SEP 26 1944

The BULLETIN

of the

VANCOUVER MEDICAL ASSOCIATION

Vol. XX AUGUST, 1944 No. 11

With Which Is Incorporated
Transactions of the

Victoria Medical Society

the

Vancouver General Hospital

and

St. Paul's Hospital

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ANNUAL MEETING BRITISH COLUMBIA MEDICAL ASSOCIATION
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THE VANCOUVER MEDICAL ASSOCIATION

BULLETIN

Pulished Monthly under the Auspices of the Vancouver Medical Association in the interests of the Medical Profession.

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VOL. XX AUGUST, 1944 No. 11

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VANCOUVER HEALTH DEPARTMENT

STATISTICS—JUNE, 1944

Total Population—Estimated	299,460
Japanese Population—Estimated	Evacuated
Chinese Population—Estimated	5,728
Hindu Population—Estimated	227

	Number	Rate per 1,000 Population
Total deaths	295	12.0
Japanese deaths	.....	Population Evacuated
Chinese deaths	21	44.7
Deaths—residents only	242	9.9
BIRTH REGISTRATIONS:		
Male, 342; Female, 337	679	27.7

INFANT MORTALITY:	June, 1944	June, 1943
Deaths under one year of age	13	16
Death rate—per 1,000 births	19.1	22.8
Stillbriths (not included above)	9	15

CASES OF COMMUNICABLE DISEASES REPORTED IN THE CITY

	May, 1944		June, 1944		July 1-15, 1944	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
Scarlet Fever	160	0	90	0	23	0
Diphtheria	0	0	0	0	0	0
Diphtheria Carrier	0	0	0	0	0	0
Chicken Pox	281	0	80	0	15	0
Measles	44	0	20	0	4	0
Rubella	116	0	67	0	4	0
Mumps	33	0	15	0	1	0
Whooping Cough	23	0	11	1	6	0
Typhoid Fever	0	0	1	0	0	0
Undulant Fever	0	0	0	0	0	0
Poliomyelitis	0	0	0	0	0	0
Tuberculosis	77	8	67	16	21	0
Erysipelas	6	0	2	0	1	0
Meningococcus Meningitis	0	0	0	0	0	0
Paratyphoid Fever	0	0	0	0	0	0
Infectious Jaundice	0	0	0	0	0	0

V. D. CASES REPORTED TO PROVINCIAL BOARD OF HEALTH
DIVISION OF VENEREAL DISEASE CONTROL

	Vancouver	Richmond	North Vancouver	Burnaby	West Vancouver
Syphilis (May)	58	1	4	0	0
Gonorrhœa (May)	93	0	2	0	0

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VANCOUVER MEDICAL ASSOCIATION

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* * * *

PROGRAMME OF THE FORTY-SEVENTH ANNUAL SESSION

GENERAL MEETINGS will be held on the first Tuesday of the month at 8:00 p.m.

CLINICAL MEETINGS will be held on the third Tuesday of the month at 8:00 p.m. These meetings will continue to be amalgamated with the clinical staff meetings of the various hospitals for the coming year. Place of meeting will appear on the agenda.

General meetings will conform to the following order:

8:00 p.m. Business as per agenda.

9:00 p.m. Paper of the evening.

October 3—GENERAL MEETING:
Symposium—Medical Education of the Future, from the standpoint of
(a) The Clinician—Dr. G. F. Strong.
(b) Preventive Medicine and Laboratory Research—Dr. C. E. Dolman.
(c) The Medical Health Officer—Dr. S. S. Murray.

October 17—COMBINED CLINICAL MEETING and STAFF MEETING at VANCOUVER GENERAL HOSPITAL.

November 7—GENERAL MEETING:
Symposium on Industrial Medicine, arranged by Dr. W. G. Saunders, Director of Industrial Medicine, Wartime Merchant Shipping Ltd.

November 21—COMBINED CLINICAL and STAFF MEETING at ST. PAUL'S HOSPITAL.

December 5—GENERAL MEETING:
Report of Work at Crippled Children's Hospital. New Methods of Treatment of Club Feet—Dr. Gerald Burke.

December 19—COMBINED CLINICAL MEETING and STAFF MEETING at SHAUGHNESSY HOSPITAL.

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Modification is often preferable since it reduces to a minimum the illness and hazards associated with measles, but does not interfere with the acquiring of the active and lasting immunity which is conferred by an attack of the disease. On the other hand, complete prevention of an attack of measles is frequently desirable, and can be accomplished provided that an ample quantity of serum is administered within five days of exposure to the disease.

For use in modification or prevention of measles, pooled human serum is available from the Connaught Laboratories in a concentrated form. While the recommended dose of this pooled and concentrated human serum for purposes of prevention is ordinarily 10 cc., the most usual dose for purposes of modification is 5 cc. The serum is therefore supplied in 5-cc. vials.

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THE EDITOR'S PAGE

At the forthcoming meeting of the British Columbia Medical Association, to which this number of the BULLETIN is especially devoted, considerable time has been allotted for discussion on medical economics—and we hope that amongst the matters discussed will be the question of our relations as a profession with the Dependents' Allowance Board of Ottawa—a body especially set up to deal with the costs of medical care to the dependents of soldiers. It is best, we think, to speak frankly about this matter, as it is becoming steadily more of a sore point with the profession of medicine, at least as regards this Province—we cannot speak for the others.

First, let us say that we think the institution of the Dependents' Allowance Board to assist dependents in meeting medical and hospital bills was an admirable idea, and there is no doubt that it has given very badly needed help to these dependents. Our quarrel is not with the principle of this institution but rather with the methods and practices of those who administer this Fund. During the past several months, representatives of the medical profession have been striving, and to a great extent in vain, to remove the objectionable features of this administration, and to obtain courteous and equitable recognition of our position.

We take issue with the Dependents' Allowance Board on two main points: Lack of candour and lack of courtesy. First as regards lack of candour. The D.A.B. assures us that they have no intention of dictating to us what our charges shall be. Yet, since the outset, this is exactly what they have done. Their first system of letters when they sent the cheque to the patient, was as near blackmail as one could very well get within legal limits. The patient was instructed to offer the cheque in settlement, and if the doctor refused, to send his name to the Board.

Later letters, to us, were an improvement: but here again we were offered a settlement on a basis of a greatly reduced fee: if we did not take it, we should get nothing. Repeated efforts to ascertain on what basis, or according to what schedule, this fee was arrived at, have been useless. We learn that there *is* a scale of fees at present forming the basis at Ottawa: we happen to know what this scale is. But we do not know who set this scale, and we cannot find out. It was not the result of "open agreements openly arrived at" between the D.A.B. and the medical profession. Surely, if we are to work on a scale of fees, we should know what that scale is, and have a say in the setting of it. If this is going to be the method, when health insurance is instituted—if some bureau at Ottawa is going to set our fees without consultation with our representatives, the Canadian Medical Association, there is going to be a great deal of friction and trouble.

But we are told that this is merely by way of assistance to the dependent. The form of the letter refutes this statement entirely. We are told that we must, if we wish to get this amount, sign a release in full. Disingenuousness could go no further.

Let is be understood clearly, we are not quarrelling with the fact that this is a reduced fee. We are quite willing to deal with dependents of servicemen on a reduced basis—but we have a right to demand that we be the ones who make the concessions—not have them made for us by an autocratic board at Ottawa, which has not shown us the courtesy of asking our leave in the matter. We are quite capable of being reasonable and generous. In the last war, we treated all these people without any charge, but things are different now, and it has been rightly decided that we should charge a reasonable fee.

The situation, as it stands, is unfair to the dependents themselves. They have been assured by the papers, and in various ways, that their bills will be paid by the D.A.B. The investigators of the latter go and urge them to avail themselves of this privilege. We are asked for our bills, as is the hospital too. Sometimes weeks, sometimes months, after the bill has been incurred, this offer of a settlement is made—and, largely owing

to the mystery which surrounds the communications from Ottawa, the complete lack of explanation of the reduction of our fees, and the lack of candour and frankness which has been shewn, the medical man concerned is annoyed and often rightfully indignant over the way his account has been treated. Yet the public thinks we are satisfied, and that our bills are being paid in full.

We think that the medical profession should make a determined effort to have this matter cleared up—and we think that it would be greatly to the advantage of the beneficiaries of the Fund that this should be done. We will never allow the dependents of servicemen to go without the very best we can give them—but we resent, and many of them too resent, the way in which this matter has been handled, and the autocratic interference with the relations between ourselves and our patients. We should demand that we have a say, and an equal say, in the setting of a scale of fees—that allowances be made for special difficulties and complications in a case, as is done in every other agreement that we have made; that payment be prompt in consideration of the concessions made—and that discourteous letters be changed into an ordinary business formula. We do not get letters from the M.S.A. or the Vancouver School Teachers, offering a sum in full settlement, and asking us to cooperate with them in seeing that the patient be not charged more than he or she can afford. Let us discuss this matter through our Association, with Ottawa, and have a clear business understanding and agreement: and let us have an end to the secrecy and utter refusal to explain or justify their actions hitherto shewn by the authorities with whom we have to deal.

LIBRARY NOTES

RECENT ACCESSIONS TO LIBRARY:

Medical Clinics of North America, Symposium on Chemotherapy, Mayo Clinic Number, July, 1944.

Backache and Sciatic Neuritis, 1943, by Philip Lewin.

Medical Annual, 1944.

INSTRUCTIVE BOOKS FOR PATIENTS

The following books are in the Library, and are available for the instruction of patients:

Diabetic Manual (For the mutual use of doctor and patient), by Elliott P. Joslin.

A Primer for Diabetic Patients, by Russell M. Wilder.

Primer of Allergy, by Warren T. Vaughan.

Expectant Motherhood, by Nicholson J. Eastman.

The Woman Asks the Doctor, by Emil Novak.

Growing Up (The story of how we become alive, are born and grow up), by Karl de Schweinitz.

The Three Gifts of Life (A girl's responsibility for race progress), by Nellie M. Smith.

The Home Care of the Infant and Child, by Frederick F. Tisdall.

Cultivating the Child's Appetite, by Charles A. Aldrich.

The First Five Years of Life (A guide to the study of the pre-school child), by Arnold Gesell, et al.

Sex in Childhood, by Ernest R. Groves and Gladys H. Groves.

Convulsive Seizures: How to deal with them. (A manual for patients, their families and friends.) By Tracy J. Putnam. (On order.)

Science and Seizures: New Light on Epilepsy and Migraine, by W. G. Lennox. (On order.)

You Don't Have to Exercise! (Rest Begins at Forty), by Peter P. Steincrohn.

Plain Words About Venereal Disease, by Thomas Parran and R. A. Vonderlehr.

Handbook of First Aid and Bandaging, by Belilos, Mulvany and Armstrong.

British Columbia Medical Association

(Canadian Medical Association, British Columbia Division)

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Executive Secretary	Dr. M. W. Thomas, Vancouver

1944 ANNUAL MEETING

SEPTEMBER 26, 27, 28, 29

EMPRESS HOTEL, VICTORIA, B. C.

