The BULLETIN

OF THE

VANCOUVER MEDICAL ASSOCIATION

UNIVERSITY OF BRITISH COLUMBIA
JUL 15 1936
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Vol. XII. JULY, 1936 No. 10

In This Issue:

Convention Number

INTERNAL DERANGEMENT OF THE KNEE JOINT

NEWS *and* NOTES

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THE VANCOUVER MEDICAL ASSOCIATION

BULLETIN

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VOL. XII. JULY, 1936 No. 10

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VANCOUVER HEALTH DEPARTMENT

STATISTICS—MAY, 1936

Total Population (estimated)	247,558
Japanese Population (estimated)	8,055
Chinese Population (estimated)	7,895
Hindu Population (estimated)	320

	Number	Rate per 1,000 Population
Total deaths	214	10.2
Japanese deaths	6	8.8
Chinese deaths	15	22.4
Deaths—residents only	184	8.7
Birth Registrations: Male, 147; Female, 118	265	12.6

INFANTILE MORTALITY—	May, 1936	May, 1935
Deaths under one year of age	5	6
Death rate—per 1,000 births	18.9	18.8
Stillbirths (not included in above)	5	3

CASES OF COMMUNICABLE DISEASES REPORTED IN THE CITY

	April, 1936		May, 1936		June 1st to 15th, 1936	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
Smallpox	0	0	0	0	0	0
Scarlet Fever	31	0	33	0	11	0
Diphtheria	0	0	0	0	0	0
Chicken Pox	64	0	57	0	28	0
Measles	31	0	17	0	1	0
Rubella	2422	0	1580	0	202	0
Mumps	243	0	224	0	114	0
Whooping Cough	15	0	23	0	38	0
Typhoid Fever	1	0	0	0	0	0
Undulant Fever	0	0	0	0	1	0
Poliomyelitis	0	0	0	0	0	0
Tuberculosis	28	10	40	20	26	--
Meningitis (Epidemic)	0	0	0	0	0	0
Erysipelas	7	0	4	0	2	0
Encephalitis Lethargica	0	0	0	0	0	0
Paratyphoid Fever	0	0	0	0	0	0

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TENTATIVE PROGRAMME
FOR
SUMMER SCHOOL

September 8, 9, 10 and 11, 1936

1. DR. GORDON B. NEW—*Prof. Oto-Laryn. and Rhin., Dept. Oral and Plastic Surgery, Mayo Clinic, Rochester, Minn.*
   - Malignant diseases of the mouth and accessory structures.
   - Tumours of the neck.
   - Reconstructive surgery of the face.
   - Tumours of the larynx.

2. DR. EVARTS A. GRAHAM—*Prof. of Surg., Washington University, St. Louis, Mo.*
   - Two lectures on Thoracic Surgery.
   - Certain phases of gallbladder disease.
   - Surgery of the pancreas.

3. DR. J. MCF. BERGLAND—*Lecturer of Clin. Obstet., Johns Hopkins Hospital, Baltimore, Md.*
   - Accidental complications of pregnancy.
   - Direct complications of pregnancy.
   - Relief of pain.
   - Puerperal infection.

4. DR. ROLLIN T. WOODYATT—*Prof. of Clin. Med., Rush Medical College, University of Chicago, Chicago, Ill.*
   - Diabetic coma.
   - Diabetes with intercurrent conditions.
   - Newer preparations of protamine insulin and their uses.
   - Treatment of nephritis.

5. DR. IRVINE MCQUARRIE—*Prof. of Pædiatrics, University of Minnesota, Minneapolis, Minn.*
   - The pathogenesis and treatment of œdema.
   - Clinical significance of the basic minerals of the body.
   - Special roles of fats and fat-like substances in health and disease.
   - The mechanisms and treatment of various convulsive disorders of childhood.

6. DR. C. B. FARRAR—*Prof. of Psychiatry, University of Toronto, Toronto.*
   - Evolution of delusion.
   - Psychoneuroses and psychotherapy.
   - Differentiation of benign and malignant symptoms in incipient mental disorders.

7. DR. C. E. DOLMAN—*Acting Prof. of Bacteriology and director of Connaught Laboratories, University of British Columbia, Vancouver, B. C.*
   - Undulant fever.

EDITOR'S PAGE

The recent Convention Week at Victoria has given us much to think about. The *raison d'etre* of the meeting was, of course, the Canadian Medical Association meeting in annual conclave. The choice of Victoria, and therefore British Columbia, as the place of meeting was a particularly wise one at the present juncture.

Among the topics discussed was that of amalgamation of the provincial with the Federal Association. One member of Council spoke very wisely and well when he said that what we should think of is not amalgamation of the provincial associations, but amalgamation of all the medical men in Canada into a coherent whole.

This is the true note to strike: these are the terms in which we should enunciate the problem which we have to solve. We hear too much and too often about the British North America Act, the autonomy of the provinces, the "impossibility" of a national conception of medical matters, till the defeatist element amongst us begins slowly, and almost in spite of us, to gain a hearing for its policy of *laissez faire,* of individualism, of provincial handling of problems, rather than a national policy to which we as medical men could subscribe.

We confess that this to us is all unnecessary, and we cannot accept these views. There is an old Zulu proverb, Rider Haggard tells us, "If we go forward we die; if we go backward we die; better to go forward and die", and the words attributed to Marshal Joffre on the Marne follow the same idea.

We are too prone to fear the "big battalions." But history, if we read it aright, will give us hope, and a test. Are we right? Are our motives sincere and just? Are we truly anxious to serve, and to give to the sick the best there is? Then we need have no fear. Reaction, timeserving, political expediency, may make us smart for a while, and possibly we deserve the smart, because we failed somewhere in our duty, but they will not last.

Canada is suffering very badly through the lack of vision of those who made of her a collection of provinces, rather than a nation. But many Canadians have seen this. There are still many thousands "who have not bowed the knee to Baal." And after all, nothing is irrevocable in nation-making. We may still retrace our steps; there may yet be a Moses to lead us out of Egypt, and who knows but what the medical profession may be that Moses?

We need not forever be bound by shackles imposed by our forefathers—We can surely think as Canadians, and perhaps medical men can do so more easily than any other group of men, since there are no provincial barriers in our business. We have had men in our ranks who could see and think nationally, and the Dominion Medical Act is one of their accomplishments. But this must not be thought of as more than the first step.

One hears occasionally a sort of threat expressed that we in the province may seek to go back to our former autonomy if things do not go our way. What sort of solution would this be? and what sort of policy of despair would this be? No, that would never solve our problems—it would simply commit us to the harmless nullity of the isolated unit, useless alike to ourselves and to the community at large.

We have two main objects of which we must never lose sight. The ultimate goal of our endeavour must be national solidarity—a welding of the whole profession.

The immediate goal must be strong units. Ontario has shewn us the

way. The address of Dr. Colbeck of that province on Tuesday night before the B. C. Medical Association deserves to be writ in letters of gold. It was not merely a fighting speech, though it was that too. It was a record of achievements—honourable and constructive—helpful not only to the profession to whose undying credit this achievement stands for a monument, but bringing, too, a real contribution to the solution of the difficult problem that faces governments and medical profession and the people of low income all equally—the problem, as Dr. Peebles put it in a speech, of bridging over the gap between the people who need medical attention, but cannot afford it, and the people who can give it.

This work in Ontario gives the greatest hope we have yet been able to see of bringing about a *rapprochement* between these two elements. It was made possible because the medical profession and the government got together in good will and sincerity, and each side worked honestly and generously to exhaust every possible means of solution. They not only succeeded, but they have started together on a road that is becoming clearer and clearer, and is leading them to a solution of other problems affecting the indigent and the unfortunates on our doorstep.

We have a situation confronting us, too, and we may well take a lesson from Ontario, and so strengthen and weld together our medical men in British Columbia as the Ontario Medical Association has done theirs. Then, as each province swings into line, active and virile and united, we can hope for a greater measure of success than ever, in our efforts at creating a truly Canadian medical body, composed of strong memberships.

Dr. Colbeck shewed us again what we must go on repeating till we all master the lesson—that strong local units, handling their own situations, disciplining their own men, solving their problems themselves, will alone form the nucleus of strong provincial units, which again will form a national unit. But we must derive our strength, and seek for the source of that strength, not from the centre to the circumference, but in the other direction. The units must be strong if the whole is to have enduring stability.

NEWS AND NOTES

Dr. Arbuckle's son "Billy" accompanied Dr. and Mrs. Spohn and their son to Europe. The two young men will visit in Leningrad as well as Vienna.

* * * *

Dr. Bagnall's son, who is on his way home for the summer, won first class honours in his fifth year Medicine at the University of Toronto.

* * * *

A son was born to Dr. and Mrs. A. B. Manson on June 23rd.

* * * *

We announce the marriage recently of Dr. Fraser Murray, at St. Paul's Church. Dr. and Mrs. Murray left immediately after the ceremony for a ten days' honeymoon.

* * * *

Dr. S. G. Elliott has returned from a trip to the prairies.

* * * *

Word has been received from Dr. Ethlyn Trapp that she is at present in Austria.

* * * *

Dr. C. E. Brown has returned from a five weeks' trip to the East, during

which time he attended the annual meeting of the Ontario Medical Association.

* * * *

The Summer School Programme is practically complete and sounds most interesting and varied. Owing to a serious operation Dr. McKim Marriott has found it impossible to keep his engagement with the Summer School Committee, but at his suggestion Dr. Irvine McQuarrie, Professor of Pædiatrics of the University of Minnesota, Minneapolis, was invited, and has accepted. Dr. Marriott has assured the Committee that Dr. McQuarrie is a brilliant speaker, and has done some very outstanding work in recent years. The list of topics on which he will speak sounds very stimulating.

