another room and enquired if he had not noticed her breath. He replied no. I cannot yet understand how this could have escaped him for he was a man of long experience and one whose ability I greatly respect. He told me afterward that he thanked me for saving his patient's life.

The third was less fortunate. A young girl had been ill for several months but was supposed to be convalescent and had been advised by her physician to take a long railway trip to visit friends for a change. She still had a troublesome headache and was sent to me in the hope that this could be relieved by glasses. Before beginning an examination I noticed her acetone breath and immediately called up her physician and acquainted him with the fact. In this case I could not make the man realize the gravity of the situation and the child was dead in forty-eight hours. I never could ascertain what her previous illness was.

Of all the senses that of taste is, I suppose, the least important, nevertheless it should not be neglected. Is it asking too much to expect the trained physician to be able, when it is possible by taste and smell, to identify those drugs which are in common use? I do not think so.

In dispensing and administering drugs or using topical applications and solutions eternal viligance is required to avoid mistakes. In the handling of bottles the druggists have a rule that we should all adopt. They look at the label before taking the bottle down, again before they pour from it, and again when they replace it. Nothing should go for a moment without a label. I have often thought that a druggist should put the label on the bottle just before starting to fill it. When unfamiliar with the taste of a drug physicians and nurses should taste preparations before administering them. I once ordered ten grains of chloral for a hospital patient to be given at once. We had a stock solution of ten grains to the drachm. The nurse made the portion in a small medicine glass, filling it to about three-quarters full with water. I asked her if she had ever tasted chloral, and being answered no, advised her to taste it. She did so, and ran spluttering and coughing to the water tap.

Before closing this chapter of my subject, I should like to quote a few passages from the writings of our revered master in whose honour we are assembled tonight. "Lack of critical judgment is another serious obstacle in the way of the young man." The faculty of right judgment in all things is granted to few men; but the physician to be of any value must, at least, aspire to that round-about common sense which was so distinguishing a feature of Sydenham." "Our work is an incessant collection of evidence, weighing of evidence and judging upon the evidence." "Credulity is of the very essence of human nature and we physicians are not exempt from the common lot." He quotes Epicharmus of Syracuse as saying: "be sober and distrustful; these are the sinews of the understanding."

How true it is that the physician who has assumed the responsibility of caring for his patient's welfare should be a man of sound judgment.

He must steer a middle course between rashness and timidity and be able to properly balance indications and contra-indications. Before deciding as to the time for operative interference he must carefully consider its urgency; must it be done at once or would it be possible by pre-operative treatment to lessen the risk and shorten the convalescence? It is always a choice of evils.

Judgment is to a large extent the fruit of experience but is dependent on something more. A man may grow old in experience without acquiring judgment. It is only by the conscious effort to apply it that sound judgment is attained. The reference to credulity is also most timely. We should be open minded and willing after proper consideration, to change our opinions; but to go to the other extreme, veering with every wind that blows, is, perhaps, worse. Cultivate a healthy scepticism; hold fast to what appears to be truth until it has been proven otherwise. A chart of our beliefs and disbeliefs should not resemble the temperature chart of a case of pyaemia.

Let us now consider the relations which should exist between our patients and "ourselves." There is an old saying, "do not make patients of your friends but make friends of your patients." The latter half of this quotation is, I am sure, a very valuable admonition and essential to getting the best results in the most pleasant way.

It requires considerable tact and some natural aptitude to do this. I think one may lay as the "corner stone" in the construction of all friendship, "Sincerity." When patients have been commenting on physicians, it often occurs to me that they place more value upon sincerity than skill, perhaps rightly so. Doubtless most of you have heard them say, "he may be a good doctor, but I don't trust him." What more damning thing could a patient say. Skill may not be attainable by all of us, but we can at least be sincere.

The next in importance is the patients' confidence in our knowledge and skill. By knowledge I do not mean our abstract knowledge alone, but an understanding of the individual case. To acquire this it is necessary to make a careful and thorough examination, for the modern patient has been educated to expect it. This was not always so. I once practised in a place where one-half of what we now consider a moderate attempt at thoroughness was thought to be an evidence of incompetence. The man who had the largest and best paying practice in a city of twenty thousand people rarely used a thermometer or a stethoscope. He did not need them, for he knew at a glance just what ailed his patient. His stock phrase was, "don't tell me a thing, I know what's the matter," and proceeded to write a prescription. This may sound like, at least, an exaggeration, but I give you my word that it is the exact truth. He was regarded as a wonderful man, and just what a real physician should be. Times have changed, however, and such powers of discernment are now accredited only to the occult.