Plan to attend your Annual Meeting.

Please make your reservations early, and directly with the Hotel.

SPEAKERS:

MAJOR GENERAL G. B. CHISHOLM, R.C.A.M.C., D.G.M.S., Ottawa.

COLONEL G. S. FAHRNI, R.C.A.M.C., Consulting Surgeon, Canadian Army.

FLIGHT-LIEUT. W. C. GIBSON, R.C.A.F., Flying Personnel Medical Section.

SURGEON COMMANDER J. W. MacLEOD, Consultant in Medicine, Navy. (Formerly Internal Medicine, Montreal.)

DR. HARRIS McPHEDRAN, Associate Professor of Medicine, Toronto.

DR. WILLIAM MAGNER, St. Michael's Hospital, Assistant Professor of Pathology, Toronto.

SURGEON COMMANDER H. S. MORTON, Surgeon, Esquimalt. (Formerly Montreal.)

DR. ALBERT ROSS, Assistant Professor of Surgery, McGill University.

DR. G. H. STEVENSON, London, Ont., Professor of Psychiatry, University of Western Ontario.

REPRESENTING CANADIAN MEDICAL ASSOCIATION:

DR. HARRIS McPHEDRAN, Toronto, President.

DR. T. C. ROUTLEY, Toronto, General Secretary.

The Committee on Programme has prepared excellent fare for this four-day meeting.

- Fifteen lectures on four mornings.
- Afternoon sessions:
  Wednesday afternoon in charge of the Committee on Economics of the Council; Chairman, Dr. H. H. Milburn.

Thursday afternoon under the Committee on Industrial Medicine; Chairman, Dr. D. J. Millar—Session on Industrial Medicine.

Conference by Committee on Emergent Epidemics; Chairman, Dr. G. O. Matthews.

- Annual Meetings:

  Tuesday evening—College of Physicians & Surgeons. All doctors should attend.

  Wednesday evening—British Columbia Medical Association (Canadian Medical Association, B. C. Division).

  Note: Annual meetings are being held on separate evenings to avoid late sessions.

- Official Luncheon, addresses by Doctors McPhedran and Routley of the C.M.A.

- Golf—Friday afternoon.

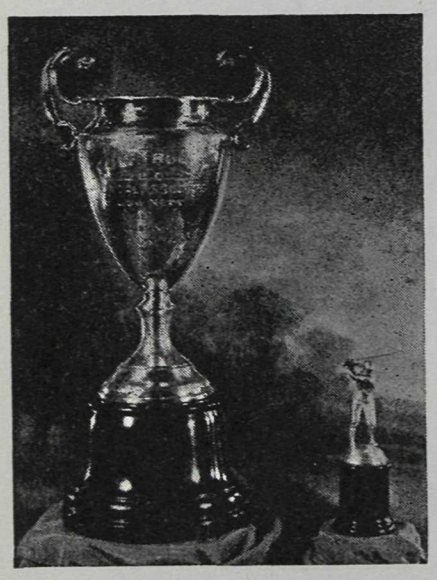
- Annual Dinner, Friday evening—Guest speaker, Dr. Norman MacKenzie, President, University of British Columbia.

- Entertainment for Ladies.

- Public Meeting—Thursday evening, addresses by Doctors Harris McPhedran, William Magner and C. E. Dolman.

PLEASE NOTE: Registration Desk Phone will be—BEACON 2241.

GOLF



Golf play on Friday afternoon, September 29th, at 1:30 p.m. at the Oak Bay Golf Links.

Dr. F. M. Bryant, 1209 Douglas St., Victoria, and Dr. E. L. McNiven, 701 Yates St., Victoria, are arranging the tournament.

The British Columbia Medical Association trophy is up for competition. Dr. G. A. Davidson is the present holder and will defend his title. Other prizes have been arranged. Send your handicap to Doctor Bryant.

LADIES' REGISTRATION AND ENTERTAINMENT

All ladies are asked to register, and attend the Ladies' Tea and the Ladies' Dinner.

Special Note: Reception at Government House.

COMMERCIAL EXHIBITS

A large number of commercial exhibits, which are always interesting, have been arranged.

PROGRAMME FOR THE VICTORIA MEETING

September 26, 27, 28, 29

TUESDAY, SEPTEMBER 26th

8:30 a.m.	Registration.
9:30 a.m.	Dr. Stevenson—"Psychiatry in General Practice."
10:15 a.m.	Dr. Magner—"Infectious Mononucleosis."
11:00 a.m.	Colonel Fahrni—"Surgery in the Army with special reference to care of the wounded."
12:00 noon.	Official Luncheon—Grill Room. Speakers: Dr. Harris McPhedran, Dr. T. C. Routley.
8:00 p.m.	Annual Meeting—College of Physicians & Surgeons of B.C. All doctors should attend.

WEDNESDAY, SEPTEMBER 27th

9:00 a.m.	Dr. McPhedran—"Management of Congestive Heart Failure."
9:45 a.m.	Dr. Magner—"Carcinoma of Lung."
10:30 a.m.	Colonel Fahrni—"Surgery in Army."
11:15 a.m.	Surg. Commander Morton—"Loose Bodies in the Elbow Joint."
12:00 noon.	Lunch hour.
2:00 p.m.	Session on Economics—Chairman, Dr. H. H. Milburn, Committee on Economics of the Council of the College.
8:00 p.m.	Annual Meeting—British Columbia Medical Association. All doctors should attend.

SPECIAL

1944 ANNUAL MEETING

September 26, 27, 28, 29

VICTORIA

LADIES' PROGRAMME

September 28th—Thursday, 4:30 p.m.: Reception at Government House.

September 29th—Friday, 7:00 p.m.: Ladies' Dinner.

THURSDAY, SEPTEMBER 28th

9:00 a.m.	Dr. Stevenson—"The Prevention of Mental Diseases."
9:45 a.m.	Surg. Commander MacLeod—Clinical Experience with Penicillin."
10:30 a.m.	Surg. Com. Morton—"External Skeletal Traction."
11:15 a.m.	Dr. Ross—"Acute Diverticulitis of the Sigmoid."
12:00 noon.	Lunch hour.
2:00 p.m.	Conference on Industrial Medicine—Chairman: Dr. D. J. Millar.
4:00 p.m.	Conference on Emergent Epidemics—Chairman: Dr. Gordon O. Matthews.
8:30 p.m.	Public Meeting—Metropolitan United Church.

FRIDAY, SEPTEMBER 29th

9:00 a.m.	Surg. Commander MacLeod—"Gastroenterological Problems in the Canadian Navy."
9:45 a.m.	Major General Chisholm—"Mental Hygiene of Soldiers."
10:30 a.m.	Dr. Ross—"Fractures of Surgical Neck of the Humerus."
11:15 a.m.	Flight-Lt. Gibson—"Medical Aspects of High Altitude Flying."
12:15 noon.	Luncheon—Board of Directors.
1:30 p.m.	Golf—Oak Bay Golf Links.
7:00 p.m.	Annual Dinner. Guest speaker, Dr. Norman MacKenzie, President, University of British Columbia.
7:00 p.m.	Ladies' Dinner.

REPORTS BY CHAIRMEN OF STANDING COMMITTEES

The following reports of Committees of the British Columbia Medical Association are published in advance in the hope that time will be saved at the Annual Meeting of the Association in Victoria on Wednesday evening, September 27th. Members are requested to read these reports. They contain much valued information and will be open for discussion at the Annual Business meeting.

REPORT OF THE COMMITTEE ON PROGRAMME AND FINANCE

Your Committee was responsible for arranging a speaker for the annual meeting of the West Kootenay Medical Association at Nelson in September, 1943. Dr. P. A. C. Cousland, the President of the British Columbia Medical Association, presented a paper on the lecture programme, and addressed the members following the annual dinner.

The annual meeting of No. 4 District Medical Association was held at Vernon, and Dr. Cousland, our President, again addressed the members at the annual dinner, and Dr. H. A. DesBrisay and Col. L. H. Leeson provided the lecture programme at the afternoon session.

Dr. Cousland attended the annual meeting of the Upper Island Medical Association at Nanaimo and addressed the members at the annual dinner.

A largely attended meeting was held when Col. L. C. Montgomery, Consultant in Medicine Overseas, and Colonel W. P. Warner, Consultant in Medicine to the D.G.M.S., Ottawa, addressed the Association.

A special meeting of the Association was held on April 19th, 1944, for the purpose of discussing Health Insurance, and the Principles approved by the Board of Directors were adopted by the Association.

It is hoped that you will enjoy the 1944 Annual Meeting being held in Victoria. The Committee wishes to acknowledge the provision by the Canadian Medical Association of four speakers on the lecture programme. We wish to record our thanks to the Director General of each of the Medical Services for speakers from the Navy, Army and Air Force.

I wish to move the adoption of this report.

J. R. NEILSON, *Chairman.*

REPORT OF THE COMMITTEE ON MEDICAL EDUCATION

In annual meeting last September, the British Columbia Medical Association approved the recommendation of this Committee that the establishment of a Faculty of Medicine was urgently needed at the University of British Columbia, and instructed the Committee to investigate ways and means to further its formation. To this end the Committee was enlarged to represent all organized medicine in the Province.

The enlarged Committee decided that the project should first be discussed with the Board of Governors of the University, and to place the situation before them a brief was prepared. The brief, even when condensed, covered ten typewritten pages, and presented very strong arguments for the immediate establishment of this additional Faculty at the University. The Board of Governors then nominated a strong committee to act with our Committee. Several meetings have been held, sub-committees organized, much work has been done and decisions made.

Two buildings will be required to house the medical school. The pre-clinical classes will be held in the medical building on the University Campus, to follow several years of pre-medical studies. This building will adjoin the Institute of Preventive Medicine presently to be constructed, where instruction will also be given. The location will also permit medical students to engage in many university student activities to their advantage. The final clinical years of the medical course will be housed in a building to be constructed close to the Vancouver General Hospital. Here the medical students will be largely segregated from University activities, but that is unavoidable.

A sub-committee under Dr. C. E. Dolman was given the task of getting data from the various medical schools of Canada concerning the size of buildings, the grouping of courses, and the operating costs of the various departments. This information is now almost complete.

It is found that student fees provide for about one-third of the operating costs of medical schools, and the balance is provided by grants from the Provincial Governments, or from endowments. A medical school graduating fifty students annually, which we will need here, will require an annual operating budget of $150,000 to $200,000. Our sister Provinces recognize the necessity of this annual outlay and provide for it. British Columbia cannot continue, as at present, to allow other Provinces to pay two-thirds of the cost of educating our medical students. Practically they are refusing to do it, and sutdents from B.C. are having increasing difficulty in being accepted in Medicine by Eastern Universities.

At the present time it costs from $1200.00 to $1500.00 per year to educate a B.C. student at an Eastern medical school. There are approximately one hundred and fifty students in this category today. Therefore, at least $180,000.00 from B.C. is being spent annually on medical education outside the Province, and many students are prevented from entering Medicine because of the expense. This large sum should be spent at home.