* * * *

The profession in British Columbia congratulates itself on the election of Dr. H. H. Milburn to the Executive Committee of the Canadian Medical Association. All who know Harry will agree that British Columbia will have a voice in the proceedings of that central body.

LIBRARY HOURS DURING JULY AND AUGUST

During the months of July and August the Librarian will be on duty until five o'clock p.m. Monday to Friday and until one p.m. on Saturdays.

RECENT ADDITIONS TO THE LIBRARY

Medical Clinics of North America—Chaicago number, January, 1936.
Medical Clinics of North America—Boston number, March, 1936.
Medical Clinics of North America—Cleveland number, May, 1936.
Surgical Clinics of North America—Chicago number, February, 1936.
Surgical Clinics of North America—Philadelphia number, April, 1936.
Trans. Amer. Ophthalmological Society, 1936.
Trans. Ophthalmological Society of United Kingdom, 1936.
Trans. A. M. A. Section on Ophthalmology, 1936.
Trans. 41st Meeting Amer. Laryn., Rhin. and Oto. Society, 1935.
Trans. A. M. A. Section on Laryngology, Otology and Rhinology, 1935.
SUTTON, R. L.—Diseases of the Skin. 9th ed., 1936.
THOMPSON-WALKER—Genito-Urinary Surgery. 2nd ed., 1936.
WIENER, A. S.—Blood Groups and Blood Transfusion. 1935.
LANDSTEINER, K.—Specificity of Serological Reactions. 1936.
Medical Annual, 1936.
BEAUMONT AND DODDS—Recent Advances in Medicine. 1936.
DORLAND, W. A. N.—Illustrated Medical Dictionary. 17th ed., 1936.

CONVENTION NEWS AND NOTES

The sixty-seventh annual meeting of the Canadian Medical Association, held in Victoria during June, has now taken its place as one of the happiest and most enjoyable in the history of our medical fraternity.

From the point of view of numbers, it was a success. To date we are not sure of the exact number, but it was very large. All hotels were crammed to bursting, and the Empress Hotel alone could easily have filled quite a large annex, say, something the size of Gerry McGeer's new City Hall, or Bill Hatfield's less pretentious pile, which, we understand, will make possible new and rapid strides towards the goal of a T.B.-free province.

Be this as it may, we merely record the fact that Victoria hotels were very busy.

From the point of view of the weather, again we must give a hundred per cent marks. Victoria is a delightful city at all times; occasionally, it is true, the effeminate and crapulous Vancouverite wishes there was not quite so much wind there between the months of January and December, but that is not to say that the wind always blows. Last week was one of the weeks when it did not blow, and the sun was gorgeous. The flowers in Victoria must be seen to be believed, and were at their very best during the week—so that scnt and colour and beauty rioted before us.

Socially, it was a success. The people of Victoria do things as they should be done, and when they play the host, they play it to perfection. Everything was open to our members, and the friendly, kindly hospitality of many of the lovely homes of the city will leave a lasting memory of pleasant enjoyment.

Those who played golf, too (and who does not?), found many opportunities to keep the head down, and follow through.

Nor must we forget the private view of the Schmeling-Louis fight, so kindly shewn at a private view by the Dominion Theatre. The interest of the many medical men who attended this at 8:15 on Tuesday morning was, of course, purely scientific, and does credit to them all—though there were occasionally regrettable expressions of an animation and enthusiasm to which the cold-blooded man of science does not often give vent.

Nor must we forget the *mise-en-scene* of the convention. The Empress Hotel is eminently suited for such a gathering, since it has large space and comfortable chairs, and quiet places.

The exhibits were excellently arranged, and very well worth seeing.

But most important of all was the fact that a great deal of very good work, from the point of view of our profession, was done at this meeting. Real progress has been made towards greater unity—frank speech and frank explanation have led to the removal of a good deal of misunderstanding and will make for a better and clearer atmosphere.

The problems of each province vary to some extent, of course, with local conditions; but on the whole, they are the same for all, and one of the greatest benefits to be derived (and it was derived) from such a gathering as this, is the interchange of experience and ideas that takes place. We learnt much from our brethren from other provinces. We saw where they had been given problems to solve, and situations to meet, and we saw that they had gone a long way to meeting and solving their difficulties, and we found that their difficulties and ours were really the same. So we are very grateful for the chance to learn—and we believe that this meeting will be of inestimable help to us all.

* * * *

One of the outstanding features of this convention has been the excellence of the newspaper reporting. All the papers of Vancouver and Victoria have earned our gratitude and thanks by the manner in which they dealt with meetings and by the almost uncanny accuracy of their reports. Usually newspaper reports on medical topics suffer, as one must naturally expect, from the highly technical nature of the subject matter, and while we may find an element of the ludicrous in some of these accounts, we should probably make a worse hash of reporting, say, the annual transactions of the Royal Society of Canada. But the reports were good, and one is more and more impressed these days by the excellent technique of the newspaper men. Their creations have a span of life comparable to that of the butterfly for

shortness, and must scintillate and be as gaily attractive as is that flippant insect; yet they must be accurate, to the point, readable, and capable of assimilation by the most mediocre intellect.

* * * *

The first day of the session was sacred to the Canadian Medical Association Council meetings, and a long list of reports of Committees was dealt with, extending over to Tuesday morning and afternoon. Tuesday was the birthday of His Majesty King Edward VIII, our gracious Patron and beloved King, and a telegram of loyal congratulation was sent to him.

Some of the reports were of special interest, notably that of Dr. D. A. Stewart on the work of the Committee on Ethics. For many years the report of this Committee consisted of a paragraph the size of a want ad inserted by a penurious and poverty-stricken Scotchman—this year's report was a joy to read. It is interesting and one of the pleasures of life to see the wheels go round, and to learn how things are made. Through a fortunate error (if indeed it is an error, and not an assist) on the part of our General Secretary, the working notes, the rough sketches, of the Committee were included with the report—and one could hear the asides and the *obiter dicta* of the Chairman, whose mind is of the Osler type, always questing and gathering and shedding as it goes, out of its brimming hands, precious bits of knowledge, sheaves which one who follows him on his road of enquiry may glean. We all mourn that Dr. Stewart was too ill to come himself, but the latest news from his bedside is good.

Every session must have its key-subject—its most important question for solution—and at this one, the really important issue was Medical Economics. The relations of the medical profession *inter se*, and above all, the question of closer relations between the provincial associations, were given a thorough discussion.

There is nothing gained by trying to deceive oneself—"kidding oneself" in the slang and most expressive phrase. There is, in each province, in each district, in each local medical society, an element which is the real obstacle to unity and progress in our growth as an organised body. By direct attack, by innuendo, by inertia, by sneers, and by logical appeal to the letter of the law, these men present constantly the negative and reactionary side of the picture. They have stock arguments: "it has never been done" :"medical men can't stick together": "the provinces have complete autonomy": "ours is too individual a profession" and so on, and so on, *ad nauseam*. Their appeal is to the lazy good-for-nothing, selfish side of our nature—and so it is a very successful appeal all too often. Theirs is the philosophy of Swinburne in his poem:

> I thank whatever gods there be
> That no man lives for ever,
> That dead men rise up never,
> That even the weariest river
> Winds somewhere safe to sea.

And of the Preacher, "Vanity of vanities, all is vanity."

These men make hard the way of Executive Secretaries, and of enthusiastic Presidents, and of the self-sacrificing workers in the hive. But, praise be to Allah, the negative never wins. "The world *do* move" and carries along with it these drones as well. And when it gets there, they are generally in front, Cassandra-like, prophesying disaster and failure at the next move.

Well, we made progress. A unanimous recommendation went forward

urging the Executive to appoint a full-time man to speed up the organisation of the profession from coast to coast, and the principle of closer union was reaffirmed.

* * * *

Tuesday afternoon and evening were given over to the B. C. Medical Association and the Council of the B. C. College of Physicians and Surgeons.

* * * *

In the afternoon, Dr. H. H. Milburn, who has been one of the keenest, most hard-working and most efficient Presidents the B. C. Medical has ever had, presided at a meeting which was a most significant one. The usual rather placid, report-accepting, mutually congratulatory sort of meeting was replaced by one where a lot of good work was done, and a number of excellent steps taken towards increasing the quality of our work.

* * * *

The Auditor's Report shewed a satisfactory balance. There was, however, a curtailment of expenses for tours, and the President asked for expressions of opinion as to the value and acceptability of these tours. The response from various members left no doubt in our minds that these tours are quite vitally important to the profession in areas outside the big cities. We take liberty to think that they are just as valuable to the bigger cities too.

* * * *

Dr. Strong read the report on Constitution and Bylaws. This brought up the question of incorporation, under the Societies Act, of the B. C. Medical Association.

Last year, the Executive was instructed to go ahead with steps towards bringing about the amalgamation of the provincial association with the Canadian Medical Association.

Dr. Strong explained that many things had come up which had led the Executive to the decision that delay was advisable.

First, we had been informed by our legal advisor that the loose voluntary organisation which is the B. C. Medical Association has no legal status, and could not amalgamate as desired. Before this could be done, we must incorporate as a definite organisation under the Societies Act. This will give us officials, a definite organisation, and will limit and define our liability in financial matters.

He made it clear that such incorporation in no way commits us to an amalgamation, but is in itself a necessary step.

Next, events of the past year have made it seem wiser that a clearer understanding as to the rights and duties of both parties to the negotiations should be reached. It was felt that a number of rather vague idealistic generalities should be brought down to a practical, clearly defined, categorical basis.