Having confidence in our sincerity and our knowledge, the patient must next have confidence in our skill in putting this knowledge into effect. His confidence, to a large degree, depends upon the confidence we have in ourselves. None but a consummate actor can inspire con-

fidence in others if he lacks it himself. The patient is abnormally acute in observing his physician; his whole mind is centered on his own case, and by the physician's manner, rather than by what he says, he judges the situation. Is the doctor really interested in me? Does he know what he is doing? Is he worried about me? Does he think that I will recover? Is he rough or gentle? Is he interested only in my recovery? Is he interested also in my comfort? In the course of our examinations, treatments, operations and dressings, the patient forms a decided opinion as to whether we are skilful or not. Finally, of course, comes the end result. In our operative procedures, we must never lose sight of the patient's chief complaint; this is what he hopes and expects will be relieved. If his expectations are not realized he will be a dissatisfied patient. I do not mean to say that we are not often called upon to perform an operation which is very necessary to the welfare of the patient but has no direct bearing on the symptoms for the relief of which he first consulted us. I know this to be often true in my own work. In such a case, however, the patient should be fully informed as to the reason for the operation and as to what results we hope to achieve. If you will pardon an illustration, which I feel sure can be applied to other conditions, let us take that of asthma. Many of these patients can be relieved by a nasal operation but the outcome is by no means certain. A patient presents himself with the chief complaint of asthma; we find that his nose is packed with polypi, producing nasal obstruction. Most of such cases are either completely or at least very much relieved by a nasal operation; some, however, receive no relief whatever so far as their asthma is concerned. It would be folly, therefore, to make an unqualified promise. One can say, however, "you need a nasal operation regardless of whether or not you have asthma; I can promise that you will be much more comfortable, and there is strong hope that your asthma will be relieved; but please understand that I cannot be positive as to the latter." With such an understanding one need fear no dissatisfaction and should the asthma disappear gratitude and pleasure will be greater than had it been a foregone conclusion.

Fortunately it is rarely necessary to give our patients pain but if compelled to resort to a disagreeable procedure, prepare your patient for it. Above all do not minimize it; nothing is so destructive to future confidence and present tolerance. If fortitude is required inform him so that he may be prepared to manifest it; on the other hand, remove all unwarranted apprehension. After having told him what he has to endure, by all means tell him what he has no need to dread. Encourage him by the assurance that he is quite able to acquit himself creditably and show him that you expect him to do so. Please notice that I said "show him," not "tell him;" the terms are quite different.

When I set out I expected to have a separate chapter on children but I now see that such a sub-division is not only unnecessary but misleading. The only variation necessary is a slight modification in our vocabulary. For instance, when about to do something unavoidably painful to a child I always say, "now, son, this is going to hurt you a little," and before he has time to react to this " but not more than you can stand." As a rule, a beautiful expression of relief passes over his

face. He seems to be saying to himself "not more than I can stand, oh that's all right so long as I know how much. I don't like those people who tell you it is not going to hurt at all, or only a little, and then they hurt you like everything." You have given him the only scale of measurement that he can understand. How does he know what you mean by "just a little," and to tell him "not at all" is a treachery that he will never pardon. Another important rule in managing children is not to permit anyone to attempt to hold them unless absolutely necessary. Just think for a moment what your own reaction would be if you had no idea what was to be done to you and the first step was to be seized by two or more strong men and forcibly held in a helpless condition while a strange man prepared to perform some sort of operation. Is it any wonder that a child under such circumstances is filled with terror. There is no field here for half way measures; either do not touch them at all, or, mummify them with a sheet so tightly that they cannot move. I am glad when a parent starts to hold a child for it gives me the opportunity of saying "no, do not hold him, he can hold himself." This gives him added assurance that nothing very dreadful is going to happen. A mother will often remark "I don't know that you can do anything with her, doctor, she is so nervous." My stock reply is, "I am not surprised, when her mother will speak so in her hearing." I have lost patients by that retort but never regretted it, and will continue to do that much in the interest of the child's future. It may do some good sometime, and such people are not apt to be satisfactory persons to work for. The sooner we part the better I like it.