A delegation from the combined committee hopes to interview our Provincial Government in the near future with a request for the necessary finances to establish our medical school. We must envisage a school which will be attractive to our students, and will give them a solid and comprehensive groundwork in the medical sciences. Naturally, we will estimate our costs at bare requirements, with the expectation that donations will be forthcoming from public minded and generous citizens for the many extras needed. We have reason to believe that we will be well received by the Government.

It is not the function of this Committee to organize a medical faculty. We hope to turn the project over to our University authorities, but organized Medicine will be vitally interested, and will work with the University.

We have carefully kept out activities from the press. The public will be informed of the necessity for a Medical Faculty at the University of British Columbia after the Provincial Government has been approached. This will strengthen the hand of the Government in making the necessary grants, and may also stimulate offers of endowments which will certainly be needed. There is no better monument than an educational

endowment to perpetuate a worthy name, and the recent gift of $750,000 from Lord Bennett to Dalhousie University might well be duplicated here from other donors.

All of which is respectfully submitted. K. D. PANTON, *Chairman.*

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REPORT OF THE COMMITTEE ON ECONOMICS

Our chief activity in the past year has been the study of the Principles of Health Insurance as adopted by the Canadian Medical Association. Early in this year the Executive of the C.M.A. suggested that each Division study the Principles as adopted at Jasper and revise or amend them to bring them into line with our present day ideas. Your Committee spent a great deal of time at this study and early in February submitted their recommendations to your Board of Directors, which body approved of the Principles on February 9th. This draft was submitted to the Committee on Economics of the Canadian Medical Association, and was studied by that group, by the Health Insurance Committee of the C.M.A., and by the Executive Committee of the C.M.A. These suggestions were then re-submitted to all Divisions. It was at this stage that a special meeting was held in the Vancouver Hotel on April 19th for the final study and adoption of the Principles as approved by the B.C. Division.

This draft was then re-considered by Council at the annual meeting of the Canadian Medical Association at Toronto, where changes were made in wording, but not in meaning (see copy C.M.A. Principles). In regard to our Principle No. 3 in which we had recommended the application of Health Insurance in successive stages, this Principle was not approved by the Canadian Medical Association, but in the opinion of your Committee, it should still have the support of this Division, and should be recommended if and when our Provincial Government considers the adoption of Health Insurance in this Province.

Principles of Health Insurance approved by the B. C. Division in meeting, April 19th, 1944.

1. We approve the adoption of the principle of contributory Health Insurance, and favor a plan which will secure the development and provision of the highest standards of health services, preventive and curative, if such plan be fair both to the insured and to all those rendering the services.

2. The health of the people depends to a great extent upon environmental conditions under which they live and work, upon security against fear and want, upon nutritional standards, upon educational facilities, and upon the opportunities for exercise and leisure. The improvement and extension of measures to satisfy these needs should precede or accompany any future organization of medical service. Failure to provide these measures will seriously jeopardize the success of any Health Insurance Scheme.

3. In our opinion it is impractical to introduce at once a nation-wide scheme of complete Health Insurance. Any such scheme should be developed in successive stages in each Province that accepts the Federal Enabling Act. *Note*: The term "successive stages" comprises:
   1. Hospitalization;
   2. Diagnostic aids, including X-ray and Laboratory facilities for ambulatory patients and those not hospitalized;
   3. Medical, surgical and obstetrical care.

Principles relating to Health Insurance, approved by General Council, C.M.A., May, 1944.

1. The Canadian Medical Association approves the adoption of the principle of contributory Health Insurance, and favours a plan which will secure the development and provision of the highest standards of health services, preventive and curative, provided the plan be fair both to the insured and to all those rendering the services.

2. Inasmuch as the health of the people depends to a great extent upon environmental conditions under which they live and work, upon security against fear and want, upon adequate nutrition, upon educational facilities and upon the opportunities for exercise and leisure, the improvement and extension of measures to satisfy these needs should precede or accompany any future organization of medical service. Failure to provide these measures will seriously jeopardize the success of any Health Insurance plan.

Principles of Health Insurance approved by the B. C. Division in meeting, April 19th, 1944.

4. Each Province should be served by an adequate Department of Public Health, organized on the basis of the provision of individual health supervision by the medical practitioner.

5. The Association believes that it is not in the public interest in Canada that the state should convert the whole medical profession into a salaried branch of any government service.

6. It is not in the public interest that the state should invade the patient-doctor relationship. This relationship includes free choice of doctor by patient, free choice of patient by doctor, and maintenance of the confidential nature of medical practice.

7. In any form of Health Insurance there should be no income limit.

8. Medical care for indigents and transient indigents should be provided under the plan, the Government to pay the premiums of the indigents, who then receive medical care under exactly the same conditions as other insured persons.

9. The dependents of insured persons shall be included in the medical benefits.

10. We favour the principle of insured persons being required to contribute to the insurance fund.

11. Any Health Insurance plan should be studied and approved actuarially before being adopted, and actuarially approved at periodic intervals.

12. In the Province where Health Insurance is established it shall be administered by a small, independent Health Insurance Commission, the Chairman of which shall be a Doctor of Medicine, regularly qualified, duly licensed, and in good standing in the Province, who has practised Medicine for at least ten years.

13. There should be a Central Advisory Committee composed of representatives from various lay and professional groups to discuss matters of policy and administration with the Health Insurance Commission.

14. The Province should be divided for purposes of administration of Health Insurance into Regions, each Region with a Regional Medical Officer, Regional Public Health Officer, and Regional Advisory Committee.

Principles relating to Health Insurance, approved by General Council, C.M.A., May, 1944.

12. Each province should be served by an adequate Department of Public Health, organized on the basis of the practising physician taking an active part in the prevention of disease.

3. It is not in the national interest that the State convert the whole medical profession into a salaried service.

4. It is not in the patient's interest that the State invade the professional aspects of the patient-doctor relationship. Subject to geographical and ethical restrictions this relationship includes free choice of doctor by patient and free choice of patient by doctor; it implies also maintenance of the confidential nature of medical practice.

5. While leaving to each province the decision as to persons to be included, the plan must be compulsory for persons having an annual income insufficient to meet the costs of adequate medical care.

7. Medical care for resident and transient indigents should be provided under the plan, the Government to pay the premiums.

6. The dependents of insured persons should be included in the health benefits.

16. The principle of insured persons being required to contribute to the insurance fund is strongly endorsed.

17. Any Health Insurance plan should be studied and approved actuarially before adoption and thereafter at periodic intervals.

10. Health Insurance should be administered by an independent non-political Commission representative of those giving and those receiving the services. Matters of professional detail should be administered by committees representative of the professional groups concerned.

Principles of Health Insurance approved by the B. C. Division in meeting, April 19th, 1944.

15. The professional side of Health Insurance medical service should be the responsibility of the medical practitioner providing the services under the Act through the appointment of a Central Medical Services Committee and Regional Medical Services Committees, to consider and advise on all questions affecting the administration of the medical benefit and preventive and public health services.

16. Under Health Insurance the Chief Medical Officer and the Regional Medical Officers should be appointed by the Health Insurance Commission from a list submitted by the organized medical profession of the Province.

17. Cash benefits should not be included in any Health Insurance Act. Should cash benefits be considered desirable from the viewpoint of social welfare, such should be provided from funds other than the Health Insurance Fund.

18. Medical Benefits to be organized as follows:
    - (a) Every qualified licensed medical practitioner to be eligible to practise under the plan.
    - (b) The medical service to be based upon making available to all a general practitioner service supplying preventive medicine and public health measures as well as the treatment of disease.
    - (c) Additional services to be secured ordinarily through the medical practitioner.
      1. (a) Specialist medical service.
         (b) Consultant medical service.
      2. Special private duty nursing service.
      3. Hospital care.
      4. Auxiliary services, usually in hospital.
      5. Pharmaceutical service.
    - (d) Dental service.

19. The medical practitioners of each Province should be remunerated according to the method or methods of payment agreed upon by the medical profession and the Commission.

20. Under Health Insurance provision must be made for:
    - (a) Adequate clinical teaching in medical schools and hospitals.
    - (b) Facilities for research work.
    - (c) Periodic post-graduate training of all medical practitioners.

Principles relating to Health Insurance, approved by General Council, C.M.A., May, 1944.

11. Under Health Insurance the Chief Executive Officer to the Commission and the Regional Executive Officers should be physicians appointed by the Commission from a list submitted by organized medicine in the province.

9. Cash benefits, if provided, should not be taken from the Health Insurance fund.

8. Health benefits should be organized as follows:
    - (a) Every regularly qualified, duly licensed medical practitioner, in good standing in the province, should be eligible to practise under the plan.
    - (b) The benefits conferred should be such as to provide for the prevention of disease and for the application of all necessary and adequate diagnostic and curative procedures and treatment. Specialists and consultant medical services should be available.
    - (c) The folowing additional services should be available through the medical practitioner:
      1. Nursing service;
      2. Hospital care;
      3. Auxiliary services, usually in hospital;
      4. Pharmaceutical service; subject to regulation.
    - (d) Dental service.

14. The method, or methods, of remuneration of the medical practitioners and the rate thereof, should be as agreed upon by the medical profession and the Commission of the province.

15. Every effort should be made to maintain health services at the highest possible level. This requires:
    - (a) Adequate facilities for clinical teaching in the medical colleges and hospitals;
    - (b) Post-graduate training of all medical practitioners at frequent intervals.
    - (c) Necessary facilities for and support of research.

Principles of Health Insurance approved by the B. C. Division in meeting, April 19th, 1944.

Comment:

3. The introduction of Health Insurance should not be undertaken until the medical personnel that is now engaged with the Armed Forces is again available for civilian duty.

Important Additional Comments:

1. It is sometimes suggested that the introduction of Health Insurance will practically eliminate the need for curative medicine, but it should be emphasized that in spite of the great importance of Preventive Medicine, even the *full* application of our presnt-day knowledge of preventive measures will not abolish all disease or eliminate the need for curative medicine.
2. We are opposed to the inclusion of any and all irregular practitioners in any scheme of Health Insurance.
3. The introduction of Health Insurance should not be undertaken until the medical personnel that is now engaged with the Armed Forces is again available for civilian duty.
4. The introduction of any system of Health Insurance into Canada should be preceded by an increase in the facilities for undergraduate and post-graduate medical training.
5. Some plan should be devised for the provision of pensions for medical practitioners.
6. A survey of existing hospital facilities and future requirements is an urgent necessity.
7. Preceding any Health Insurance programme there should be initiated avast plan of new hospital construction.
8. In accordance with our recommendation that Health Insurance be introduced in successive stages we believe that a compulsory hospital insurance scheme would be the logical first stage.

Principles relating to Health Insurance, approved by General Council, C.M.A., May, 1944.

13. The granting of a licence to practise medicine was designed primarily to protect the public. Therefore it is in the interests of the patient that all who desire licensure to practice a healing art should be required to conform to a uniformly high standard of preliminary education and of training in the recognized basic sciences as well as to furnish proof of adequate preparation in the clinical and technical subjects.

