THE VANCOUVER MEDICAL ASSOCIATION

# BULLETIN

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Vol. XXII JUNE, 1946 No. 9

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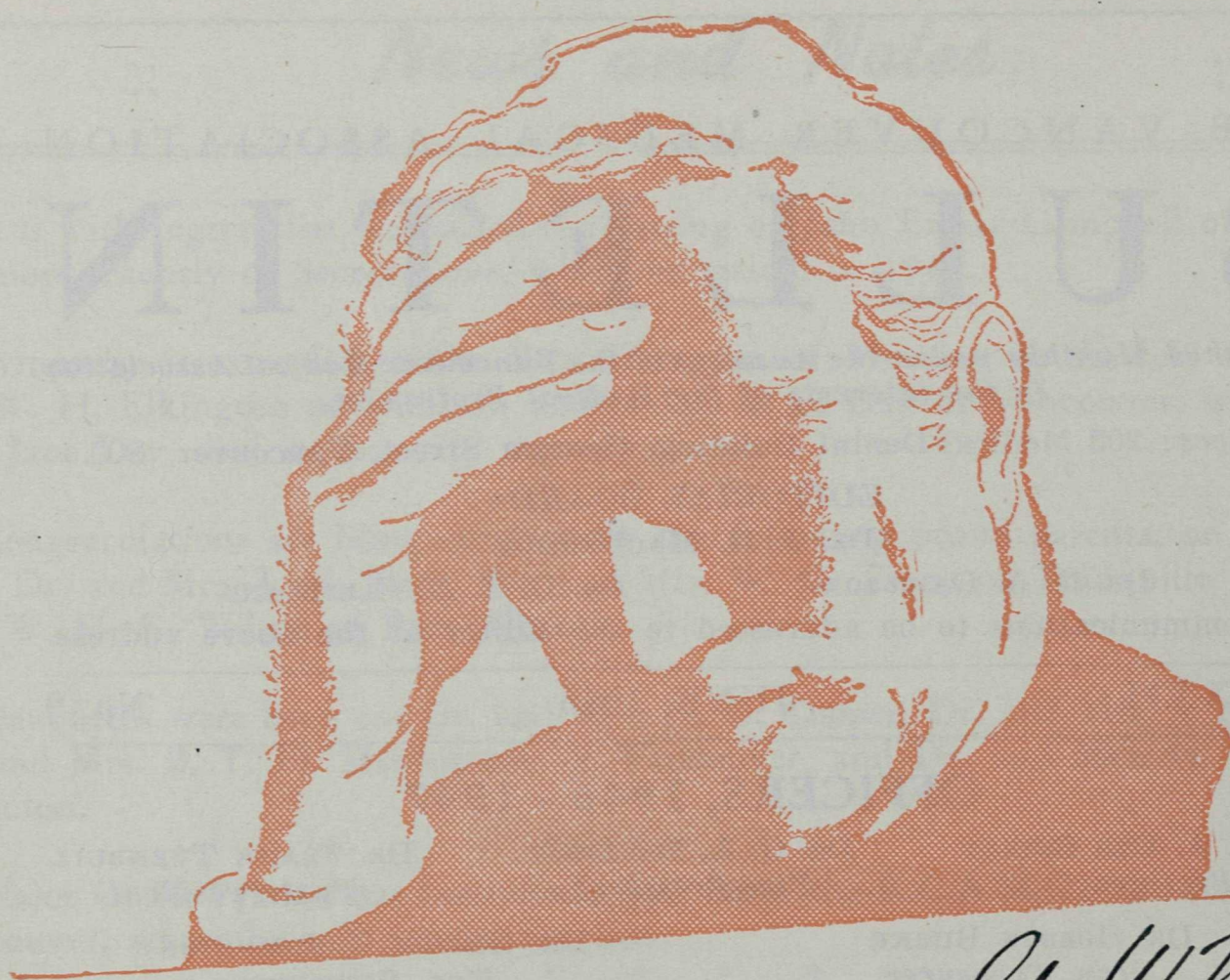

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1. Spies, Tom D.; Cogswell, Robert C., and Vilter, Carl: J.A.M.A. (Nov. 18) 1944. Spies, Tom D.: Med. Clin. N. Am. **27**:273, 1943. 2. Spies, Tom D.: J.A.M.A. **122**:911 (July 31) 1943. 3. Jolliffe, Norman, and Smith, James J.: Med. Clin. N. Am. **27**:567 (March) 1943.