I never cease being amazed at how much children will stand without complaining if they like you and have confidence in you. Confidence that you are kind and not going to spare trouble to prevent all needless discomfort and pain. The confidence of a child is one of the most beautiful and satisfying experiences in a doctor's life.

Having gained a patient's confidence or, hoping to do so, how important it is not to cause more pain than he can bear. Here one must use the greatest judgment as to the individual. How much has this one already gone through? How much available fortitude still remains? Temperament and general circumstances play an important part in the estimate. I used to have an idea that ordeals developed strength and fortitude; I no longer believe it. My experience is that the more one has gone through, the less able one is to endure more. Instead of developing tolerance we are using it up. This, of course, does not apply to those procedures which are *in themselves* painless, but have been made so by apprehension and resistence; here considerable tolerance may be acquire and unfounded apprehension overcome.

The modern surgeon with all his mechanical skill and scientific technique often fails to get the result that he might, or be the blessing that he should, because he fails to realize that he is operating on the mind as well as on the body of his patient. The surgeon is too often satisfied with doing a brilliant operation regardless of the fact that he has failed to satisfy his patient. Much needless misery might be avoided and the period of convalescence be made shorter, happier and more complete, if the surgeon had the ability, and gave the subject sufficient considera-

tion, to enquire into his patient's state of mind both before and after an operation.

The surgeon who feels that he has fulfilled his whole duty after discharging his patient with a normal pulse, temperature and respiration rate, leaving it to him to fight his way back to health and strength unaided, is falling short of his opportunity. Many patients expect to feel almost immediately well after undergoing an operation to relieve them of a disability which they have been told was the cause of their previous illness. This is, of course, ignorance but it is a pardonable ignorance based on inexperience and is pitiful when based on an exaggerated idea of the magic of the skilful surgeon.

The period of convalescence is often tedious and depressing; why wonder that some become hopeless and turn to Christian Science, or some form of quackery; or that such institutions, rather than the surgeon, finally receive credit for curing them.

A cheerful optimism is, of course, essential in radiating hope and courage to the patient; without hope, life would be intolerable. Faith and hope are the sheet anchors which enable us to outride periods of storm and stress and keep us headed right during the sometimes trying period of convalescence.

Some persons cheer us as soon as they enter the room, others have the opposite effect. How often one hears a patient say that his physician's visit alone make him feel better. Some men try to be cheerful without the tact requisite to do it properly. Nothing is so offensive to a sick person as a boisterous exhibition of exuberance; we should try to find a happy medium between the manner of a romping school boy and that of an undertaker. A proper sympathy is also essential, but there are two sorts of sympathy; one is a tonic and the other a poison. Sympathy also requires tact; some when trying to be sympathetic become maudlin. I do not altogether like the word sympathy as ordinarily applied, I should prefer sympathetic kindness to kind sympathy. This may be a rather fine distinction but conveys the shade of difference that I am trying to express. I shall never forget a grotesque incident that once happened me when as a patient, I was soon to be taken to the operating room. A strange interne came in and without saying so much as "good morning" asked abruptly—"how old are you." I gave him my exact age to the day and there must have been something in my smile that exposed my thoughts for he asked the nurse in the office, "is the man in that room a doctor?" Imagine the effect such an incident might produce upon the mind of a nervous, apprehensive patient.

Speaking of optimism, I doubt if any of us realize how far its influence extends. We know very little of the forces which activate and govern the metabolism of the tissue cells and the functions of the body. We do know that grief, fear, worry and anxiety have a detrimental effect, causing loss of sleep, loss of appetite, improper digestion and assimilation. We have often seen people lose ten or more pounds of body weight under their influence. How far then can optimism produce an opposite effect? We realize that the frequent beneficial effect of the various forms of "faith cure' 'are due to the return of hope and