Again, legislation as regards Health Insurance occupied the forefront of our attention, and since any changes in status involved opening the Medical Act, it was felt to be wiser not to do this at present.

The meeting authorised the Executive to take immediate steps towards incorporation.

Dr. Colin Graham read the report of the Programme and Budget Committee. An innovation this year is the payment of the expenses of the delegates from other parts, when they attend executive meetings. Out-of-pocket expenses alone are paid, but the meeting agreed with the Executive

that this was a good step to take, and added greatly to the value of executive meetings.

* * * *

The Committee on Economics reported through Dr. A. W. Hunter.

In the discussion of the report of the Committee on Public Health, two questions of major importance were brought up.

1. *Codeine.*—Letters were read from the Chief of Police of Vancouver, the City Prosecutor, and Magistrate Wood, stressing emphatically the genuineness of the menace which codeine is to health and well being of the community. The facts adduced are shocking beyond words; the prevalence, and steady growth, of the codeine habit, the degradation caused by it, the crimes, especially theft, committed by those who feel the urge of this drug; the threat to the younger people—all these points were brought out.

The following resolution was passed, and ordered sent to the proper

"That this Association go on record as of the opinion that Codeine is a habit-forming drug, of the same nature as morphine, heroin and similar derivatives of opium, and that it should be placed on the list of prohibited drugs as defined by the Narcotic Drugs Act of Canada, and should be subject to the same restrictions as regards manufacture, sale and dispensing."

2. *Milk.*—Here again a very important threat to our infant and child welfare lies in the continual discharge by interested parties of most vicious propaganda directed against the pasteurization of milk. Evidence was adduced shewing that direct untruths are broadcast, that this is being done by smaller, less reputable dairies, seeking to evade the cost of proper pasteurising machinery and peddling improperly safeguarded raw milk to an uninformed public.

INTERNAL DERANGEMENT OF THE KNEE JOINT

By J. R. Naden, M.D.

Read before the Osler Club, May 27, 1936.

The knee joint is the largest joint in the body, and it derives its great strength from the powerful ligaments that units the two component bones and especially to the muscles and fasciæ that surround it. It derives no strength from the shape of the articular surfaces; since they are merely placed in contact with one another, for in no position of the joint is there ever more than a small area of the femur in contact with the tibia, the semilunar cartilages intervening.

The lateral ligaments are comparatively feeble, are tense in extension and slightly relaxed in flexion. The internal lateral ligament is a flat band which is attached above to the inner side of the internal condyle of the femur, just below the adductor tubercle, or about an inch above the articular margin. Passing downwards and a little forwards, it is inserted into the inner side of the head of the tibia and into the shaft immediately below. As it crosses the joint, its deeper fibres gain a firm attachment to the upper border of the internal semilunar cartilage. Elsewhere, the connection of the internal lateral ligament to the deeper parts is by loose areolar tissue.

The external lateral ligament is a round cord-like structure attached above to the outer side of the external condyle of the femur, and below to

the head of the fibula just in front of its apex. It stands well away from the joint, crossing the tendon of the popliteus on the side of the femoral condyle, and splitting the tendon of the biceps muscle at its insertion into the head of the fibula. It has no direct attachment to the external cartilage.

The crucial ligaments are two in number and extend from the intercondylar notch of the femur to the upper surface of the tibia. They are about the thickness of a pencil and are intracapsular but extrasynovial. The anterior crucial is attached to the depression in front of the spine of the tibia, being blended with the anterior extremity of the external semilunar cartilage. It passes obliquely backwards, upwards and outwards to be inserted into the inner and posterior part of the outer condyle of the femur.

The semilunar cartilages are two fibrocartilaginous discs which are interposed between the condyles of the femur and the head of the tibia. They are deficient centrally, where each forms a thin free concave edge directed towards the centre of the joint, and they are thick towards the circumference of the joint, where they are attached for the most part loosely to the capsule. The extremities or horns of the semilunar cartilages are attached to the head of the tibia in the middle line between the articular surfaces. The horns of the external cartilage are attached close together, the anterior immediately in front of the tibial spine, the posterior to its summit, and it should be noted that these attachments are close to the axis of rotation of the tibia, so that the fixed portions of the external cartilage move very little during rotary movements of the leg.

The horns of the internal semilunar cartilage are attached further apart, the anterior horn being attached to the rough area at the head of the tibia in front of the anterior crucial ligament, while the posterior horn is attached behind the tibial spine immediately in front of the posterior crucial ligament. It should be noted particularly that the attachment of the anterior horn is at some distance from the axis of rotation of the tibia, so that its excursion is appreciable during movements of the leg.

It is very important to discuss the normal physiology of the knee joint. The knee is not well adapted to rotation strains. There is little mechanism apart from the quadraceps which prevents rotation until the knee is locked in full extension. The muscles are the first line of defence against strain, and it is only when the first line breaks down that strain of the ligaments comes into play.

Stability of the knee-joint in the lateral direction is secured by the lateral and crucial ligaments which retain the broad condyles of the femur in contact with the head of the tibia in all positions of the joint. In the normal adult knee no appreciable lateral motion is possible without sprain or rupture of one of the lateral ligaments.

Stability in the antero-posterior direction is secured by the crucial ligaments, which prevent forward or backward displacement of the head of the tibia, and by postural muscles of the thigh, which regulate the normal movements of flexion and extension. In all natural standing attitudes the knee-joint is slightly bent, as anyone may observe for himself on his own knee. From this attitude of ease the knee may be thrust into full extension by an effort; but this is unnatural, and fatiguing. The quadraceps is the great postural muscle of the thigh; by its reflex contraction it takes up the strain of the body-weight and prevents the knee from bending, both in standing and in all other active uses of the limb. Conversely, weakness or "insufficiency" of the quadraceps is a frequent cause of "giving way" or insecurity of the knee after injuries or diseases of the joint, which lead to a loss of tone and wasting of the muscles. Hyperextension ordinarily is pre-

vented by the hamstring muscles which, acting in conjunction or reciprocally with the quadraceps, maintain the desired position of the joint at any moment. Only paralytics achieve stability by hyperextension of the knee so that tension is thrown on the posterior ligaments of the joint.

Stability with respect to rotatory movements of the leg is just as important as that in other directions. Rotation of the tibia beneath the femoral condyles is a normal movement of appreciable extent, and, while it is limited anatomically by passive structures, it is controlled physiologically, like other movements, by muscular action. External rotation of the tibia (or internal rotation of the femur) is controlled, i.e., prevented by the popliteus muscle and by the semitendinosus, gracilis and the sartorius. Internal rotation of the tibia is controlled, when the knee is flexed, by the biceps.

The movements which occur at the knee-joint are flexion, extension, and rotation of the head of the tibia upon the condyles of the femur or of the condyles of the femur upon the tibia, as the case may be.

Flexion and extension occur between the condyles of the femur and the upper surfaces of the semilunar cartilages. During these movements the semilunar cartilages (with, of course, the head of the tibia) glide round the inferior surfaces of the condyles of the femur in an anteroposterior direction. Flexion is limited by contact between the leg and the thigh. Extension is limited automatically by tension of the posterior, lateral and the anterior crucial ligaments, and in the absence of muscular control, violent hyperextension of the knee is likely to produce sprain or rupture of the last named structure (Ant. crucial).

Rotation occurs between the head of the tibia and the under surface of the semilunar cartilages. But this movement is possible only when the knee is bent, because in this position the ligaments are relaxed, whereas, when the knee is straight, the ligaments are tense and rotation of the tibia is prevented. Rotation is greatest when the joint is flexed to about a right angle, being then possible through a range of about 36 degrees.

The anterior crucial ligament limits extension in part, prevents forward displacement of the tibia and rotation inwards of the leg. The posterior crucial ligament resists extreme flexion and displacement backwards of the tibia.

There are three main types of injury to the knee, which are distinct as regards mechanism and which are seldom combined:

1. *Lateral strain,* when force is applied to adduct the knee or abduct the leg, resulting in a simple strain of the internal lateral ligaments or rupture of the femoral attachments of the ligament; more rarely there is an injury of the external lateral ligament due to an abduction of the knee or a forced adduction of the leg.
2. *Rotation strain,* when the weight is borne on the limb with a resulting injury to the cartilage, or when there is no direct transmission of weight through the joint a resulting damage to the coronary or other attachment of the cartilage.
3. *Hyperextension strain,* resulting in a tear of the anterior crucial ligament or an evulsion fracture of the tibial spine.

The commonest cause of internal derangement of the knee joint is injury to the internal semilunar cartilage.

The relative frequency of the injury to the internal semi-lunar cartilage as opposed to the external is explained by the mechanism of the injury. The external cartilage is more likely to escape the grinding force of the femur for two reasons. In the first place, it is less fixed and the coronary ligament allows freer excursion of the cartilage, both because of its great length and

because of the gap which occurs posteriorly in connection with the tendon of the popliteus. The second factor which saves the external cartilage is its shape. It is a circular ring, accommodating the external condyle of the femur and it is better adapted for rotation than is the less circular internal cartilage. There is less likelihood of damage to the external cartilage because it does not have to accommodate itself to the so-called gliding movement which the internal femoral condyle makes in full extension, for it is the pivot around which this movement takes place.