*For literature write*

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# VANCOUVER HEALTH DEPARTMENT

## STATISTICS—APRIL, 1946

| | |
|---|---|
| Total Population—Estimated | 323,850 |
| Chinese Population—Estimated | 6,566 |
| Hindu Population—Estimated | 361 |

| | Number | Rate per 1000 Population |
|---|---|---|
| Total deaths | 343 | 12.9 |
| Chinese deaths | 21 | 38.9 |
| Deaths, residents only | 326 | 12.2 |
| | 670 | 25.2 |

BIRTH REGISTRATIONS:

| | |
|---|---|
| Male | 331 |
| Female | 339 |

| INFANT MORTALITY: | April 1946 | April 1945 |
|---|---|---|
| Deaths under 1 year of age | 13 | 17 |
| Death rate—per 1000 live births | 19.4 | 25.6 |
| Stillbirths (not included above) | 6 | 9. |

## CASES OF COMMUNICABLE DISEASE REPORTED IN THE CITY

| | March, 1946 | | April, 1946 | | May 1-15, 1946 | |
|---|---|---|---|---|---|---|
| | Cases | Deaths | Cases | Deaths | Cases | Deaths |
| Scarlet Fever | 36 | 0 | 12 | 0 | 41 | 0 |
| Diphtheria | 2 | 0 | 1 | 0 | — | 0 |
| Diphtheria Carrier | 0 | 0 | 0 | 0 | 0 | 0 |
| Chicken Pox | 133 | 0 | 136 | 0 | 206 | 0 |
| Measles | 6 | 0 | 2 | 0 | 10 | 0 |
| Rubella | 1 | 0 | 5 | 0 | 3 | 0 |
| Mumps | 186 | 0 | 245 | 0 | 132 | 0 |
| Whooping Cough | 0 | 0 | 0 | 0 | 0 | 0 |
| Typhoid Fever | 1 | 0 | 0 | 0 | 0 | 0 |
| Typhoid Fever Carrier | 0 | 0 | 0 | 0 | 0 | 0 |
| Undulant Fever | 0 | 0 | 0 | 0 | 0 | 0 |
| Poliomyelitis | 0 | 0 | 0 | 0 | 0 | 0 |
| Tuberculosis | 81 | 11 | 0 | 0 | 81 | 8 |
| Erysipelas | 3 | 0 | 1 | 0 | 1 | 0 |
| Meningoccus Meningitis | 2 | 0 | 3 | 0 | 0 | 0 |
| Infectious Jaundice | 1 | 0 | 0 | 0 | 0 | 0 |
| Salmonellosis | 15 | 0 | 13 | 0 | 6 | 0 |
| Salmonellosis (Carrier) | 10 | 0 | 0 | 0 | 1 | 0 |
| Dysentery | 0 | 0 | 0 | 0 | 2 | 0 |
| Syphillis | 65 | 1 | 0 | 0 | 105 | 2 |
| Gonorrhoea | 196 | 0 | 0 | 0 | 237 | 0 |
| Cancer (Reportable) Resident | 62 | 0 | 0 | 0 | 90 | 0 |
| non-Resident | 28 | 0 | 0 | 0 | 34 | 0 |