confidence, but do we make sufficient use of this knowledge in our practice? There is a valuable little book, written by a layman who knows what he is talking about, called "Optimism in Medicine." It is well worth reading. I got one idea from it that is worth ten times the cost of the book. The writer admonished us never to think that a patient is not deeply concerned about himself, because he makes light of the necessity for an examination. If he were not anxious he would not go to the trouble of consulting us and we should make a point of assuring him definitely, when we can do so, that he has no serious disease. Shortly after reading this, an opportunity to test it out presented itself. A man consulted me about his throat; said that he felt sure that I would find nothing much wrong, he had a little cough probably from smoking too much and his wife wanted him to see me about it. He treated the affair as a piece of ridiculous nonsense. As a matter of fact his own diagnosis was correct, and he had nothing more than a "smoker's throat." Ordinarily I would have treated the matter as lightly as he seemed to do; but bearing in mind what I had recently read, I assured him that he had no evidence of disease whatever, no sign of cancer, tuberculosis, nor any other disease. He asked immediately if he could use my phone, called up his wife and told her that the doctor had just made a thorough examination of his throat and found not the slightest sign of cancer nor anything else, closing the conversation by saying "so you see, dear, we have had all our worry for nothing" It was most evident that this man, in spite of his bravado, had really been fearing that he had cancer. Had I not relieved his mind, by definitely telling him that he did not have cancer, he would not have called up his wife, she would have asked him that evening what I had said; he would probably have replied, "Oh! nothing much" and neither of them would have been completely satisfied. The moral of this story is self evident.

When speaking of inspiring confidence in others I remarked that the first essential was to have it ourselves. The same is true in inspiring hope. I trust that you will allow me to dwell somewhat on this subject for it is one that I feel to be of the utmost importance. It is true that it will not help us in certain conditions, such for instance as deafness and others of like nature, but I believe that it is almost always a factor in recovery and often the chief factor. In such a material condition as a fractured bone, I believe that the chance of a better union will be enhanced by a hopeful and cheerful state of mind. I also believe that we can do better work if we are hopeful ourselves. You may say that this is often impossible. I grant you that it is *sometimes* so, but *often* is too strong. As many of you know I have a lot to do with cancer, usually cases that are inoperable, and a more difficult test of one's ability to be hopeful I think you will admit would be hard to find. In spite of the difficulty I must manage it, if I am to give these unfortunate people all that I can. In the first place, I regard myself as the buffer between the individual and the realization of his horrible fate. To do this I must alleviate his symptoms so far as possible, and above all keep him as long as possible from hopelessness. The latter I can do only by refusing to accept the situation myself. I tell myself that the diagnosis may be a mistaken one—such things have happened. Then I fix my mind on the possibility of giving him considerable relief which fortunately can

often be done. Unfortunately I am a poor actor, and when confronted by some specially untoward evidence am apt to show it by my expression. In spite of this I manage fairly well and have had a number of patients reach the end without ever knowing that their condition was hopeless. So far as I know, none have committed suicide because of my lack of effort to prevent it. I do not wish to be understood as regarding this as an awful tragedy from their point of view but I do not wish to be responsible for it myself. To manufacture confidence, fortitude and hope out of nothing is, I admit, a difficult task, and takes a lot out of one.

I have sometimes been criticised for my attitude in the matter of handling patients with cancer. Some say why bother with them, why not let them die as quickly as possible. My answer is this—no one shall die of slow strangulation or thirst, if I can help it. Furthermore many can be kept comfortable to the end. Others say, these patients should be told of the situation, so that they may make terms with the Almighty or get their worldly affairs in shape. To this I reply, that I have not the slightest belief in the efficacy of death bed repentance and that if their spiritual advisor wishes to take the responsibility of telling them that they are dying, that is within his province, not mine. As to straightening out their business affairs, very few of my patients have any. In any case I always inform the immediate family or friends, as the case may be, and am glad to help out if necessary. Even this can be managed tactfully, without passing the "death sentence." The death sentence of a judge is not so bad as it sounds; there is always a hope of appeal, mitigation, or what not; so, that the condemned man does not lose all hope, up to the moment the trap drops. It is quite different with the death sentence of the physician. The criminal may deserve his fate, but what has the poor victim of cancer done that he should be condemned to a lingering death of torture—such as no one would inflict upon the worst criminal. Although I may be unable to prevent it, he will not be sentenced by me.