18. In the provision of health services, cognizance should be taken of the fact that well over a third of Canadian doctors are now in the Armed Forces. If Health Insurance should be implemented in any province before demobilization, the interests of the medical officers in the Services should be fully protected.

Acting as a sub-committee of the Canadian Medical Association Committee on Economics, some additional time was spent on the study of fee schedules across Canada, and the following report made—

1. Present Medical Fee Situation in Canada.

The schedules of regular medical fees and of Compensation Board fees in all the Provinces of Canada, with the exception of Prince Edward Island, have been studied and compared and certain conclusions have been reached. In general, medical charges are highest in the West and lowest in the Maritime Provinces. Manitoba tops all Provinces in fees, and is closely followed by British Columbia, which is very similar to Ontario. It is probable that one reason for the difference between the West and the East is to be

found in the relatively lower expenses of physicians in the Maritimes where offices are usually in the homes and where distances to patients are not so great. There is also an apparent difference in the actual cost of living. It would appear that there will continue to be higher charges as a rule in the Western Provinces.

If the various charges are examined separately it is found that in general routine minor procedures, such as office consultations, home visits, mileage and so forth, British Columbia allows the highest fees, while in major work, such as surgery, obstetrics and gynæcology, orthopædics, Manitoba leads in charges. In only one branch of major surgery is British Columbia highest, and that is in genito-urinary work. In orthopædics British Columbia is lower than both Ontario and Quebec. Incidentally, British Columbia is the only Province that allows a fee of $150.00 for all types of appendectomy. The drop in fees in New Brunswick and Nova Scotia is very noticeable. Two dollars is still the charge for office consultations and house visits and $25.00 for normal obstetrical cases, which is the same as in Quebec, while Manitoba charges $50.00, with an additional $10.00 or $15.00 for anything not absolutely normal.

A table of twenty-seven procedures has been prepared, showing charges for each in the eight Provinces, from which we have information. These procedures were selected, first, in order to cover certain common things about which information was desired; second, to show that in some procedures there is some uniformity in fee, and third, to illustrate the fact that in other procedures there is the greatest disparity. (See *C.M.A. Journal,* Sept., 1944, p. 37.)

The Workmen's Compensation fees have been compared and are found to vary from East to West much as the ordinary fees. Generally, British Columbia is highest and the Maritimes lowest. In home visits, subsequent visits, night visits and mileage British Columbia is highest as it is in nearly all minor procedures, such as removal of foreign body from the eye ($5.00 allowed in British Columbia compared to $2.00 in all other Provinces) and aspiration of bursa ($5.00 allowed in British Columbia as compared to $3.00 elsewhere). One Compensation Board fee in British Columbia is lowest in Canada —$50.00 for exploratory laparotomy for which $75.00 or $100.00 is allowed in all of the other Provinces. Fractures are about the same across Canada, except slightly higher in Manitoba and definitely lower in New Brunswick and Nova Scotia. Dislocations are poorly paid in these two Provinces, as are amputations.

Conclusions drawn from these comparisons of fees are that there will be many difficulties in arranging one schedule which would be satisfactory to all Provincse. It would seem advisable that some of the charges for major operations in British Columbia and Manitoba, particularly, should be reduced, and that the Eastern Provinces should raise their entire schedule. In Nova Scotia the fee allowed for complete obstetrical case, including pre- and post-natal care, is still $25.00; while $$100.00 is allowed for simple herniotomy and appendectomy. This does not appear a proper relationship for the skill and amount of medical care required. In general, it would seem that there is an overemphasis on surgery, and not enough consideration given to skilled medical work. The value of the first examination should be recognized and the fee proportionately raised. The value of medical care where special skill is involved should not be based on a charge per visit.

In view of the facts set out above, this Committee feels that it is out of the question to attempt to have one schedule of fees for the whole of the Dominion. We are strongly of the opinion, however, that there should be uniformity in the relative value of medical services. To illustrate, we feel that the relation between the charge for a normal obstetrical case and the charge for a simple appendectomy should be altered to take into consideration the skill and medical care required, and the relative values should be the same in every Province. To this end the following resolution was passed:

> "A schedule of fees that could be used as a basis for payment of doctors in any part of Canada should be based on a unit system. This schedule should relate only to the relative value of fees—expressed in terms of a unit—and not expressed in dollars. Appendectomy, for example, would have a certain set relation to maternity case. The practitioners of each Province could then decide the

value in dollars of one unit. This value would vary across Canada and be determined by such factors as the cost of medical practice and the general cost of living in each Province."

Your Committee would recommend that this subject be given further study.

2. Method of Remuneration of Doctors under Health Insurance.

As can be imagined, this subject was given a very great deal of consideration. Although opinion in this regard was available from only a few of our corresponding members, there was unanimity only as to the fact that we are not in favour of a salaried system for all. In other words, we are opposed to State Medicine. It is recognized, of course, that the salaried services that now exist are satisfactory in principle, but the salaries are usually much too low. It is also recognized that in sparsely settled areas a salary, or partial salary, may be required. Your Sub-Committee came to the conclusion that the question of the method of remuneration of doctors under Health Insurance must still be left to the decision of representatives of organized Medicine in each individual Province, and we are not prepared to make any further recommendation at this time.

In conclusion, your Committee would recommend to this Annual Meeting:

(1) That we endorse the Principles relating to Health Insurance as approved by the General Council of the Canadian Medical Association in May, 1944, to the end the the medical profession all over Canada may present a united front.

(2) That we reiterate our belief that Health Insurance should be applied in successive stages.

(3) That there be continued study of the medical fee situation.

All of which is respectfully submitted.

G. F. STRONG, *Chairman.*

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REPORT OF THE COMMITTEE ON HOSPITAL SERVICE

I have pleasure in submitting this Annual Report as Chairman of the Hospital Service Committee for 1943-44. The members of the Committee are as follows:

Dr. R. A. Seymour (Chairman), Vancouver; Dr. R. P. Kinsman, Vancouver; Dr. R. A. Gilchrist, Vancouver; Mr. E. J. Lyon, Prince George; Dr. A. G. Naismith, Kamloops; Dr. H. Campbell-Brown, Vernon; Dr. W. F. Anderson, Kelowna; Dr. J. R. Parmley, Penticton; Dr. A. B. Hall, Nanaimo.

Because of the geographical distribution of the members of this Committee there have been no special meetings called. No business or problems have been referred to this Committee by your Board or by individual members during the current year.

Respectfully submitted,

R. A. SEYMOUR, *Chairman.*

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REPORT OF THE COMMITTEE ON THE STUDY OF CANCER

During the urgency of war unassociated committees and their reasons for existence are apt to be forgotten; may I, therefore, be forgiven for reminding you once more that this Committee is the B. C. representative of the Department of Cancer Control of the Canadian Medical Association; that it has existed as such since 1937 when this Department of the Canadian Medical Association was established by means of funds set aside by the trustees of the King George V Silver Jubilee Cancer Fund, and that its object is the furthering of the knowledge of Cancer among the profession. Its present Chairman of the Department is Professor William Boyd of Toronto University and the local committee has held four meetings during the past year.

The last meeting was called to consider a recent letter from Dr. T. C. Routley asking for suggestions for the extension of the Cancer programme, especially with respect to the following:

1. Medical education in diagnosis and treatment of cancer.
2. Establishment of a clinical research fellowship at a University centre.

3. Establishment of a programme for cancer education of nurses.
4. The use of films for cancer education.

These points were discussed and suggestions made as follows:

1. Medical Education—
   (a) There should be lectures at Annual Meetings—at least one lecture.
   (b) Special lecturers or lecturer sent to District Associations.
   (c) Special meetings devoted to Cancer by District Associations.
   (d) Lecture tours to larger centres.
   (e) Educational films for the profession.
   (f) Collection of an exhibit for education among undergraduates and graduates.
   (g) The use of colour photography in preparing slides or pictures showing types, stages, treatment and progress.
   (h) Organized instruction among under-graduates.
   (i) Cancer education could be stressed during post-war refresher courses.
   (j) (1) Bulletins and journals encouraged to publish articles on cancer.
       (2) These periodicals could develop a cancer section to provide that short articles should appear regularly.
       (3) Reviews of and abstracts from longer articles.
   (k) Doctors taking course leading to D.P.H. provide opportunity for post-graduate education.
   (l) The enlistment of interest of pathologists holding conferences on pathology.
   (m) Tumour clinics.
   (n) Cancer Study Groups.
2. Question 2 dealt with the establishment of a clinical research fellowship at a university centre. The question of clinical research was discussed and it was considered to fall into separate groups: :
   (a) The epidemiological and statistical approach as a definite research for one fellowship with particular reference to the picture in Canada.
   (b) Clinical studies.
   (c) The pathology of the disease.

   It was noted here that at present clinical observation of a group of presumably normal young women with specific relation to breast changes was being carried out.

   The interest of life insurance companies might be enlisted to support financially cancer prevention clinics. In the course of routine examinations at these centres cancer is frequently discovered, largely because people may come for this cause. Life insurance companies should be interested in epidemiological and statistical research.
3. Programme for education of nurses.

   A planned programme adequately arranged by doctors should be developed for under-graduate nurses, graduate nurses, public health nurses, and may be extended to include social workers.
4. Films—

   It was decided that a film library should be built, which would be available to serve the needs of the association, its divisions and district societies.

In reply to Doctor Routley's letter, it was decided that the suggestions outlined as above should be forwarded.

Your Committee would be grateful for further suggestions or comments from district cancer committees or from any member of the profession interested in contributing to this important problem of cancer control.

All of which is respectfully submitted.

ETHLYN TRAPP, *Chairman.*

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REPORT OF THE COMMITTEE ON INDUSTRIAL MEDICINE

Looking back over the past two years in which this Committee has been actively working and putting into operation Industrial Medicine, one can see that much has been accomplished; but sober reflection prompts me to say that a great deal has yet to be done

before this branch of active medical practice is put on a sound and enduring basis.

Our present active participation in industry has and continues to be dependent upon contributions from the Dominion Government through Wartime Shipbuildig Limited. What will happen when the Dominion Government discontinues the war industry? Can we simply retire from the field or should ge not now prepare for the change to Provincial and private control? Your Committee feels much concerned over this and is attempting to find a way to meet the situation when it arises.

It has been established that great saving has been effected by the work our Doctors are doing in the various plants in which there has been established a department of Industrial Medicine. It is probable that when these War Plants revert to private work, that our showing will induce the management of such plants to take on the expense and continue the work; but we are a little fearful of letting the employer control the service. We think that without outside control and guidance the Industrial Surgeon may become nothing more than a glorified First Aid service and a convenience for his employer.

We want the Provincial Government to set up a department of Industrial Medicine with a full time Director and to put into effect regulations necessary to keep the service what it should be. To this end we are now working.

We regret the lack of enthusiastic support which we naturally expected would be forthcoming from the Workmen's Compensation Board of the Province. Perhaps we have not approached them in the proper manner or perhaps they have not taken the time to ascertain how very important this work is or could be in assisting to solve some of the problems which are met with in administrating the Workmen's Compensation Act.