When the knee is bent, and the femur is forcibly rotated inwards upon the tibia—as when the foot is fixed upon the ground, and the body swings inwards towards the midline—the tibia (relatively) rotates outwards beneath the semilunar cartilage as far as it will go. A state of tension then arises, and, if the force continues, something has to give way. On the inner side, where the movement is greatest, the anterior horn of the internal cartilage is carried forwards and inwards, and the tibia then tries to drag it forward from beneath the condyle of the femur. But the posterior end of the cartilage is held back, partly by its attachment to the internal lateral ligament and partly by the close contact between the femoral condyle and the head of the tibia. So that a great longitudinal strain is thrown upon the cartilage, the anterior end of which is carried forwards, while its posterior end is held back.

Now, it is obvious that the effect of such a strain upon a curved structure, such as the semilunar cartilage, will be to straighten out the curve, and, when the cartilage is suddenly straightened by a longitudinal stretching force, it is often torn from its peripheral attachment to the capsule, and pulled in towards the centre of the joint, where it is liable to become caught between the condyle of the femur and the tibia. This is the familiar "bucket-handle" detachment of the internal semilunar cartilage. Other types of cartilage injury may be produced by the same stretching force. Even more common than the "bucket-handle" is detachment of the anterior horn of the cartilage, which is pulled off from the head of the tibia, with more or less detachment of the cartilage behind it. Again the cartilage may be torn transversely somewhere about its middle or at the junction of the more moveable anterior two-thirds with the more fixed posterior third. Lastly but much less often, the posterior horn may be pulled forwards between the condyle and the head of the tibia.

All these different types of injury to the internal cartilage are produced by forcible internal rotation of the femur upon the fixed tibia, when the knee is more or less bent, and they give rise to a characteristic train of symptoms.

The history of a patient with a torn internal semilunar cartilage is usually characteristic. There is an injury to the knee when there is weight bearing with an inward twist accompanied by an acute pain on the inner side of the knee with "locking," that is, the knee is fixed in a partly bent position. There is usually persistent pain with inability to straighten the knee; or often to move the knee at all on account of the severe pain. There is an effusion into the joint almost immediately. Pain and tenderness are usually referred to the inner side of the joint particularly in front, in the angle formed by the inner condyle of the femur and the head of the tibia, or further back along the joint line. If there is not immediate "unlocking" of the joint, the injury is followed by atrophy of the quadraceps, especially the vastus internus, with loss of muscle tone. The very typical unlocking is even more characteristic than the locking.

Any of the types of injuries to the cartilage as previously described may

have occurred. If the injury has been of the "buckethandle" variety, when the joint is unlocked, or "reduced," the cartilage is always further displaced towards the centre of the joint where it lies in the intercondylar notch. If it has been the anterior portion of the cartilage involved it will be possible to release the imprisoned end and it will nearly always remain free in the anterior part of the joint.

It is almost an axiom, "once a torn cartilage, always a torn catrilage." A semilunar cartilage once torn and displaced will nearly always give rise to further trouble sooner or later, either in the form of recurrent displacement or locking, or in setting up of osteoarthritic changes.

There is usually little difficulty in arriving at a correct diagnosis of a recurrent displacement when an accurate history is obtained of a previous injury and of repeated times when the joint has given way or has locked. Usually the patients have methods of their own for reducing the displaced cartilage.

Dislocation of the external semilunar cartilage is much less common than injury to the internal cartilage. The history is not usually clear cut and it is often difficult for the patient to accurately interpret his symptoms, as frequently there is a feeling of pain over the outer side of the knee when there is an injury to the internal cartilage. The relative frequency of injury to the internal semilunar cartilage compared with injury to the external is roughly six to one.

Cysts of the semilunar cartilages may give symptoms very similar to those of injury to the semilunar cartilages with laceration, but there is no locking, and there is usually an area of elastic tenderness over the cartilage. Cysts are much more common in the external cartilage than the internal, the ratio being roughly four to one. In a large percentage of patients there is a history of trauma which is more often that of a blow than a twist or strain.

Rupture of the crucial ligaments and fracture of the tibial spine will be discussed together on account of their frequent association. The two conditions may be associated or either may exist alone. If after an injury of the knee the tibia can be displaced backward or forward or rotated inward in the extended position, an injury of one or both crucial ligaments may be diagnosed. If in the extended position the tibia cannot be displaced forward it may be assumed that the anterior crucial ligament is not torn across. If in full flexion the tibia cannot be displaced backward, the posterior ligament is presumably not ruptured. The history of injury is very important, as similar findings may be demonstrated after long standing effusion into the joint, Carcot's disease, and in locomotor ataxia.

Avulsion of the tibial spine or its internal tuberosity is produced by violent tension on the anterior crucial ligament, a mechanism similar to that which produces rupture of the crucial ligaments.

It is believed by some authorities that the anterior crucial ligament is not a vitally necessary structure, and that its loss is thoroughly compatible with relatively normal function of the knee; and that the disability is due primarily to the loss of the integrity of the internal lateral ligament.

It is only with some difficulty at times that it is possible to differentiate between a torn cartilage and a loose body in the joint. Very often the patient has been able to localize the loose fragment. It is important to take an x-ray in all patients with joint injuries.

With a loose body there is usually true locking but lasting only a moment and releasing on any movement, and the pain on locking is referred to different parts of the joint on different occasions.

The condition of osteochondritis dissecans can usually be determined by a careful examination of the x-ray plates, the loose body having a smooth and a rough surface, and it is almost always possible to determine the bed from which the fragment has come, the position being most often on the outer (lateral) side of the internal condyle of the femur, near the attachment of the posterior crucial ligament. Two cases have been described lately; one with bilateral osteochondritis dissecans of the patella, and the other with involvement of one side only.

Hypertrophy of the infrapatellar fat pad will often give rise to symptoms referable to the the front of the knee joint, especially beneath the patella. These patients will most often complain of pain below the patella when they are going up or down stairs, the pain being most severe when the weight is taken on the affected leg with the knee slightly flexed, and on examination there is usually some increased thickening about the fat pad with some tenderness on pressure. In the later stages of fat pad congestion it is often difficult to differentiate between a fat pad and a cartilage injury, but there is no limitation of movement or locking.

Synovial chrondromatosis will often fill the joint space with multiple loose bodies, and may be secondary to osteoarthritis.

Osteoarthritis involving a knee joint will often simulate a joint with injury to the cartilages. In these cases the history is very important; there is no history of sudden injury with locking and the characteristic unlocking; there will often be limitation of full extension, with pain at the extremes, but under appropriate treatment the knee will extend fully. Along with the history, there is usually synovial thickening with some local heat and local tenderness not confined to the line of the semilunar cartilages.

A discoid semilunar cartilage will give indefinite symptoms of internal derangement, the onset often being in childhood. The differential diagnosis has not included dislocation of the knee or recurring dislocation of the patella, as these obviously do not complicate the picture.

The remaining condition which will be briefly mentioned is chronic knee sprain. The common knee sprain of the upper attachment of the internal ligament is caused, not by internal rotation of the femur but by forced abduction of the leg. The injury is caused by the same force acting but without the same degree of severity that would if carried through cause a tear of the cartilage from its attachment. The symptoms caused by this condition are very like those of actual injury to the semilunar cartilage, but usually milder in degree and always without the characteristic locking, which is almost pathognomonic of a displaced cartilage.

A very few words about treatment. Our opinion is that displaced and torn semilunar cartilages should be completely removed. Loose bodies should be removed. Rupture of the crucial ligaments should be repaired if giving severe symptoms, and the lateral ligaments repaired at the same time. Avulsed tibial spines should be replaced if possible or removed. Hypertrophy of the infra-patellar fat pad should be treated conservatively by means of a reverse figure of eight bandage with the knee slightly flexed, for a number of weeks, and later surgical removal if not improved. With the cysts the cartilage should be completely removed.

In conclusion, our diagnosis is based on an accurate history, with knowledge of the mechanism of the joint, a careful and complete examination including x-rays, aided by our judgment founded on experience.

Our treatment is guided by our diagnosis.

Our results depend on an accurate diagnosis with appropriate treatment.

B. C. MEDICAL ASSOCIATION MEETING

The Annual Dinner of the B. C. Medical Association was held in the Ballroom of the Empress Hotel, Victoria, on Tuesday evening, June 23rd.

Dr. S. G. Kenning of Victoria presided, and had at the head table with him various distinguished-looking individuals, of various ages, and from various parts of Canada.

The guest speaker for the evening was Major Harold Brown, of Vancouver and British Columbia, managing director of the Union Steamship Co.

Some two hundred or two hundred and fifty medical men were there, and had a very pleasant dinner. Cocktails were served in the downstairs Lounge, evidently with a sort of idea of a process of exclusion, à la Gideon's army. Those fitted by nature or by self-control to survive, found their way upstairs. One cannot help but feel that there must be some sort of cumulative action about cocktails and their like, since certain large gentlemen, one well-known in Victoria and its suburb of Vancouver as a specialist (we forbear to mention the brand), and the other, we believe, a classmate of his 'way back in the gay nineties, shewed the effects for a long time. They circumnavigated the room two or three times, visiting each table in turn, and shewing the greatest affection for all their colleagues.

Major Brown's speech was the highlight of the evening. It was an unusual speech for a medical dinner. The speaker is well known to all who live in B. C., and to many elsewhere, as a delightful speaker, who is never content with generalities or platitudes, but thinks for himself, has thought long and deeply over many philosophical topics, and is always ready to give utterance to the faith that is in him.

His use of English is a delight to hear. He knows words and knows them as friends. He does not abuse his friends' confidence, nor tax their patience. He uses each word rightly and well, and has a wide acquaintance amongst them. So that, just as an effort of elocution, it was very well worth while to hear.