As a rule the seriousness of the situation gradually dawns on these people, and they do not need telling. A rather large experience satisfies me that my method is the correct one. I am speaking, of course, of inoperable cases; with those that are operable, the situation is entirely different but always demands the greatest tact. Some of you may think that if you had cancer yourself you would prefer to know it. I am afraid that if such were really the case, you would find you were sadly mistaken and that your present idea was due to a lack of mature consideration an dexperience. In this, as in all other situations in life, the "Golden Rule" holds good—"do unto others as you would have others do unto you." This is not only the golden rule of conduct but also the golden rule of tact.

Just a few words as to the duty of the older members of our profession to the younger. We must not expect them to be altogether wise in choosing the most important things to learn. I am thinking chiefly of our hospital internes. They are naturally most attracted by major surgery. Should not minor surgery and emergency operations form a larger portion of their training, so that they will be fitted to take

up the routine work of their practice? Is it not of greater importance that they should be able to treat an infected hand properly, or do a tracheotomy safely, than to attempt an operation on the gall bladder?

I trust that you will pardon me, if I make special reference to the operation and after care of tracheotomy, since this has come particularly to my notice. If there be one operation more than another, that a hospital interne should be competent to perform it is, I think, that of tracheotomy; and yet I feel safe in saying that not one in ten of our internes, when they leave our hospital, know anything about it. Another emergency condition which often requires immediate recognition and relief, is retro-pharyngeal abscess. Granted sufficient time, the attending surgeon should, of course, be called for both of these operations, but there are times when he would arrive too late. The same is true to a certain extent of post operative tonsil haemorrhage and nose bleed.

I mention these things because they come more immediately in the line of my work; many other illustrations will doubtless occur to you. Most of all they should strive to learn to make a correct diagnosis. In the preface to a recent book on Surgical Diagnosis, the writer so well expresses my though that I will take the liberty of quoting an excerpt bearing on the point. He says: "there is a tendency for the knowledge and practice of operative treatment to outstep that of surgical diagnosis and the opinion has been widely expressed that in this lies the weakness of modern surgery. It is undoubtedly more difficult to determine when and how to operate than to carry out the details of any given operation. There is also, in this and in other countries, a growing tendency to lay stress—and perhaps an undue stress—upon the value of laboratory and other special methods of investigation. The careful consideration of the clinical history and the physical examination of the patient still remain the most valuable methods of diagnosis, to which the other methods should be regarded merely as accessory."

The correct diagnosis of the various forms of dyspnoea should be the subject of a lecture every year, and every opportunity taken for demonstration, so that the interne can differentiate the dyspnoea due to laryngeal stenosis from all other forms. I have several times been asked to perform tracheotomy for the relief of pneumonia.

The young practitioner may very well manage such cases as permit of study and reference to his books, but certain emergencies give him no time for this, and it is such things that demand previous training in order that he may prove equal to the occasion. As I have suggested, it devolves upon those of us who know this by experience to see to it that those who receive their training under our administration go forth adequately equipped both to save lives and do credit to themselves and to our institution.

Finally, does it not seem that our skill in surgery has outrun our knowledge? Who can say how far the various dyscrasias may go in the causation of what we now regard as chronic surgical diseases, and operate on so smugly? From the results already obtained in the study of biochemistry it does not seem unlikely that the pendulum will swing back to more constitutional treatment and less surgery, especially in chronic conditions. It seems doubtful whether we are yet in a position to

be positive in most of our conclusions, and we are now between what might be termed the Surgical Era and the Era of Physiology and Biochemistry. Having developed our surgical skill to a high degree, let us now try to bring our other knowledge to the same level.

The time has, I think, already arrived when the interne—if he be what he should—need no longer be envious of the surgeon. In other words, future advancement depends upon the study of the pathology of function rather than anatomy.

I recall the time when, in my youthful folly, I fancied that I had arrived too late; that no field remained for future research. I now feel that the little we have learned is as nothing in comparison to what remains to be discovered.

Knowledge is to be gained only by study. The profession, as a whole, is surrounded by vast fields of the unknown, while each of us is surrounded by lesser fields of what is known to others, but, not to "ourselves."

WANTED

Young physician and surgeon to take charge of district and hospital. Subsidy $800.00. Free living quarters.