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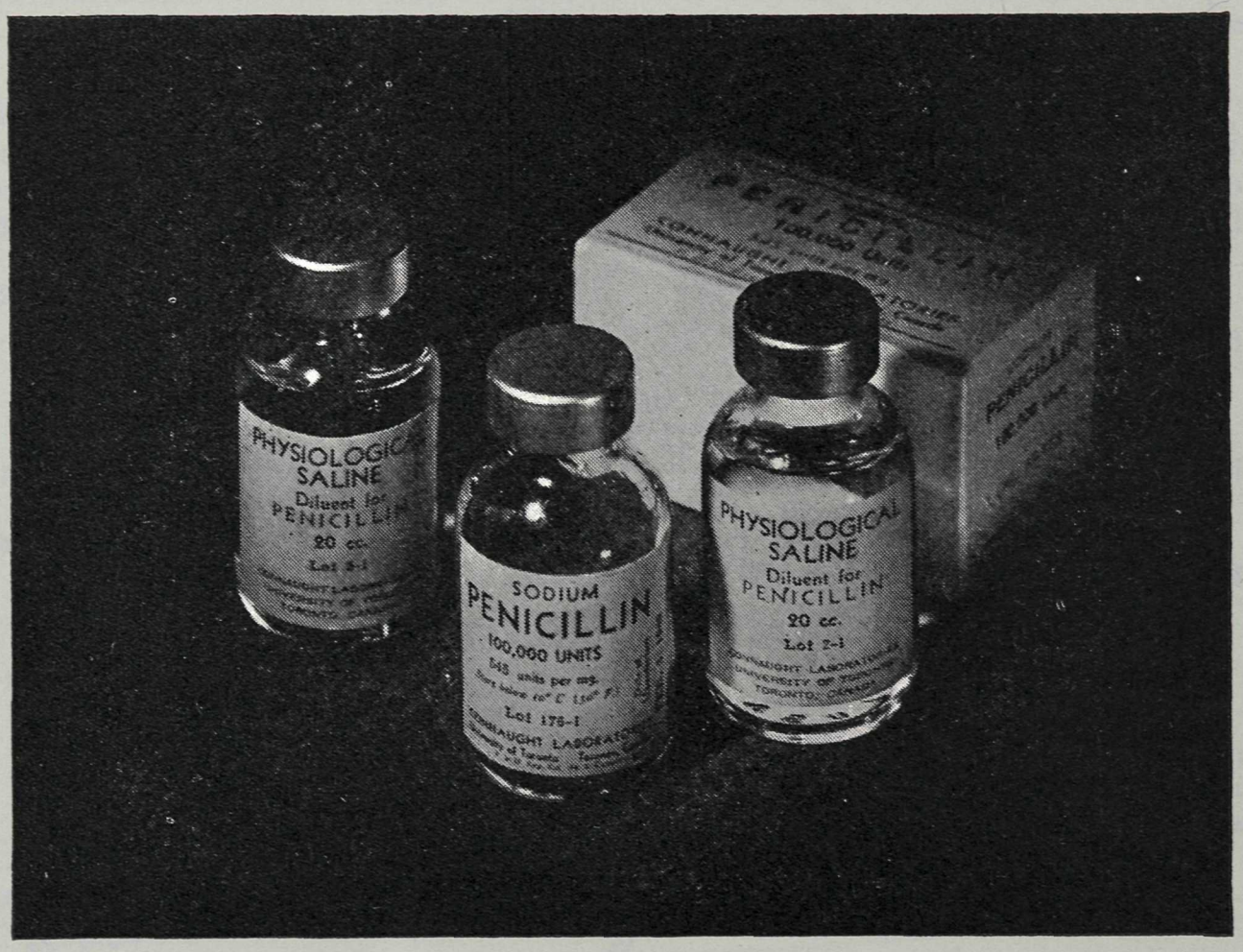


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# The Editor's Page

We are publishing in this issue the report made by Dr. G. F. Strong to the Annual Meeting of the B. C. Medical Association in June at Banff. We should have been very glad to publish, alongside of this report at last an adequate precis of the original report made by Dr. C. E. Dolman to the Senate of the University of British Columbia, following his survey of the whole question of the establishment of a Medical School at our University.

We wrote to Dr. Dolman, asking him if he would care to give us such a precis of his report, in view of the fact that his communication was made, not to any medical body, but to the University authorities—it seemed to us that all medical men would welcome the opportunity to read and study this for themselves. Dr. Dolman very promptly answered our letter, and told us that he would have been very willing to do as we asked, but that this would be rather superfluous, as he was making arrangements to send a copy of the report to every medical man in the Province. This is, of course, far better than a mere summary would be, and we are very glad that this is being done. The report will probably reach our readers before this issue of the Bulletin is printed and in their hands; and this is perhaps as well, since the chronological order of the two reports will thus be preserved. Dr. Dolman has kindly asked us to say, that if any medical man in the Province does not receive his copy, he will be very glad to hear from him, and will see to it that he gets one.

The two reports should be carefully read and considered before any opinion on the matter is definitely adopted; and this is why we were so anxious to have both of them made available to our readers. We have read them both, and feel that we should say something about the matter. Both reports reflect a great deal of hard, sincere effort, and while there are certain major differences of opinion expressed by the two authors, these are, in the main, based upon two main considerations, though there are some other very significant divergences of opinion in matters of detail.

The first consideration, as we see it, is the matter of location of the Medical School. One view is that it must be entirely intramural, with all medical buildings, including a University Hospital, to be situated on the campus of the University, and entirely under its control. The other view favours the utilisation of existing City Hospitals, their conversion in whole or in part into teaching hospitals, with adequate control by the University authorities—this latter, of course, is a *sine qua non,* if constant friction and political quarrels are to be avoided.

The other main consideration is one of timing, both as regards the question of urgency, and the need for immediate action towards the establishment of a Medical School, and also as regards the question of finance, and the likelihood or otherwise of a sufficiently ample supply of money being available at the present time, to ensure the adequate development of a first-class Medical School.