But there was much more to it than this. He sounded a deep note: he appealed to the thoughtful and responsible part of our makeup. He paid us, as medical men, the fine compliment of assuming that we have enough intelligence and honesty and good citizenship to lead us to respond to this appeal, for a sincere attitude towards conditions as they are, for an honest effort towards the solution of the huge problems that confront the world. After all, while his training and experience of life lead the doctor to shun the emotional and sentimental, and to suspect the wordy efflux from these elements in the mind of man, still he can understand and respond to the appeal to his idealism and the deep sense of the transcendental, almost the mysticism, that perpetual contact with the great realities of birth, life and death must engender in us. And Major Brown sounded this note of appeal. He reminded us that while we sat in ease and with all our æsthetic appetites catered to, the world was crashing about our ears. That our seeming security and peace are on this side of a curtain, which may go up at any moment, and reveal the stark horror of chaos behind. That this curtain, hitherto, has remained unlifted is due not to us, but to the efforts throughout the ages of a select few whose minds and souls have been in tune with the great spiritual realities of the universe.

We have the brains, and the courage, and the ability, said the speaker, to discover and apply the solution, and check the disintegration that is going on. What we lack is spiritual leadership, and a willingness to assume that leadership when we realise that we should do so.

We must, he went on, in some way reach and maintain our conviction with spiritual power. Too long we have left this to charlatans and quacks and false prophets, and have followed those who have held up only material things for us to grasp.

Major Brown's speech was relieved again and again by quips and humourous sallies, which kept it from any appearance of mere evangelism, or pietism: and we were very grateful to him for what was a very fine speech, finely delivered in beautiful language.

The election of officers followed, and the names of those elected follow:

President: Dr. G. F. Strong of Vancouver.

Vice-President and President-Elect: Dr. Gordon C. Kenning of Victoria.

Immediate Past President: Dr. H. H. Milburn of Vancouver.

Second Vice-President: Dr. D. E. H. Cleveland of Vancouver.

Hon. Secretary-Treasurer: Dr. J. R. Naden of Vancouver.

After this, the meeting changed into the third Annual Meeting of the B. C. College of Physicians and Surgeons.

The third Annual Meeting of the members of the College of Physicians and Surgeons of B. C. was held in the Ballroom of the Empress Hotel at 10 p.m. on Tuesday, June 23rd, 1936, with the President, Dr. Thos. McPherson, in the chair.

The meeting stood during the reading, by the Registrar, Dr. A. J. MacLachlan, of the list of those members of the College of Physicians and Surgeons who had been removed by death since the last meeting of the College.

The minutes of the last meeting, held Sept. 19th, 1935, were adopted as read.

Dr. Thos. McPherson spoke briefly, referring to the matter of medical care of indigents, and introduced Dr. Colbeck of Welland, Ontario, the President of the Ontario Medical Association, who addressed the meeting, dealing with the question of relief in the Province of Ontario.

Dr. Colbeck gave us the history of the negotiations, for long fruitless, between the Government of Ontario and the Ontario Medical Association.

Both under the Henry Government and the Hepburn Government, the task of administering relief and paying for medical attention on any sort of basis proved to be beyond the capacity of the governmental departments, and Mr. Henry and Mr. Croll, the present Minister of Health, alike threw up their hands.

The difficulty seemed to arise mainly from the presence amongst the members of the profession of what Dr. Colbeck called "till-tappers": though any bad name would do equally well. These men, constituting some 3 to 5 per cent of the profession, never more, are quite impervious to any appeal to their sense of honesty or generosity. These would seem to be atrophic or congenitally absent.

The Medical Association, however, persisted, and eventually were given one final chance. They must, within a week, present a scheme that would work. With fear and trembling the Association assumed the responsibility, and within a week evolved a scheme.

The money offered was 25 cents a month per indigent head: i.e., $3.00 a year.

The O. M. A. conceived the idea of centralising the administration of the money and decentralizing the control of medical bills.

Ontario is divided into 11 districts and these into 50 counties. In nearly all of these there are very active district or county societies. The county society became the disciplinary and assembling unit.

A central committee of three was appointed to deal with the Government, hear appeals, and be the final arbiter of accounts if disputed.

The idea was to pay bills out of the pool *pro rata*. Only office and house calls and maternity cases were paid for.

A meeting was held in Toronto to settle details, at a cost of $2000.

The result of all these was a very large measure of peace and success. Our of 35,000 accounts, only 50 were submitted to the central court of appeal, the local committees adjusting all others.

Then the O. M. A. made a further discovery. These fifty accounts were accompanied by tremendous noise and protest on the part of those whose bills they were, who resented bitterly any sort of dictation. Apparently, nobody was going to audit *their* bills except over their dead bodies. Again it meant too much uproar and confusion. So the central committee ceased to function as an appeal board, and these accounts were turned back to the local county society and their decision made final.

The delinquent doctor, the dishonest doctor, or the careless doctor, is henceforth judged by his peers, his immediate colleagues.

This has worked exceedingly well. Some 400,000 people have been cared for, and only *two* complaints in eighteen months have been made direct to the Minister of Health about doctors, as compared with a former steady stream of complaints. The very small number of doctors whose errors and wrongdoing were the direct cause of wrecking the whole scheme at first, are now controlled and rendered harmless by this plan.

The *cost of administration* is an important feature of this scheme.

In Great Britain, after 25 years of operation, Health Insurance administration costs are 14.6% of the whole.

In Ontario, 5.2% pays for the costs of a very similar scheme, *when the doctors themselves administer the money.*

The Government is exceedingly well pleased with the results, is co-operating willingly with the O. M. A., and it is unthinkable that any government would want to go back to government control, with its added cost and worry to itself.

This was for the indigent alone; however, what about the low income groups? In Windsor were men who had a real vision. They started in to evolve a method of medical treatment for low income people, they started research on costs of disease by age and groups. They put in a card index scheme, changed it four times as experience demanded, and eventually produced an excellent plan, with, as a by-product, a great result of statistics and figures which are of real value.

Mr. Wolfenden, a well-known actuary, was employed by the O. M. A. to check this, and reported that it was a very good, up-to-date scheme, with entirely new possibilities for actuarial study, which would provide figures and statistics which were of immense importance, but hitherto have been unobtainable.

These medical men spent $4000 of their own money in this study, and then presented the scheme to the O. M. A.

A voluntary Health Insurance scheme is now under way in different parts of the province.

Control is by the local societies, discipline is in their hands; they settle disputes, assemble taxed bills, and send them in to the Central Committee, which handles the money, sends out cheques, etc.

A great point in this is that it has not been done merely for dollars and cents. The money available was small: a mere pittance for the work done But the medical profession started out with the idea that, regardless of the

money, they would give a first-class medical service anyway, well-run along high ethical lines—and talk about money afterward.

What has been the result? A solidity and welding of the medical profession that has never before been attained, so that now the O. M. A. has the backing of almost every man in the province. It has *won the confidence* of these men, and now no man can afford to stay out.

It has won the confidence of the Government. It co-operates with the latter; they get together, and the Government accepts gladly the principle that the medical profession should manage its own affairs and dispense the money itself.

Excellent medical service has been provided. The financial returns are inadequate—but there is room for improvement, and the Government is coming to realise the need for this—and has sympathy with us in this.

Valuable information of all kinds is being obtained—information and statistics that will be of great value in future investigations.

An example has been set to the medical profession all over Canada—and the knowledge that the O. M. A. has painfully acquired is now available to all. This is one of the greatest contributions to national unity of our profession.

Dr. Colbeck advised us, as he closed, to exhaust every avenue of conciliation and co-operation before we gave up hope of obtaining satisfactory terms.

Dr. McPherson thanked Dr. Colbeck on behalf of the College of Physicians and Surgeons of B. C. for his excellent address.

Dr. MacLachlan then read the minutes of the last meeting of the College, held in Vancouver September 20th, 1935, which were adopted as read.

Dr. McPherson, the President, addressed the meeting. He said much had taken place in the past year, the most serious occurrence being that Dr. Ainley had been forced to resign as Chairman of the Health Insurance Committee owing to ill-health. His resignation was accepted on the condition that he remain on the Executive of the Council of the College. He (Dr. McPherson) had been appointed in his stead as Victoria was considered the pivotal point, and Dr. Wallace Wilson was appointed Vice-Chairman.

Dr. Wallace Wilson was called on to speak. He said he had very little to say, as the profession had been advised by mail. One or two facts he would like to emphasize; first, to play a waiting game. One or two meetings have been held with the Commission and they wish to co-operate. They realise that we hold the key. They do not know as yet the solution of the indigent problem, but the Premier has promised legislation, also Dr. Weir. He reminded the profession that it need not worry if it is organized. The Health Insurance Committee feels that all members should be considered and that the consent and approval of the medical men is needed.

Dr. R. W. Irving moved a vote of thanks to Dr. J. J. Gillis and Dr. W. H. Sutherland for the wonderful fight they had put up on behalf of the medical men. Seconded. Carried.

Dr. J. J. Gillis thanked the meeting on behalf of Dr. Sutherland and himself. He stressed the point that cohesion was everything as far as the medical profession was concerned. It must stand behind the Health Insurance Committee, as it is working for the best interests of the profession.

Dr. Kenning spoke of the proposed amendments to the Act. He explained that as the Government had made no move to revise the statutes it was considered unwise to open the act while the Health Insurance Bill

was under discussion. He stated that the following amendments were proposed:

1. The term of office to be for four years;
2. To change the boundaries of Electoral Districts;
3. To allow men who had been practising in the Province for forty years to remain on the register without payment of dues;
4. Necessary amendment if B. C. Medical Association becomes a branch of the Canadian Medical Association;
5. Sanctions authorized for the incorporation of the B. C. Medical Association.