Furher particulars, apply to

Secretary, Francois Lake Hospital, Southbank P.O., B.C.

Every Diphtheria Case Should Recover

If diagnosed EARLY *and if enough Diphtheria Antitoxin is used*

FREQUENTLY the physician is not called until dangerously late. Then, especially, a most dependable Diphtheria Antitoxin is required and repeated injections may even be needed.

Under such circumstances select Diphtheria Antitoxin, P. D. & Co. It is highly concentrated and purified; limpid and water-clear, with a minimum content of protein substances. The syringe contains 40% more antitoxin units than the label calls for. This provides for possible lessening of activity with lapse of time, assuring full label dosage up to the date stamped on the package.

Diphtheria Antitoxin, P. D. & Co., is supplied in syringe packages of latest improved type, ready for instant use.

1,000 UNITS · 3,000 UNITS · 5,000 UNITS · 10,000 UNITS · 20,000 UNITS

PARKE, DAVIS & COMPANY

License No. 1 for the Manufacture of Biological Products

DIPHTHERIA ANTITOXIN, P. D. & CO., IS INCLUDED IN N. N. R. BY THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION

FIBROSITIS

Although the true nature of musclar rheumatism or fibrositis is not yet determined, authorities generally agree that this affection of the voluntary muscles is almost always due to cold or damp, inducing, in chronic cases, an inflammatory proliferation of the connective tissue.

With rest as the first indication, the local application to the affected muscles of a hot

Antiphlogistine

dressing will do much toward the stimulation of a free flow of lymph through the painful part and constitutes a rapid and successful treatment in acute cases.

"In cases of neurofi brositis kaolin poultice (antiphlogistine) affords in the majority of cases great benefit."
Fibrositis—The Prescriber, Nov., 1926

Antiphlogistine is no ordinary poultice. By virtue of its thermogenetic property it strengthens the tissues by increasing the activity of the circulation, and by diffusing the products of congestion, muscular rigidity and tenderness is diminished bringing with it almost instant relief from pain.

The Denver Chemical Mfg. Co.
163 Varick St., New York City

Dear Sirs:

Please send me clinical data and sample of Antiphlogistine.

.....M.D.

.....St.

City.....Prov.....

Say it with Flowers

Cut Flowers, Potted Plants, Bulbs, Trees, Shrubs,
Roots, Wedding Bouquets.

Florists' Supplies and Funeral Designs a Specialty

Three Stores to Serve You:

48 Hastings St. E.
665 Granville St.
151 Hastings St. W.

One Phone:
Seymour 8033
Connecting all three stores.

Brown Bros. & Co. Ltd.

VANCOUVER, B. C.

H. K. Lewis & Co. Ltd.

Medical Publishers and Book Sellers

Very Large Stock of Text-Books and Recent Literature in all Branches of Medicine and Surgery

Large Stock of SECOND HAND BOOKS always available at 140, Gower Street
Catalogue post free on application

COLONIAL LIBRARIES, COLLEGES AND SIMILAR INSTITUTIONS—

Special facilities for executing Large Orders for Shipment to all parts of the world.

Effectually protective packing used without charge.

To Residents in Canada, South Africa, India, Australia, etc., H. K. Lewis & Co. can supply (direct by first mail) the Publications of all Publishers.

Books sent C. O. D. or V. P. P. where available.

Any Books in General Literature not in stock supplied to Order.

London: H. K. Lewis & Co. Ltd., 136 Gower St., W.C.1.

DR. C. S. McKEE
AND
DR. R. E. COLEMAN

announce that in future their Clinical Laboratory Services will be combined and a twenty-four hour service maintained.

Telephones
Seymour 2996, Bayview 268 and Bayview 5194

Offices:
201, 206 and 214 Vancouver Block

McBeath-
Campbell
Limited

Printers and Publishers

Vancouver, B. C.

The Owl Drug Co., Ltd.