During the year a special Sub-Committee was set up to make a complete survey of First Aid Service as regulated and supervised by the Workmen's Compensation Board of B.C. A very comprehensive report of findings was made to your Committee with recommendations for improvement of the Service. As you are aware, we presented these recommendations to your Directorate, where they were duly approved, and we were advised to approach the Workmen's Compensation Board with the suggested changes. The President of the College (Dr. H. H. Milburn), the Executive Secretary (Dr. M. W. Thomas) and your reporter met the Chairman and members of the Board and presented the recommendations, together with a request for a reply as to whether they wished the medical profession to work with them. We have not yet had any advice from the Board, although some months have passed since the interview. We have still hope that something may come of this very great amount of work put on the subject.

For whatever progress we have made in this Committee we want to thank all the members who so readily gave of time and thought to the work during the past year. Particularly do we want to mention Dr. W. G. Saunders, who in addition to guiding the work as active Director of the Service, has acted on all important Sub-Committees. We also thank Dr. Lyall Hodgins, who headed up the advisory sub-committee. This sub-commitete is a most important one and will become even more important in any set up contemplated for the future. Dr. M. W. Thomas, your Executive Secretary, has been of inestimable assistance, freely giving time and advice as Secretary. We thank the Provincial Health Officer, Doctor Amyot, for his presence at most of our meetings and for his interest in the work of the Committee. We are assured that he will get behind any scheme we are able to have set up under Provincial control.

Respectfully yours,

D. J. MILLAR, *Chairman.*

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REPORT OF THE COMMITTEE ON EMERGENT EPIDEMICS

The Committee on Emergent Epidemics is a national organization, sponsored and organized by the Canadian Medical Association, but made up of representatives from the Canadian Red Cross, the St. John Ambulance Association, the Canadian Nurses' Association, the Canadian Hospital Association, the Indian Affairs Department and the Department of Pensions and National Health.

There is a central and national Committee to advise and stimulate, and Provincial Committees to direct all attention within the said Province, sponsored and organized by the Provincial Division of the Caandian Medical Association, in our case, the Brtish Columba Medical Association.

Fortunately, your Committee has had no need to function, except in an organizing sense. Last November, your Chairman attended a Central Committee meeting held in Ottawa, and sponsored by the Department of Pensions and National Health. In attendance were duly authorized representatives from every Provincial Sub-Committee, as well as representatives from every national organization represented on our Committee, also from National Women's organizations, both French and English, and strong representations from Universities and teaching hospitals.

A full discussion of all phases of epidemics took place, and finally a suggestive plan of action for the Provincial Committees to follow was submitted.

Last January, your Provincial Committee met in Vancouver, and the above plan of the Central Committee was adopted with a few minor changes.

It can now be reported that with the co-operation of the Provincial Health Officer, all the Medical Health Officers of the Province have been contacted and they have formed, or have in the process of formation, local sub-committees, composed of the leaders of the different organizations interested. Therefore, if we do have visited upon us a catastrophe such as a virulent pandemic, we will have in every locality in our Province a committee that is forearmed, organized and well prepared to quickly throw the necessary material resources and personnel into combating it. Any epidemic, if any, will be wide-spread, and so we are happy to report our present plan of decentralization.

My thanks to all members of the Committee and to their respective organizations, and also to Doctor Amyot, without whose help what little organizing has been done would have been quite impossible.

As the Committee on Public Health is part of the Committee on Emergent Epidemics, this could be considered a report of both Committees.

G. O. MATTHEWS, *Chairman.*

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REPORT OF EDITORIAL BOARD

There is not a great deal to report on the work of this Committee for the past year. Each month news or notes of any significant matters are sent to the *Canadian Medical Journal,* which has been very generous in affording space, and in publishing any special note—as, for example, in the matter of the speech made by Major A. E. Jukes before the Vancouver Medical Assocaition, which was widely circulated in the East, and gave rise to some adverse comment, as it was misreported.

The News and Notes of the British Columbia Medical Association are published in the *Bulletin of the Vancouver Medical Association,* and owing to the admirable system of news gathering worked out by Dr. M. W. Thomas, they are remarkably full and complete, covering all areas of the province. We find that they are eagerly read.

The Editorial Board feels that grteful acknowledgment is due to the Vancouver Medical Association for the generous manner in which the *Bulletin* has given full publicity in regard to this Annual meeting; we are glad, too, to have regular space in the *Bulletin* for reports of matters of importance and interest to the profession of B.C.

All of which is respectfully submitted.

J. H. MacDERMOT, *Chairman.*

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REPORT OF THE DIVISIONAL ADVISORY COMMITTEE

Your Divisional Advisory Committee has completed its fifth year in office. During the past year we have met twelve times and have conducted the business of the committee, we hope, in a satisfactory manner. Our meetings have been well attended and

special credit should be given to the out-of-town members who have been unfailing in their attendance and invaluable in their contributions. I believe that our president, Dr. Cousland, has been in attendance at every meeting. The medical heads of the Armed Forces are of the greatest assistance at our meetings.

Our relationship with the National Selective Service continues to be most satisfactory. Colonel Simpson, the personal representative of the G. O. C., Pacific Command, sits on the N. S. S. board and also on our committee. All N. S. S. matters pertaining to medical men are brought to our committee by this liaison officer. The decision of the D. A. C. has been accepted by the N. S. S. in every case without exception.

The committee was represented at a meeting of the D. A. C. in Ottawa in February. There legislation was enacted whereby medical men in uniform could be placed in areas badly in need of civilian medical services. The scheme enacted did not meet with the approval of this D. A. C., although the Province of British Columbia has approved of the arrangement in principle. Up to date it has not been acted upon in this province. We believe it fair to say that with very few exceptions the civilian population of this province enjoys fairly complete coverage.

MURRAY BLAIR,
Chairman.

ITEMS OF GENERAL INTEREST

The Library is receiving considerable literature dealing with Post-War Planning: e.g., the Report of a Conference held in Toronto at the 73rd Annual General Meeting of the Canadian Manufacturers' Association.

The greatest attention is directed, of course, to trade, markets, production, etc., but it is encouraging, too, to note that research is a prominent item in the recommendations made. Reserach, adequate laboratories, utilization of men specially fitted for research work, are advocated. We feel that it is impossible to exaggerate the importance of research, and are glad to note these items.

The American College of Surgeons has cancelled its Annual Clinical Congress, to help the authorities in their efforts to keep down traffic, and relieve the strain on transportation systems. A very interesting releave on this subject, with comments by the Surgeon-General of the U. S. Army, R. H. Clare, Asst. Director, Passenger Section, Div. of Traffic Movt., O.P.A., and others, is in the Library.

A release from the National Foundation for Infantile Paralysis, Inc., states that in the first 31 weeks of 1944, the U.S.A. has had more cases of infantile paralysis reported than at any comparable time in 28 years. 3,992 cases are reported, with increases in all the states referred to. The original is in the Library. Another report from the same source shows that the American people have contributed $10,473,491 to the 1944 Fund-Raising Appeal of the Foundation. The film industry, sports world, press, radio, war workers, and labour are all contributing and cooperating, and the March of Dimes, contributed to by school children, has raised enormous sums. In North Carolina alone a million and a half dimes "are at work."

THE MANAGEMENT OF AMPUTATIONS AND THE USE OF SATISFACTORY PROSTHESIS

By Colonel R. I. Harris

Given at Vancouver Medical Association Summer School, 1944.

This is a singularly appropriate time for us to be discussing the question of amputations and reviewing our knowledge of the subject and the various uses of prosthesis; because we are faced again with the prospect of large numbers of casualties, and amongst those casualties will be those who have lost their extremities, so that we must again be prepared to deal with amputation problems and prosthetic problems as we were in the last war. So what I have to say is of necessity intimately concerned with war amputations. It nevertheless has a very important application in civil practice. Amputations are no different in civil practice from war amputations, except that they are less complicated and much simpler to handle. So, if we can decide on good and sound methods of handling war amputations, we have laid the foundation of good handling of industrial and traumatic surgery in civil life.

The experience of the last war in Canada and in England and to some extent in the United States has laid the foundation for our present knowledge of amputation surgery. The necessity of handling large numbers of amputees resulted in the establishment of methods in all three of these English-speaking countries which, in broad outline, were similar, and perhaps the most essential and important part in the management was the fact that all three nations learned very quickly the wisdom of segregating amputation problems in special centres. In Canada that led to the development of an amputation centre in what was then the Dominion Orthopædic Hospital in Toronto, and it also led, because of difficulties in the supply of artificial limbs, to the establishment of an artificial limb factory being set up, staffed and run by the government through what is now the Department of Pensions and National Health. In England similar experience led, through similar reasoning, to a similar though not exactly the same result. They have gathered their amputation problems together in one place, Roehampton, and they also manufacture their artificial limbs under government supervision, though they do it now by contract with a single firm. At one time they had several firms; now they have one firm which manufactures artificial limbs according to specifications laid down by the Ministry of Pensions and conforming to inspection standards, which are governed. So, in effect, they have the same system as we have; viz., the segregation of amputation problems in one place and the supply of artificial limbs made, here, by a government factory; there, by contract under government supervision. In the United States the same procedure was set up to a certain point. Amputation surgical problems were gathered together in special centres, and dealt with by a special staff, and they were supplied with a temporary artificial limb and then discharged from hospital. From there on the handling of the problem of these veterans has been different. Their veterans' bureau has developed the policy of using the established manufacturers of artificial limbs for the provision of aids for these men, and the soldier goes with an order from the veterans' bureau to certain numbers of approved firms who manufacture the limb, which is accepted after inspection by the veterans' bureau. You will realize that this procedure has resulted in the accumulation of a large amount of information, under the direct supervision of surgeons who were interested in the problem, or who became quickly interested in the problem. As a matter of fact, this mass of experience—and particularly the necessity of the surgeon's controlling the type of artificial limb which was supplied—is the experience upon which American amputation surgery is founded. Prior to that experience, the surgeon amputated his patient's limb with too little consideration as to how that stump would function after he had amputated the limb. The limb manufacturer took the stump which the surgeon gave him and as best he could he fashioned the artificial limb for it. The result was far from ideal. There are certain stumps which function better than others and it has been this association of surgeon and limb manufacturer that has been the mark of the progress which has arisen out of the

experience of the last war. Anything that we do in this war, and anything that we do in civil practice, will be good if it is based on that similar association of surgeon with limb manufacturer. The limb manufacturer has skill and experience to bring to the aid of the surgeon and the amputee. The surgeon, on the other hand, has knowledge particularly of the anatomy and physiology of the extremity, and surgical skill without which a good functioning stump cannot be obtained. Both have contributed to what we now have in amputation surgery.

If we start off with war problems we must say that in war amputation surgery, the ever-present menace of infection governs the surgeon's activity. You cannot, in the field, amputate an extremity with the expectation that the amputation performed will be the last amputation that the man will need to have, and that ultimately the amputation stump will be fitted with a limb and will function well. In order to have a good stump which functions well, and a good artificial limb, it is necessary that the wound of the amputation heal by primary union. If it does not, the stump all too frequently is a poor stump, and has to have something done as a secondary operation. Since primary healing of wounds in the field is as yet almost too much to expect, we must, therefore, divide our amputation surgery of war into two stages:

(1) The procedure which has to do with the fashioning of the stump, and that is again divided into two stages—1. The amputation which is undertaken in the field, the object of which is to save the man's life; and 2. A second stage in which we remodel the emergency amputation done in the field into a stump which will have the best possible prospect of good functioning.