Dr. Strong in presenting his report for the Constitution and By-laws Committee spoke of the proposed amalgamation with the Canadian Medical Association. He confirmed Dr. Kenning's report that it was considered inadvisable to open the Medical Act or to make any changes at the last meeting of the Legislature. He informed the meeting of the proposed incorporation of the B. C. Medical Association under the Societies Act.

Dr. S. C. MacEwen, speaking for the Economics Committee, reported that it was just starting to collect data in regard to contracts throughout the Province. He asked the men of the profession to co-operate and send in their reports, as the committee was working for their protection.

SOME NOTES FROM THE OFFICE OF OUR EXECUTIVE SECRETARY

Your Executive Secretary, Dr. M. W. Thomas, has visited Prince Rupert, Ocean Falls, and other points on the coast, as well as Lytton, Lillooet, Pioneer, Bralorne, Minto City, Williams Lake, Quesnel, Wells, Prince George, Vanderhoof, Fraser Lake, Burns Lake, Smithers and Ashcroft, returning in time for the Victoria meeting.

He returns from the tour and the meeting convinced that the profession in this Province is worthy of the best effort of those whose responsibility it is to render them service. On the Coast, the Bulkley Valley, the Omineca, the Cariboo, Bridge River and these other points, the men are giving to the people an efficient service, this being conducted against great handicaps in winter. Dr. Thomas found the men cheery and always optimistic in their splendid professional attitude.

They are 100% behind their elected authority, the B. C. Medical Council, and its Health Insurance Committee. This confidence is an inspiration and a challenge. The great problem at all points, outside of contract practice, was due to the scant remuneration for medical relief and the many difficulties surrounding this work and in obtaining recognition in sufficient measure. If the regularly employed moderate income groups, who present no urgent problem, are to be regimented under a Health Insurance scheme, some very definite plan must be evolved by the Government to provide medical care for those larger groups of unfortunates who create the real problem for the profession in this Province. The profession owes it to these pioneer practitioners in the outlying parts to see that their loyalty is reciprocated.

The Secretary found these men doing successfully all general work and enjoying the deserved confidence of the people.

The profession in the larger centres is asked to co-operate fully with the local doctor in all cases coming from the inland districts so that his status may be preserved. In some (rather many) instances he found that patients

returned with no reports and no communication of any kind bearing on the nature of the case or its subsequent care, and this had placed the local practitioner in an unenviable position and was an embarrassment to both patient and doctor, impairing efficiency and tending to destroy confidence, upsetting the relationship that means so much in practice.

The *bulwark of organization* lies in *service,* and it is the sincere desire of your Executive Secretary to see that this feature is progressively developed and asks the co-operation of every practitioner in this matter. *Service* will strengthen the organization and will cement the profession into one consolidated unit.

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Where municipalities are neglecting to recognize, even in a partial way, Medical Relief, the matter was discussed with the competent authority, notably in Prince Rupert and Prince George, and assurance of immediate action was obtained. If other organized communities are shifting their responsibilities to the shoulders of the willing doctor and accepting his past generosity as their right, Doctor Thomas is ready to assist any local group in presenting the request for recognition.

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One of the outstanding bright reflections of the Victoria meeting was the exhibition of loyalty to and appreciation of our profession by the many lay individuals and groups in Victoria and vicinity, as evidenced by the ready assistance in entertainment and transportation. This dignified meeting with its splendid programme impressed the whole community, as expressed in the editorial columns of the *Victoria Colonist*.

* * * *

Those members who have accounts for Provincial Relief cases are reminded that they should secure authority from the Government Agent or Disbursing Officer in their district, and that accounts showing work done should be rendered in triplicate and approved by the local authority before being forwarded to Dr. J. G. McCammon, Standard Bank Building, Vancouver. It is important that accounts be forwarded regularly at the first of each month. Much dissatisfaction and misunderstanding may be avoided.

Dr. McCammon would appreciate a personal visit from any member at any time.

* * * *

Accounts for those who should be classed as "Destitute, Poor and Sick," and distinct from Provincial Relief cases, are paid out of a separate fund and should be forwarded to Department of Welfare, Parliament Buildings, Victoria.

* * * *

There is being sent to every member a questionnaire, the completion of which will provide valuable information which will allow the Secretary to classify contracts into types and aid members to evaluate these services. Many contracts in this Province are neither satisfactory nor sufficiently remunerative, and it is felt that this can be remedied.

* * * *

Dr. F. D. Sinclair, who has practised in Cloverdale for twenty-five years, called on Dr. Thomas this week and had a choice reminiscence which will bear retailing.

While visiting a school on a tour of inspection, Dr. Sinclair found a class in session and listened-in as the teacher asked the children to define "a gentleman." One little girl was particularly vehement in her hand-waving

attempting to attract attention. The teacher wondered and said, "Well, Mary, what is a gentleman?" Mary, springing to her feet, shouted, "Doctor Drew."

There are many of us who think that Mary's illustrative reply was very aptly chosen.

DR. COLBECK ON HEALTH INSURANCE

The following is a brief report of Dr. Colbeck's speech at the meeting of the Council, Tuesday, June 23rd, 1936, at the Empress Hotel, 10:30 a.m.

I have been a student of this since 1912. I happened to be in England when Lloyd George brought in his scheme. I recently took out of old trunks copies of the *Times*, etc., which brought back forcibly the struggle in England with Lloyd George. Of course, we all know the outcome of that. We also realize that their problem is different rom our problem. We do know that their cost of administration, after all these years, is still 14.6%. It is amazing to me that it should still go on where distances are short.

In Ontario the Government were not very interested but they have now got to the point where they are really worried, because the taxpayer has come to the point where he is about at the breaking point. We find that the Government is becoming very anxious about overhead. We in the east have two sources of information through organized medicine. We are in very close touch with this Province. Even with these two sources and with Dr. Routley out here, our information was fragmentary until I got here. It is very easy for men to be misled by dispatches and press.

As I understand it, by devious routes, you have landed with a commission of four, whose business would be to gather in this money of 1% from employers and 2% from employees, taking in all up to $1800. They are to gather in the money and disburse it, and then propose to take in medical attention with specialties. I take it they are to take in and pay part of the drug supply and they are to pay the hospitals, and they are confronted now with the business of getting the money in and setting up the system of accounting. They have got to the point where they have to decide how they are going to do the field work.

It was the impression among a great many in the East, from the information we got, that the Government did not know where the costs would be; there was this minimum and maximum, there was this minimum of $4.50 for the doctors, but the Government did not have the faintest idea what it was going to cost.

In Toronto, where the Academy of Medicine will take over, they are working it out with the hospitals and doctors and will likely know very shortly now. The Academy of Medicine anticipates it will work out to about $13 for the doctors and $4.50 for the hospitals. Based on a $3.50 rate for the hospital per year and hospitalization, is paying three days per patient per year. They had brought it up to $4.55. The average across Ontario is three days.

In Ontario the medical profession obtains the money from the Government. From 240 municipalities we centralize the money and decentralize the administration. Both the Conservative and present Government tried it and failed. We asked each of fifty county branches to appoint a local medical relief committee and then to the 3000 doctors we gave a contract, and if they wished to do relief work they must sign this contract. The "teeth" in it was they agreed to abide by the finding of the local medical relief committee. Some 50 counties ran up to 96 committees, but in spite of everything—96 committees working, appointed by 50 counties—instead of

working with a lot of friction, at the end of the year 35,000 accounts had been passed through their hands and we only had 30 taxed by a committee of our own doctors. That convinced the Government there was only one way to run this show, and we were amazed it worked so well. We had hard feeling over the 25c per month allowed indigents, but we were dealing with the layman. The fact remains that the people were well satisfied with the service, the Government was not bothered by complaints, and we discovered local medical committees could get their own house in order better than anybody else.

Our central committee is composed of three outstanding men. The doctors resented that central appeal board; on the other hand, there was not one man brave enough to go on the floor of the successive societies and try to justify their charges. As a result, we have shoved it all back to the counties. We have the administration shoved out in the field; everything is beyond headquarters. We have set up a Finance Committee to keep the books, run the show and all else.

We are pleased to be able to show that we can carry on business. We administered $1,224,000 and the expense allowed to take over our local medical relief committees was only 2.6%. So in a new game, which we only had three weeks to set in action, we have a much lower overhead than anything that has ever been known before. The advantage of that is that we know, with these 50 committees, if we were thrown into Health Insurance tomorrow, not one of us has any doubt these committees would function under a Health Insurance scheme easier than under this relief scheme. We will have the key that will unlock the door so we can control the unethical medical man or surgeon, the 2% or 3% that give us a bad name.

HEALTH INSURANCE

A brief report by Dr. Wallace Wilson

While the Health Insurance Committee has nothing further of a tangible nature to give to the profession at this time, it would like to briefly report on its activities at the annual meeting in Victoria.

During that week members of the Council and members of the Committee on several occasions met the members of the Health Insurance Commission. At these meetings the discussions were entirely of a general nature. Nothing else was possible at the present time, because there is still another member to be appointed by the Commission, the Medical Director has not yet been appointed and the Commission will not go forward until its personnel is complete.

In the meantime we were informed on each occasion that the Commission is most anxious to co-operate in every way with the medical profession. This is good news, because your Committee, also anxious to co-operate, realizes, as does the Commission, that unless this mutual co-operation takes place nothing satisfactory or lasting will be evolved.