Both sides agree that a Medical School should be built—but one side wants to wait till we can equip and finance a first-class School with full-time professors, ample opportunities for research, and so on—and feels that there is no great urgency for immediate action—that quality must come first, and that the University is not at present justified in starting on the venture—that a Medical School built under present conditions would be a second-rate and inferior affair.

The other side of the argument feels that there *is* an immediate urgency—that we owe it to the youth of the Province to afford to them an opportunity for medical training *now,* a training that must, through the limitations at present existing, be denied to many who are anxious to obtain it. This, of course, would not be a sufficient argument by itself—the mere fact that a great many men and women want training

does not justify us in instituting a School which would be inferior, and second or third rate. But they feel that we have here now, ample facilities to make a beginning, and to develop a good Medical School—that we should begin with what we have, and build on the foundations now at our disposal with the building material that we already have; and that these things are sufficient to ensure our attaining the necessary standards of quality.

We plead guilty to a sympathy with this latter view—for many reasons. We are thoroughly convinced that Canada needs more medical schools—no social programme can reach any distance of development, until and unless we have more medical men at our disposal; this goes for Health Insurance, Public Health work, child welfare, school medical services, etc.

We feel that there is a certain danger here that we may adopt an ultra-perfectionist attitude towards this matter. We cannot but respect the views of those who want only the best, and will not be satisfied with less. But there is more than one road to Rome, and the danger of over-refining the ideals and principles of which we base our actions, is that it leads to loss of enthusiasm, and a blunting of the keen edge of that enthusiasm. We must not, in our nostalgic yearnings for the greater rivers of Abana and Pharpar, overlook the River Jordan which flows past our back door, and has much virtue in its waters.

If we wait here in British Columbia, till we have all the money we need, all the prestige that only a wealthy and a very fully-equipped University can give, before we embark on the venture of a Medical School, it is doubtful if we shall ever have one—and all precedent is in favour of the other course, of starting with what we have—provided, we agree, that a certain minimum of standard of requirements can be met, and we believe it can. This is the way, surely, that all the major medical schools began—it is, indeed the way that all the great Universities began. Oxford and Cambridge, Edinburgh and London, McGill and Toronto, Harvard and the other great American Universities—all of them began in a small way, many of them with so little in the way of resources that it is a miracle that they survived at all. But the need for them was there, and the passion for learning—the divine fire, if only as a spark, was there, and as the years have gone by, the small flame has kindled a great matter.

Nor can we see the necessity for a University Hospital, to be situated in the grounds of the University. We would go further, and say that we believe it is the last place that should be chosen for such a Hospital—quite apart from the expense of erecting such a building, which expense alone would postpone the inception of a Medical School for many years. We do not believe that this is a good place to put the Hospital in which students would have to learn their clinical medicine and surgery. The great bulk of the average doctor's work, and especially for most of the earlier years of his practice, is the outdoor type of case—the run of the mine stuff that is found in abundance in the outpatient departments of the big hospitals. In Vancouver, the factories, the mills, the industrial plants, are in the area around False Creek, and heading towards New Westminster and Burnaby—and it is inconceivable that this most essential and vitally necessary teaching material or any reasonable part of it, would ever find its way out to the University area, which seems to have been chosen as the area most permanently remote from the centre of Vancouver. In our humble opinion, the professions of law and medicine are best taught in close proximity to the laboratories of their work—the law courts and the big city hospitals—where material is most abundant and readily accessible. Here the learner sees the constant and detailed application of his art, in all its branches, great and small—the latter being probably the most important. Here he is in touch, not only with the academic and didactic part of his instruction given in lectures and classroom teaching, but with the men who are practicing their profession, from whose example and precept he can learn the details of actual practice, which are so essential to the training of a doctor or lawyer, and especially of a general practitioner. We feel that this is only available where the great bulk of clinical

material is to be found—and further that it cannot be made available at such a distance from the business centre of the city.

If we want a medical school badly enough, if we need it badly enough, and if we are willing to work hard enough for its attainment, we can see no reason at all why we should not have one, and have it now. But there is no elevator to take us to the top of Hill Difficulty. Like Christian of old, we have to climb it a step at a time, with a pack on our back. Like him, we shall find lions in the path, like him too, we believe that when we actually face the lions, we shall find that "they are chained and are placed there for trial of faith" and cannot harm us. But like Christian again, we must keep on "in the midst of the path."