I have tried to indicate on a diagram the problems of amputation surgery, and these are problems in war amputation. Up to this stage the problems are the same for civil practice.

There are two phases of amputation surgery: (1) the surgeon's phase, which is concerned chiefly with producing the stump, and (2) the limb maker's phase, which is concerned with the prosthesis.

In war surgery, in view of what is going to happen to this stump later, it is necessary that we amputate the limb as soon as possible so that the later operation may be done. In order to combat infection, the wound must be left open; we must perform an operation which is guillotine in type. In favorable cases, when the infection has been controlled in 10 days' or 3 weeks' time, we can close the wound by primary closure. In our army that operation will be performed in field surgical units, the operating unit which is immediately behind the line and to which all major surgical cases are sent for operation.

This problem of fashioning the stump is continued at a later date when the primary wound has healed, and then the surgeon's problem is to fashion a stump which will fit an artificial limb, and which will function well in an artificial limb. In order to do that to his satisfaction, he must have as much stump left as possible and not be restricted by undue shortening of the stump or undue scarring at the end of the stump. That is the importance of leaving, in the field, as much as possible. A good example of this is shown by the value that we place upon a Syme's amputation. When a man in the field has been wounded so that his foot is shattered and amputation is necessary, a simple and easy solution in the field would be to amputate the leg in the middle of the tibia. It would be much better for his future function if the foot were amputated and the heel flap saved in order that he might later have a Syme's amputation. This preliminary operation, which should be done in amputation centres set up for that purpose, in order to be as good as possible must heal by primary union. It is best undertaken only when the operation done in the field is completely healed. It is necessary to ensure that the stump will be put into the best possible position for wearing the artificial limb. This eliminates flexor deformities, increasing the strength of the muscles which may have become flabby, teaching the amputee to use his extremity and to use the muscles of it in a new way, because many amputations interfere with the exertion of muscles and the patient has to re-learn the use of what muscles are left, and also shrinking the stump so that it will not be flabby and will fit the artificial limb as satisfactorily as may be.

It also involves fitting the prosthesis to the stump. I have indicated in my diagram how these things can most satisfactorily be done at an amputation centre.

In our country and in the United States these amputation centres have been set up. We have faced the problem as to whether or not we should provide our amputees with artificial limbs through the Ministry of Pensions and have decided against such a policy as being wasteful of time, wasteful of effort, involving the necessity of setting up amputation centres in England and dividing our effort into two phases.

Finally, we have to deal with problems relating to the prosthesis—its design, its manufacture and its fitting. That is the concern of the limb factory, except that this problem is a problem which is a joint responsibility of the surgeon and of the limb maker and fitter. That problem is shared jointly with the amputation centre and by the limb factory.

One cannot emphasize the value of bone amputations when they are necessary for trauma or infection. This is the best way of managing wounds in which we know infection is a problem. The bone amputation may be by fashioning of flaps and not suturing them, but, better still, it is by a modified guillotine amputation. This is a circular amputation in which the limb is removed by dividing the soft tissues and the bone at successively high levels so that when the amputation has been performed, we have a stump that looks something like this (slide shown), in which the bone is higher than the skin margin. If that is undertaken for gross infection already established, the wound must be left without anything further until the infection is under control. When the infection is under control, or in cases in which the infection is less serious or less evident, skin traction should be applied. If not, the skin will shrink far off the limb and necessitate a re-amputation. Skin traction can be applied by a sleeve of stockinette fastened to the skin by adhesive and held in place by a crepe bandage, and a rope on the end of the stockinette gives traction to the skin. This slide shows the appearance of the skin two weeks after and five weeks after the operation. If you commit yourself to guillotine operations like this, it is important that you handle the stump in the manner that I have illustrated by skin traction and healing by granulation. If you don't do so, if you attempt to close the wound at the end of a week or ten days by secondary suture, the resulting stump will not be as good as in this other way. This ensures that the end of the stump will be conical, there will be a firm but not excessive scar and there will not be any gross bulky mass of tissue over the stump.

If you decide, therefore, to manage your case by circular amputation, make up your mind that this involves healing by granulation with skin traction.

When we come to consider amputations of the lower extremities—and I am thinking now of the last operation, the one that is going to give the man the functioning stump—there are two kinds of stump which experience has proved to be valuable to the patient. Under certain circumstances we can fashion a stump either for the above-knee amputation or the below-knee amputation which will bear the weight on the end of the stump. In both cases this type of stump necessitates that the bone be tansected through the expanded cancellous lower end and if the amputation cannot be done there then that patient cannot have a good stump. So that we may transect the tibia just above the ankle joint or the femur just above the knee joint and cover the end of the stump with skin accustomed to bear weight and, with a little skill, secure a stump on the end of which the patient can bear all of his weight. The advantages of such stumps are very great. The patient easily bears all his weight on the end of such stumps, they are fitted with a simpler prosthesis, they enable the patient to walk and stand much better than with other types and, therefore, they are very desirable. So they are to be used wherever it is possible to use them. And that is one reason why the primary amputation in the field should be undertaken in such a manner as to save the largest possible amount of the limb.

If the patient cannot have an end-bearing amputation then he will have a stump on which the weight of his body will be borne, not on the distal end of the stump but on the top end of the stump. Since he is going to bear his weight on the top of the arti-

ficial limb applied against the top of the stump, the length of the stump in these cases is of value only for motivating the artificial limb, and it is not true that the longer the stump the better the limb. Indeed, in the below-knee stump there are many arguments for having as short a stump as possible and, generally speaking, the length of the stump, if the limb is not going to be an end-bearing one, is fixed within narrow limits and it is determined by the length of stump which will make the artificial limb move satisfactorily.

You may ask why a longer stump would not help the man to walk better. Well, as far as motivating his artificial limb is concerned, it might help him to walk better, but it brings with it certain problems. The fact that he bears his weight means that it is wedged in there with some force and every time he walks he thrusts it down and as he takes his weight off it, it comes up a little bit from the artificial limb. It tends to jam his stump into the artificial limb. The patient tends to lace the corset of the artificial limb tightly and that interferes with the circulation in the stump and a swollen stump jams itself still more tightly into the artificial limb. This may become the cause of serious troubles in the limb. The longer the stump the more likely those troubles are to occur. There are other troubles associated with below-knee amputations which I will mention in a moment.

Let us discuss for a moment the Syme's amputation. The Canadian surgeons have been strong advocates of the Syme's amputation as a good stump. It was designed by the great master surgeon, Syme, chiefly for tuberculosis of the ankle joint or tarsal bone at a time when artificial limbs as we know them today did not exist, and he was trying to get an amputation stump which a man could put into his own boot and get around. It is today the best amputation for limbs below the knee. This slide shows the technique of this type of operation. Here we see the appearance of a good Syme's stump. Here is another good Syme's stump. This is a picture of the artificial limb which that patient wears and here is another example of it. It consists of the standard foot and then, above that, a rather heavy metal skeleton with a leather corset which laces around the stump.

In this picture you can see the only shortcoming of the Syme's operation; viz., that you can't get, in the prosthesis of a Syme's amputation, a good likeness of the normal leg. Here we have a double Syme's amputation with artificial limbs which this man has worn for 27 years. These are the prostheses that he wears.

I am very much indebted to the Department of Pensions and National Health, who, through the good offices of Major Bell, has sent from Ottawa these cases of artificial limbs.

This shows a girl who suffered from a congenital non-union of the tibia. Here is the non-union of the tibia as seen in the X-ray. She was 21 years of age, weighed over 200 lbs., wore an enormous thing on her leg which weighed 25 lbs., and was very much depressed about her condition. A Symes amputation was done, but because of the enormous shortening, one leg was very much shorter than the other one. However, a limb manufacturer made this artificial limb for her so that it looke quite a bit like her normal leg.

This is a good example of how valuable a Syme's amputation can be. Canadian surgeons are very much in favour of Syme's amputations, but there has not been universal acceptance. I cannot explain the objections raised. I think that condemnation of it it not justifiable. If there are vascular changes they may be related to such things as chilblains, which are very common in England but not common here in Canada. Now the American Army has adopted the Syme's type of amputation.

If the limb below the knee cannot be amputated so as to produce an end-bearing stump, then it must be amputated in such a manner that the weight will be borne in another way. The amputation should be done by choice so as to produce a stump about 6" long. The flaps are best equal. This slide shows the technique of this other type of amputation. The stump when finished should be cone-shaped and tapered uniformly at

the top and bottom. This slide shows a good below-knee stump. This shows an artificial limb of the English type. The skin which bears the weight is not adapted to bearing weight. The constant trauma of bearing weight often leads to trouble, such as infection in a series of furuncles. Some of that problem can be diminished by the manner in which the corset above the knee is handled. If it is stiffened and carried up higher, then a greater amount of the man's weight can be carried on his thigh. If the corset is made stiffer and carried up higher, he can take all the weight of his below-knee stump.

This slide shows the three types of artificial limbs for this type of amputation. It does not, as a general rule, however, permit the man to work on his feet all day long. The surgeon to the Goodyear Tire and Rubber Co. recently has surveyed all the amputees in his firm to see how the below-knee amputations stood up and he found that they cannot stand up at their work all day long.

If one cannot fashion a below-knee stump then the next best stump is one through the condyles of the femur, the so-called Gritti-Stokes amputation. This slide shows the technique of this type of amputation. There are other types of weight-bearing stumps which are good but the Canadian surgeons have had no experience with them. This shows a good Gritti-Stokes amputation. Here is an X-ray picture of the patella in this case. The patient lacks voluntary movement of his knee joint, and if one has to choose between the two, one should choose the below-knee stump and let the man demonstrate what he can do. If it gives him trouble, it can always be amputated into a Gritti-Stokes.

This is a good mid-thigh stump and this is a type of artificial limb supplied for it. It is a metal limb with a pelvic belt. This is a limb for a patient whose stump is so short that he cannot wear a mid-thigh limb or who has lost his femur by disarticulation.

I won't say much about arm amputations except this—that the function that we can obtain from this is incomparably less than we can obtain from the prosthesis of lower extremity amputations. The complex mechanism of the hand cannot ever be produced by any kind of prosthesis because we cannot ever reproduce the fine movements of the fingers nor can we give a man the fine sensations that are in the normal hand. We can give him an appliance which is useful to him if we abandon the thought of giving him a normal-looking hand. He gets on best with an ingenious hook.

As to the psychological aspect of amputations, a man who has lost an extremity—especially a young man—faces a profound psychological revision of his attitude towards the world. He wonders whether he can get along and perhaps he wonders whether his family and his girl are going to like him as well as they used to. The most important thing we must do for these men is to assure them that they can lead normal lives in spite of their mutilation.