The Health Insurance Committee has only two objectives—a "square deal" for those who cannot purchase their medical care, and reasonable remuneration with just working conditions for those rendering the service. Of course we do not know what will be done with regard to the indigent at the autumn meeting of the Legislature, nor do we know whether the Commission will consult the profession in the drawing up of the particular regulations affecting the medical care of the insured, but we are very willing to co-operate in every way that will go towards ensuring an arrangement that will be satisfactory and fair to all concerned.

Members of the Committee were glad of the opportunity they had in Victoria of talking with men from various parts of the Province. The Committee realizes that, due to local conditions, many men have problems of practice that are peculiar to the place in which they live and it is understood that their problems will require individual considerations before any final decision is made.

The profession will shortly receive a questionnaire re contracts from Dr. Thomas, the Secretary. We hope this will be fully and promptly answered, also that men who are not working under contract but whose work is done under some other arrangement will explain it fully on the questionnaire.

The Committee wishes to thank all members who sent in their returns on income. Over 50 per cent have now done so and we hope the remainder do not think it is now too late. It is not. The returns from another 40 per cent would immeasurably increase the value of the figures we are trying to obtain.

At the annual meeting of the College in Victoria, Dr. Colbeck, President of the Ontario Medical Association, gave a stimulating and heartening talk. The men in Ontario are now united as they never were before and because of their unity they are "going places" with their Provincial Government in the handling of the problems of the medical care of the indigent.

From every province came news of the economic problems that the medical men are faced with and in those provinces where the profession was most strongly banded together they were making the most progress.

We in British Columbia are also united as we never were before and if we only stay that way we will eventually see daylight ahead.

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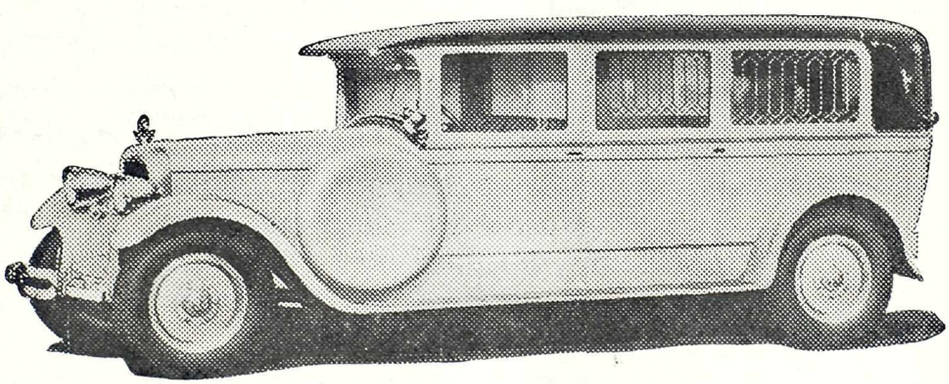

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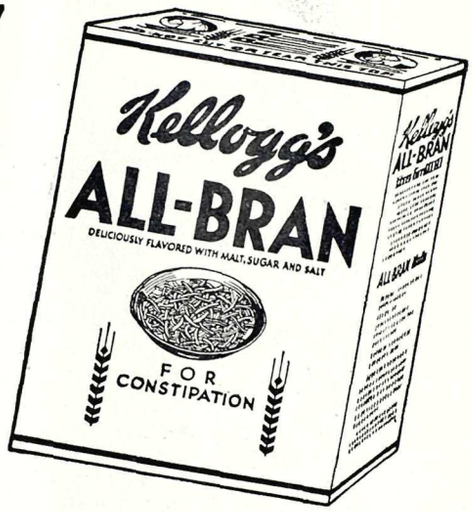

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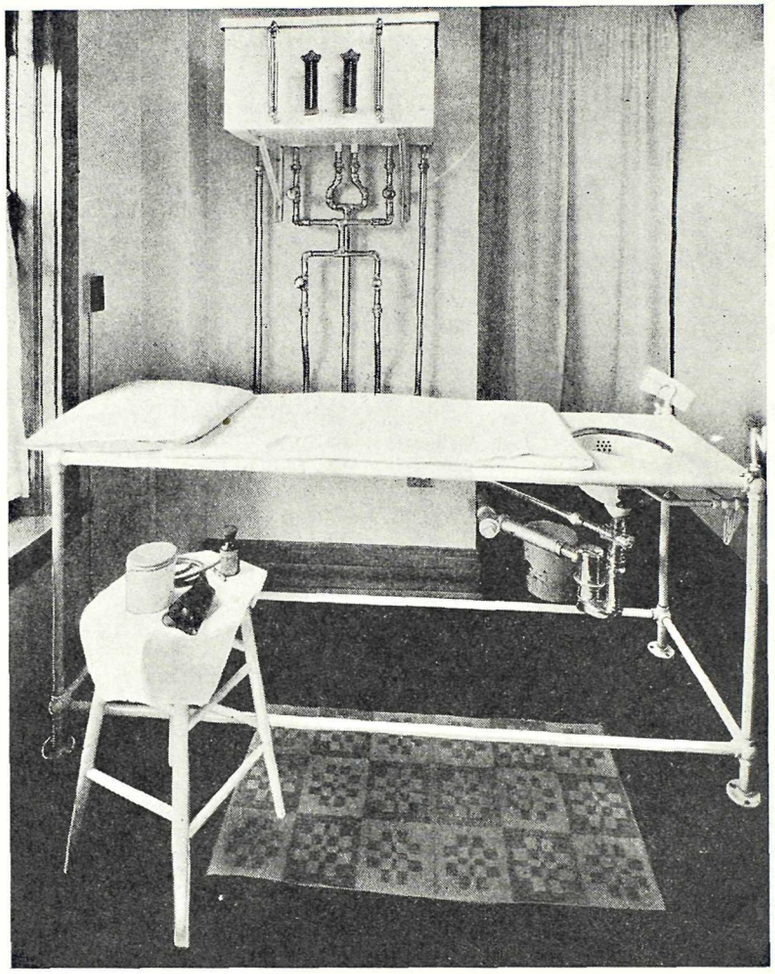

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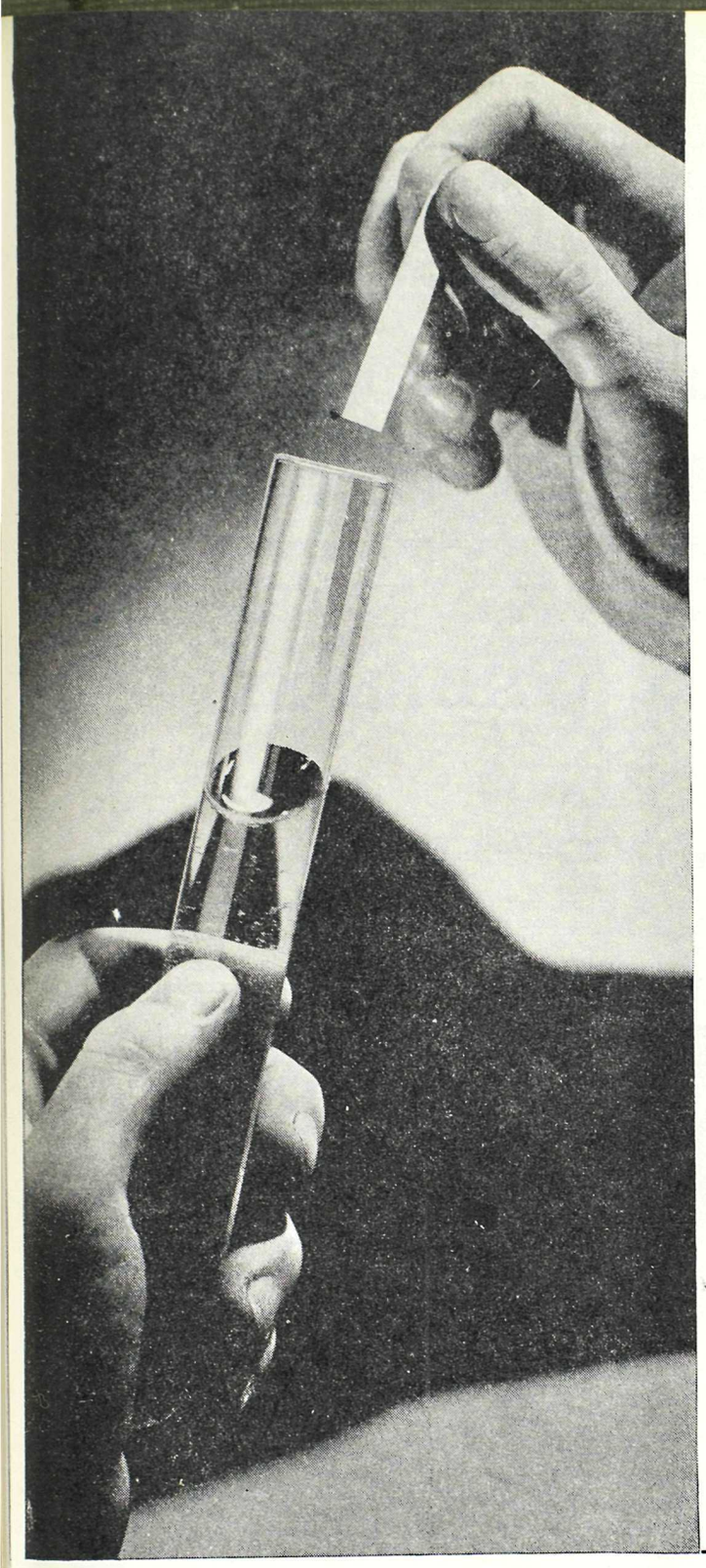