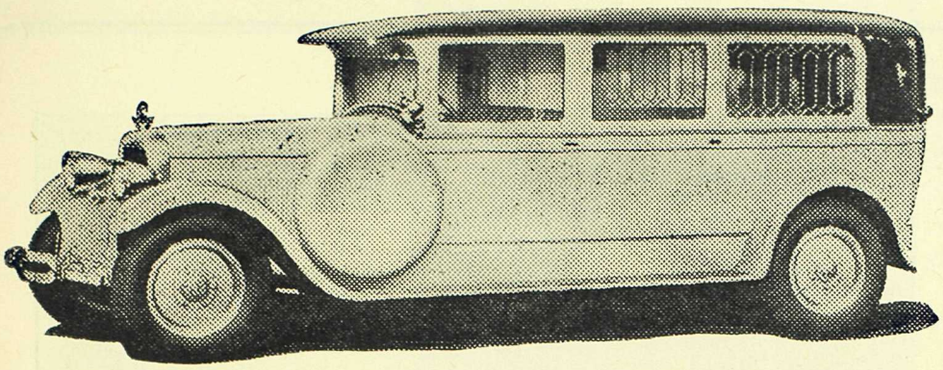
All prescriptions dispensed by qualified Druggists.

You can depend on the Owl for Accuracy and despatch.

We deliver free of charge.

5 Stores, centrally located.

We would appreciate a call while in our territory.



536 13th Avenue West Fairmont 80

Exclusive Ambulance Service

FAIRMONT 80

ALL ATTENDANTS QUALIFIED IN FIRST AID
"St. John's Ambulance Association"

WE SPECIALIZE IN AMBULANCE SERVICE ONLY

R. J. Campbell J. H. Crellin W. L. Bertrand

STEVENS'
SAFETY PACKAGE

STERILE GAUZE

is a handy, convenient, clean commodity
for the bag or the office.

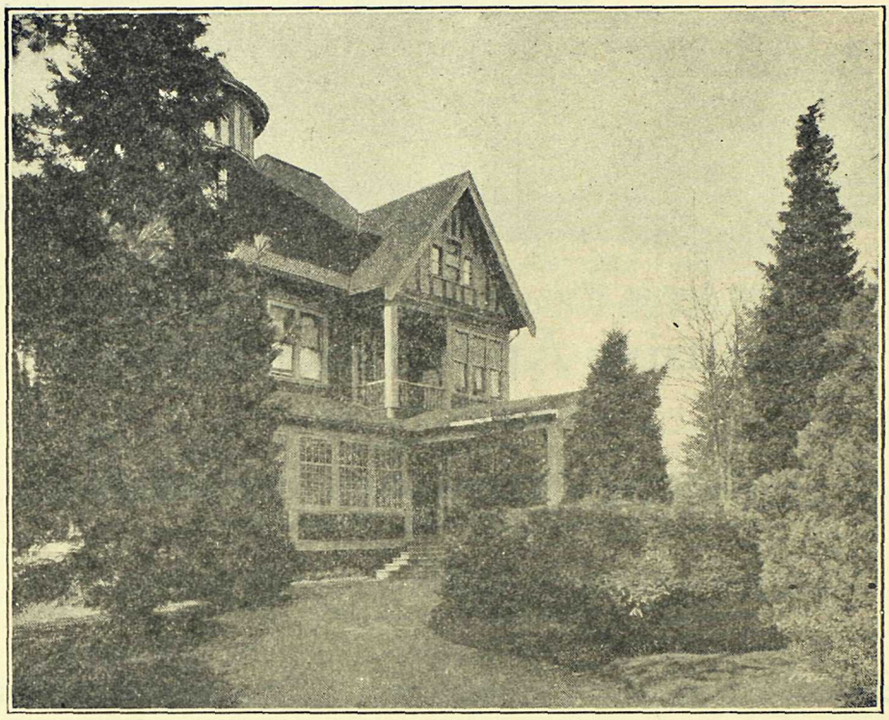
Supplied in one yard, five yards and
twenty-five yard packages.

ESTABLISHED NEARLY A CENTURY
COMPANIES

B. C. STEVENS CO.

Phone
Seymour 698

730 Richards Street
Vancouver, B. C.



Hollywood Sanitarium

LIMITED

For the treatment of

Alcoholic, Nervous and Psychopathic Cases
Exclusively

Reference ~ B. C. Medical Association

For information apply to

Medical Superintendent, New Westminster, B. C.
or 515 Birks Building, Vancouver

Seymour 4183 Westminster 288