We had an amputation conference here in February. It was very interesting and I think it was productive of some important measures, but to me one of the most impressive events of that conference was something that was entirely unpremeditated. When the conference was under way we received a letter from the War Amputations Association of Canada, which said: "We owe a lot to doctors and we would like to invite you to a dinner in Toronto." After some hesitation we accepted the invitation and we had one of the most unique experiences of our lives.

That psychological aspect is important, and to all of you who have anything to do with amputees I would stress that you keep in mind the psychological aspects. One of the most valuable things is to prepare a little film which I am going to show you now.

NEWS AND NOTES

The profession was shocked to learn of the sudden passing of Dr. Peter Sinclair McCaffrey of Agassiz. Dr. "Pete" McCaffrey held a warm place in the hearts of his colleagues.

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The sympathy of the profession is extended to Doctors T. R. B. Nelles, W. L. Pedlow, G. H. Worthington and Major R. P. Borden in the loss of their sons while on Service with the Infantry.

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Dr. Thomas McPherson of Victoria and Miss Dorothy Grubb were married recently.

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Dr. McPherson of Victoria, Dr. H. H. Milburn and Dr. P. A. McLennan of Vancouver are in Ottawa attending the meeting of the Medical Council of Canada.

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Lieut. Robert Knox, R.C.N.V.R., is visiting with his parents, Dr. and Mrs. W. J. Knox in Kelowna, after service overseas.

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Lieut. Steve Covernton, son of Dr. C. F. Covernton of Vancouver, is visiting on the coast after service overseas.

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Major C. H. Ployart, R.C.A.M.C., formerly in practice at Lillooet, has returned from overseas to be stationed on this coast.

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Dr. S. W. Baker has returned to his practice at Ladysmith after some weeks' vacation.

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Dr. S. P. Findlay of Fraser Lake was at the coast for a short visit in August.

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Dr. C. C. Browne of Nanaimo had a pleasant ten-day cruise in his sloop *Ann*.

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Dr. P. L. Straith of Courtenay has just returned from Rochester and Eastern cities, where he has been doing post-graduate work.

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Dr. F. M. Bryant of Victoria has been visiting in Vancouver, and enjoying some very good golf.

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Dr. R. Geddes Large of Prince Rupert has been down to military camp as medical officer with a Reserve Unit.

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Dr. C. H. Hankinson of Prince Rupert had a vacation on Vancouver Island.

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Dr. W. T. Kergin, who formerly practised in Prince Rupert, has been visiting there and renewing old acquaintances.

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Dr. J. P. Cade of Prince Rupert has had a month's vacation.

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Dr. L. W. Kergin had a trip along the new highway from Prince Rupert, which has opened up some virgin fishing.

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Dr. E. S. Hoare had a holiday at Trail.

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Dr. D. J. M. Crawford of Trail visited in Medicine Hat.

Capt. W. J. Endicott, formerly of Trail, is now overseas.

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Dr. R. W. Garner of Port Alberni is in the East.

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Dr. George Young and family, formerly of Salmo, now with the Department of Pensions and National Health, Calgary, spent his vacation in Nelson.

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Major S. L. Williams, stationed in Eastern Canada, visited Nanaimo. Part of his time, accompanied by the family, he was holidaying in the Forbidden Plateau. Dr. E. D. Emery and wife accompanied Major Williams to the Forbidden Plateau.

* * * *

Dr. C. C. Browne of Nanaimo is going to Mayo Clinic and will spend several weeks there. He will be accompanied by his wife. Doctor Browne is entering his sloop *Ann* in competition against the R.V.Y.C. yachts at Yellow Point on September 3rd.

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Dr. A. H. Meneely of Nanaimo and family will have a short Labour Day week-end at Qualicum.

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Dr. L. Giovando of Nanaimo is planning to do some bird hunting at Campbell River.

* * * *

Dr. Allan Hall is spending Labour Day week-end at his cottage at Rothtreeves Beach.

ANNUAL MEETING—September 26th-29th

Special Announcement

LADIES' PROGRAMME AT VICTORIA

Thursday, 28th, 4:30 p.m.—Reception at Government House.

Friday 29th 7:00 p.m.—Ladies' Dinner.

Colonel D. H. Williams was visiting on the coast and he and his family stopped at Vaucroft.

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Major E. J. Curtis called at the office while visiting his family in Vancouver last month.

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Dr. R. W. Irving was in town and very inetrested in the feats of the ponies at Hastings Park.

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Dr. H. F. Tyerman of Ashcroft made a flying visit to Vancouver recently.

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We are glad to report that Dr. E. J. Lyon of Prince George and wife are none the worse for their experience on Stuart Lake.

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Capt. F. L. Wilson had an unusual fishing trip at the top of Stuart Lake. They threw back everything under 7 pounds. Some trout!

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Dr. R. G. Turner, formerly at Pinchi Lake, also fished in Stuart Lake and vouches for the size of the trout, which run up to 18 lbs. and are bonny fighters.

Major R. R. Laird and wife have returned from Great Britain. Major Laird formerly lived in Oliver, was an interne at the Vancouver General Hospital, and just prior to entering the R.C.A.M.C. was ship surgeon on the *Empress of Russia.* Major and Mrs. Laird have the best wishes of the profession.

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Dr. A. R. Wilson of Chilliwack is spending a vacation at Qualicum Beach, Vancouver Island.

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Dr. G. A. C. Roberts of Chilliwack has returned from two weeks' respite from work at Savary Island.

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Dr. G. F. Enns is planning to spend two months on post-graduate courses in Chicago.

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Captain Harold Stockton, R.C.A.M.C., formerly of the No. 3 Canadain General Hospital, is expected to be repatriated soon as a result of injuries received on active service last March.

Obiit

PETER SINCLAIR McCAFFREY

Sept. 5, 1944

In the death of Dr. P. S. McCaffrey of Agassiz, the medical profession of B. C. has lost one of its finest characters, and one of its best-loved members—the Fraser Valley, and especially Agassiz, has lost one of its bset and most valuable citizens, and a most devoted practitioner of medicine.

"Pete," as everyone who knew him well called him naturally (who is it that said that the man who has no nickname has very few friends?) has served his community for a long time, over thirty years: and during that time he has built himself an enduring place in the confidence and affection of those he served. He did good work, and he had lots of it to do. Withal, he developed, as the years went by, into a wise counsellor, and a man of weight in the community. Amongst other medical men he was always eagerly welcomed and at home. He had a delightful wit, and it was always a pleasure to hear him speak at a meeting: he hated shams and pretentiousness, and was himself most straightforward and sincere, even to bluntness. But his sympathy was always for the younger men, and those in the less favoured places, and his voice was always raised on their behalf. We shall miss his wisdom and experience.

To his wife and family we extend sincerest sympathy.

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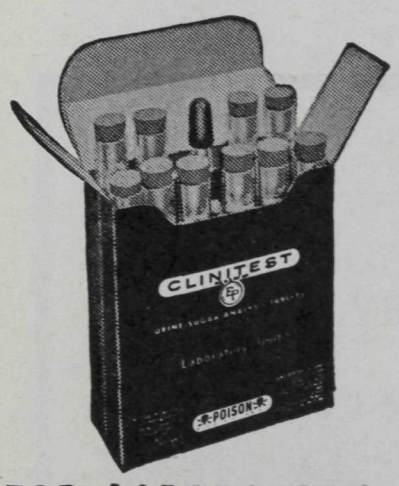

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SPEED . . . Just add a Clinitest Tablet to proper amount of diluted urine. Allow a few seconds for reaction.

DEPENDABILITY . . . Compare with color scale for urine-sugar percentage reading.

CONVENIENCE . . . Eliminates flame, external heating, water-bath, complicated apparatus.

No Powder to Spill . . . The use of tablet and test tube confines the test to the known agents and reagents. It guards the test from possible oxidization by atmospheric oxygen.

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The Clinitest Laboratory Unit contains 10 vials of 25 tablets each...250 tests ...together with Clinitest dropper and instruction book with color scale. Reasonably priced.

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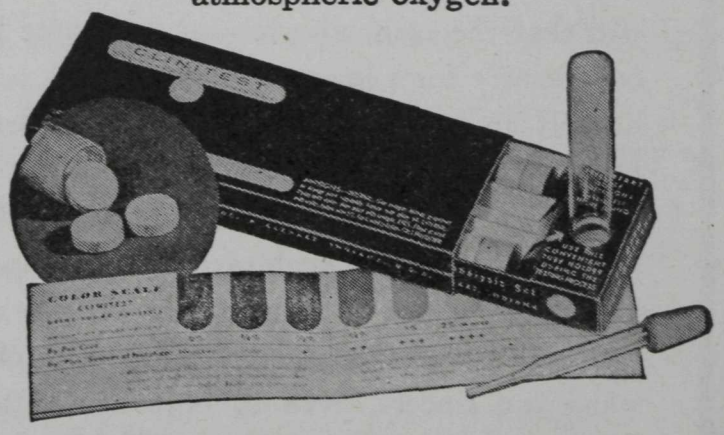

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TENDS TO BREAK "Laxative Habit" but is not habit-forming of itself

Mucara is purely physical in action. It is neither digested nor absorbed during its passage through the intestinal tract.

Mucara will not produce abnormal motility of the bowel, and patients should be advised of this fact.

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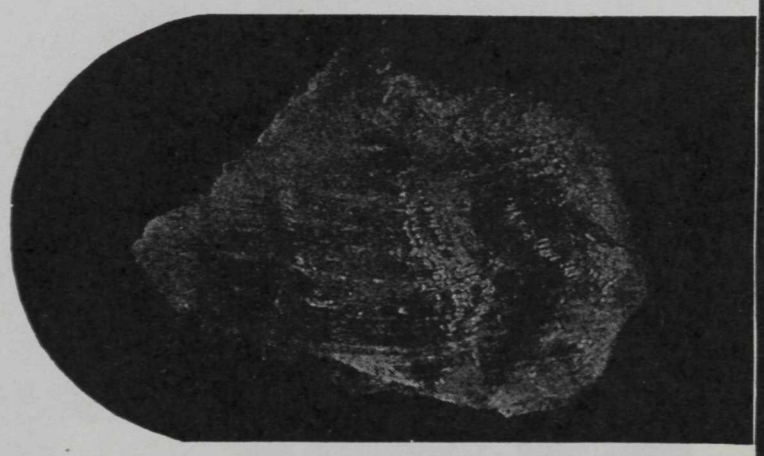
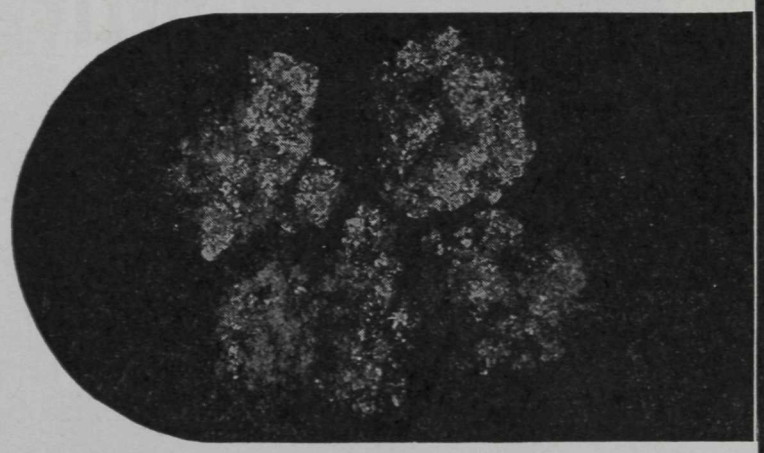


KARAYA GUM—SOLID GRANULAR FORM
(Magnified)

Note hard, flint-like surface and also limited amount of surface area exposed to intestinal fluids.