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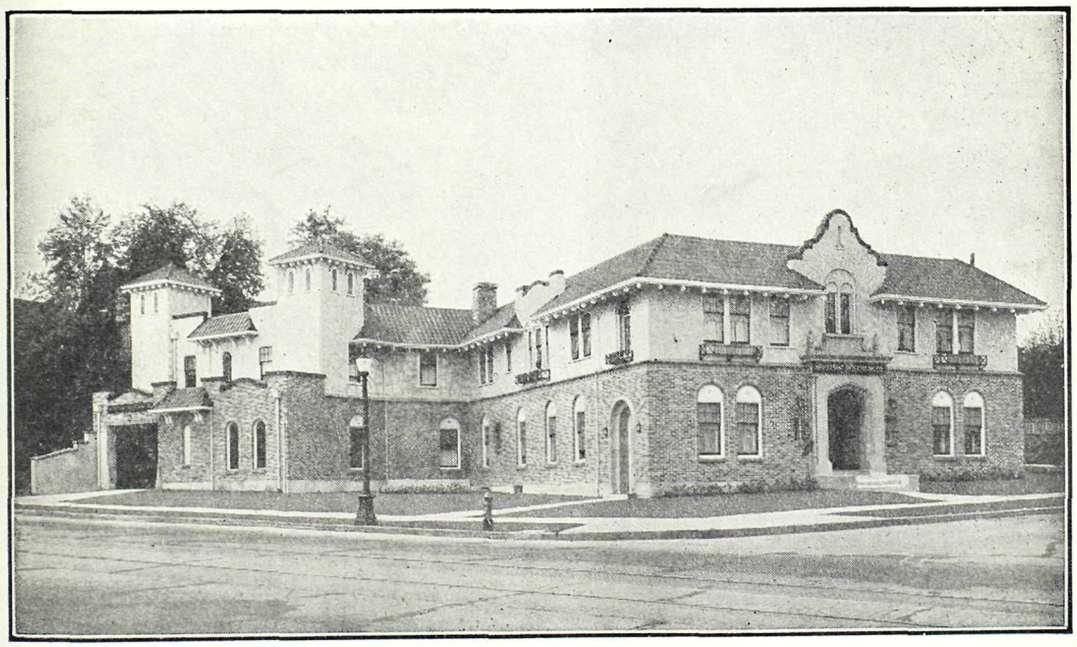

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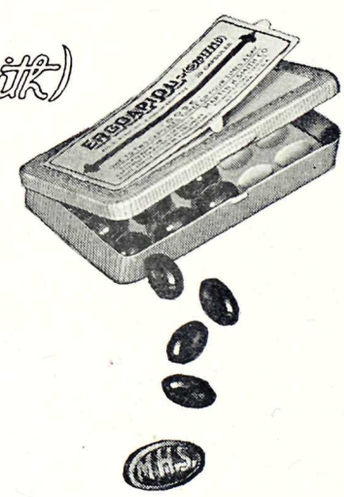

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In diarrhea, "Carbohydrates, in the form dextri-maltose, well cooked cereals or rice, usuall can be handled without trouble."—*B. B. Jone A discussion of some of the commoner infantile diarrhea, and the ... the diets used in ...*

"Dextri-maltose is a very excellent carbohydrate. It is made up of maltose, a disaccharide which in turn is broken up into two molecules of glucose—a sugar that is not as readily fermentable as levulose and galactose—and dextrin, a partially hydrolyzed starch. Because of the dextrin, there is less fermentation and we can therefore give larger amounts of this carbohydrate without fear of any tendency of fermentative diarrhea."—*A. Capper: Facts and fads in infant feeding, Weekly ...*

"Maltose is more easily absorbed than cane or milk sugar, so by changing the carbohydrate one may prevent a deficient supply of sugar."

"When sugar causes diarrhoea one can change the form of it. Mead's Dextrimaltose in small doses is more quickly absorbed and so superior to castor [cane] sugar. Lactose is expensive and seems not to be better than castor sugar."—*H. B. Gladstone Infant Feeding and Nutrition William Heinemann, Ltd., London, 1928, pp. 11, 79.*

In cases of diarrhea, "For the first day or so no sugar should be added to the milk. If the bowel movements improve carbohydrates may be added. This should be the one that is most easily assimilated, so dextri-maltose is the carbohydrate of choice."—*W. H. McCaslan: Summer diarrheas in infants and young children, ... Alabama, 1:278-282*

... bowel and have a definite laxative tendency, which may when carried to excess, cause severe intestinal irritation.

"The more complex carbohydrates, of which dextrin is the type, ferment more gradually and do not have this laxative effect."

Regarding the treatment of diarrhea, "In our experience, the most satisfactory carbohydrate for routine use is Mead's dextri-maltose No. 1."—*F. R. Taylor: "Summer Complaints," Southern Med. & Surg., pp. 555-559, Aug.*

"If there is an improvement in ... ments carbohydrate may be added ... ing the teaching of the originator ... the carbohydrate added should be ... most easily assimilated. Dextri-maltose is therefore the carbohydrate of choice."—*Summer diarrheas in the young, International ... 9:111-118, ...*

In the treatment of diarrhea, "The sugar is added gradually as conditions admit, some sugar other than milk sugar or cane sugar being used, preferably dextrin and maltose."—*H. E. Small: Diarrhoea in bottle-fed infants, J. Maine M. A. 12:154-158, Jan. 1922.*

"The condition in which dextri-maltose is partic ... in acute attacks of vomiting, diarrhea and fever. It seems that ... covery is more rapid and recurrence less likely to take place if dextri-maltose is substituted for milk sugar or cane sugar when these have been used, and the subsequent gain in weight is more rapid.

"In brief, I think it safe to say that pediatricians are relying less implicitly on milk sugar, but are inclined to split the sugar element giving cane sugar a place of value, and dextri-maltose a decidedly prominent place, particularly in acute and difficult cases."—*W. L. Hoskins: Present tendencies in infant feeding, Indianapolis M. J. July, 1914.*

"It should be ... of lactose may cause diarrhoea. If a higher percentage of sugar be required it is better to replace it by dextri-maltose, such as Mead's Nos. 1 and 2, where the maltose is only slightly in excess of the dextrins, thus diminishing the possibility of excessive fermentation."—*W. J. Pearson: Common practices in infant feeding, Post-Graduate Med. J. 6:38, 1930; abst. Brit. J. Child. Dis. 28:152-153, April-June, 1931.*

... gradual transition to a whole milk or evaporated milk formula, which will supply about one and one-half to two ounces of whole milk to every pound of body weight, is reached. This also should finally have the addition of dextri-maltose amounting to five to seven per cent."—*R. A. Strong: Summer diarrheas in infancy and early childhood, Arch. Pediat. ...*

... that group of organisms thrive on) and high in protein. Calcium caseinate milk accomplishes this purpose. In our series of cases, we found it was necessary to use the casein calcium for from 5-8 days; we then stopped it and added dextri-maltose to the formula."—*A. G. DeSanctis and L. V. Paider: The value of calcium caseinate milk in fermentative diarrhea, Arch. Pediat. 38:233-236, April, 1921.*

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There is a widespread opinion that, thanks to improved sanitation, infantile diarrhea is no longer of serious aspect. But Holt and McIntosh declare that diarrhea "is still a problem of the foremost importance, producing a number of deaths each year. . . ." Because dehydration is so often an insidious development even in mild cases, prompt and effective treatment is vital. Little states (Canad. Med. A. J. 13:803, 1923), "There are cases on record where death has taken place within 24 hours of the time of onset of the first symptoms."

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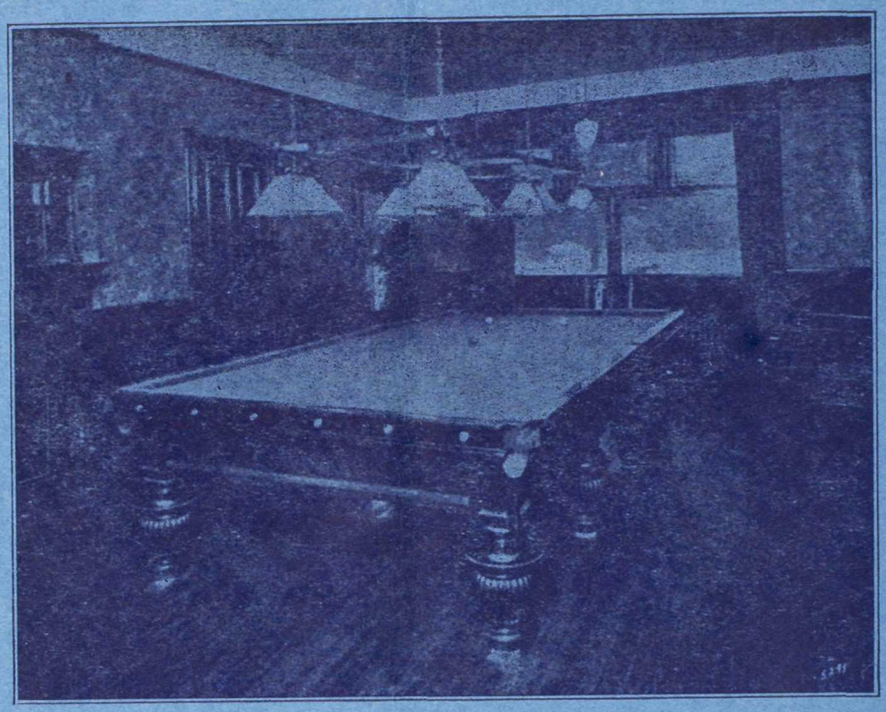

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