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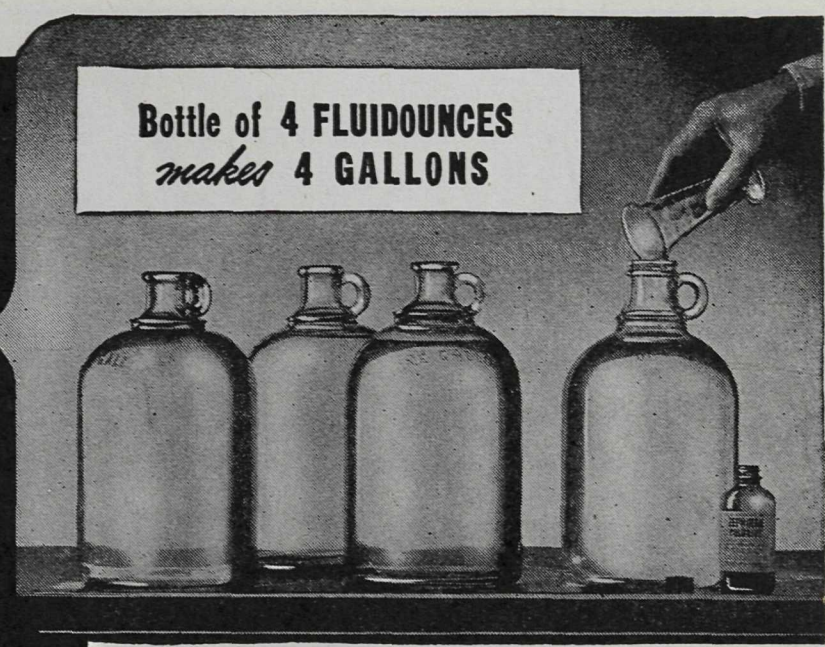

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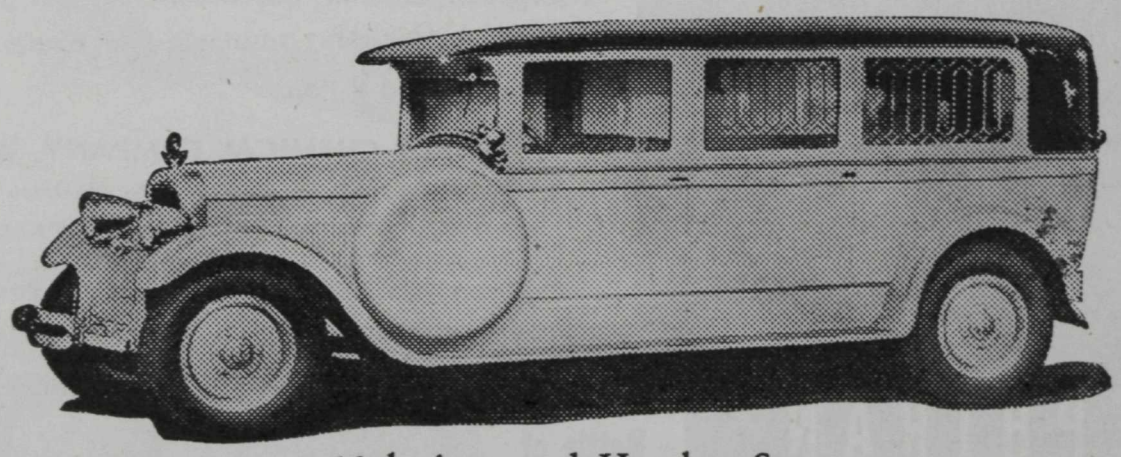

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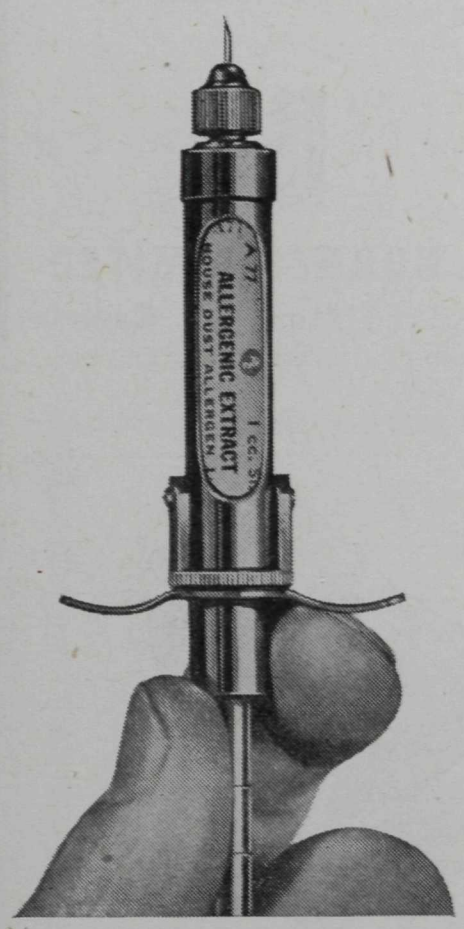

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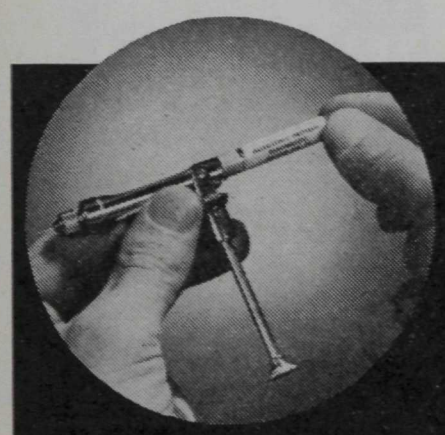

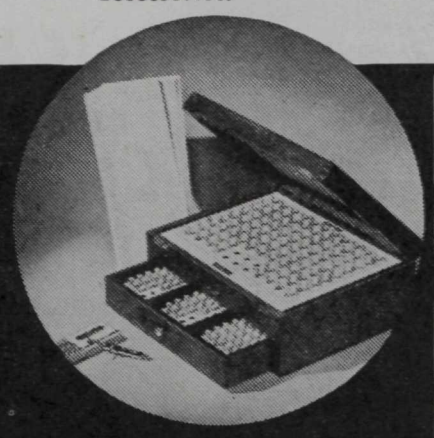

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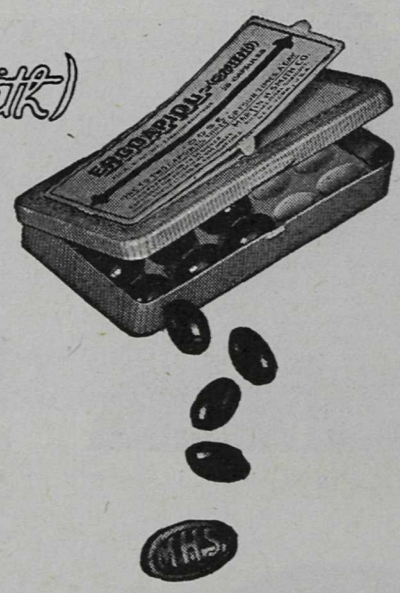

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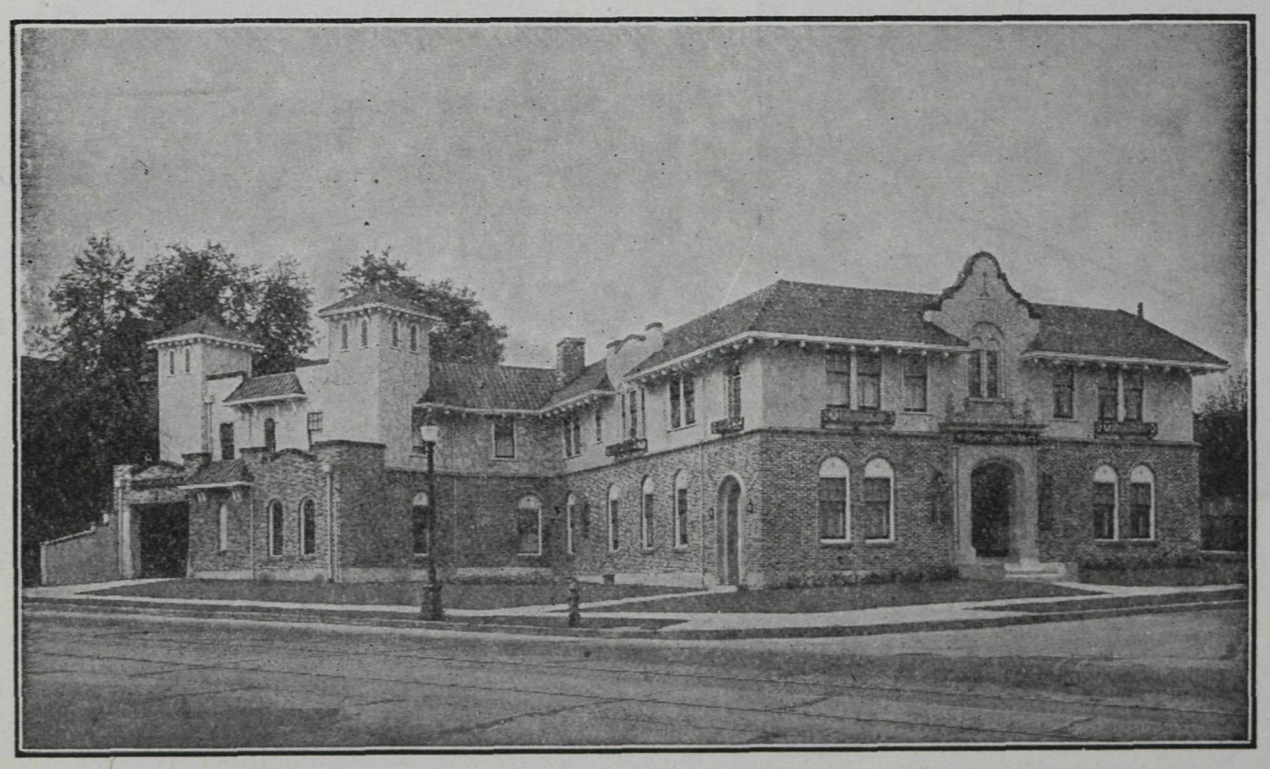

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For the treatment of

NEUROPSYCHIATRIC
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Reference—B. C. Medical Association

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