Our friends the Chinese are credited with many wise sayings. Perhaps they are not responsible for them all—but some of the sayings have much to commend them all the same. We would close with one of them "it is better to light a very small candle than to wail at the darkness".

* * * *

# CORRESPONDENCE

1477 Chomedy St., Montreal, P.Q.,
June 9th, 1946.

To The Editor,
Vancouver Medical Association Bulletin,
Georgia St., Vancouver, B.C.

Dear Sir:

On May 30th I was privileged to attend a meeting of the Montreal Medical-Chirurgical Society at which the distinguished orthopædic surgeon, Sir Reginald Watson-Jones, and the equally distinguished abdominal surgeon, Sir Gordon Gordon-Taylor, delivered addresses. In connection with his opening remarks on the contributions of Canadian surgeons in R.A.F. Orthopædic Centres in the early years of the war, Sir Reginald Watson-Jones paid high tribute to the skill and zeal of the late Dr. Murray Meekison of Vancouver. As one who had known and worked with Dr. Meekison it was warming to hear this praise of one of Vancouver's own doctors from the lips of Watson-Jones, who is certainly the most outstanding orthopædic surgeon in Britain today.

Watson-Jones stated it as his conviction that Meekison's untimely passing must be classed as a casualty of the war, in that the selfless zeal and unflagging energy he showed during those desperate days and nights undoubtedly left their stamp upon his physical frame.

Meekison's skill was singled out for special praise in connection with one case involving multiple fractures of an airman's arm, in which there was extensive skin-loss also. The lecturer said that no one but a man of Meekison's courageous mould would have considered anything but immediate operation. As it turned out, not only was the limb saved but a good functional result secured.

I thought the Vancouver doctors who were associated with Meekison would have been glad to learn of the high regard in which he was held in Great Britain and of this fine tribute from an outstanding figure in British surgery.

Yours sincerely,

GILLIAN MacKINNON, M.D.

# Vancouver Medical Association

| | |
|---|---|
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## SUMMER SCHOOL
## VANCOUVER MEDICAL ASSOCIATION
## HOTEL VANCOUVER
### September 9th to 13th incl.

Plans are being made to hold the annual Summer School in September, on the above dates, and this year the lectures will be arranged over a five-day period, instead of the usual four, to allow for some leisure time in the evenings. The slate of speakers is now complete and we take pleasure in announcing that the following outstanding men will participate in our programme:

Dr. Elmer Belt, Urologist, Los Angeles.

Dr. Simeon T. Cantril, Director of the Tumor Institute of the Swedish Hospital, Seattle.

Dr. Russell L. Cecil, Professor of Clinical Medicine, Cornell University Medical College, New York.

Dr. J. R. Lindsay, Professor of Surgery (Otolaryngology) University of Chicago.

Dr. Roy D. McClure, Surgeon in Chief, Henry Ford Hospital, Dtroit.

Dr. N. W. Philpott, Dept. of Obstetrics & Gynaecology, McGill University, Montreal.

## THE LIBRARY

HOURS: (Summer Months)

Monday through Friday, 9:00 a.m. to 5:00 p.m.
Saturday, 9:00 a.m. to 1:00 p.m.

RECENT ACCESSIONS TO LIBRARY:

Medical Clinics of North America, Symposium on Rheumatic Diseases, New York Number, May, 1946.

The Chemical Composition of Foods, 2nd ed. 1946, by McCance and Widdowson.

Postwar Venereal Disease Control, (Proceedings of National Conference, St. Louis, Mo. November, 1944). U. S. Public Health Service.

The Genus Ixodes in North America, National Institute of Health Bulletin No. 184, by R. A. Cooley and Glen M. Kohls. U. S. Public Health Service.

Medical Research Council—

Special Report Series No. 253—Tables of representative values of foods commonly used in tropical countries, by B. S. Platt.

Special Report Series No. 254—An experimental study of rationing, by R. A. McCance and E. M. Widdowson.

## NOTICE

**Please note that the evening hours in the library will be discontinued during the summer months but will be resumed in the fall.**

# THE CANADIAN MEDICAL ASSOCIATION ANNUAL MEETING AT BANFF JUNE, 1946.

The Seventy-Seventh Annual Meeting of the Canadian Medical Association has passed into history, and one can look at it rather more objectively than was possible during the rather hectic week of its existence.

There is no doubt that it was a great success—we have heard nobody speak of it in terms of disappointment, and everyone, we think, found in this meeting much to delight and interest him. Everyone had a good time. The machinery of the Hotel worked silently and perfectly, as far as we were concerned—though it took heroic improvising on the part of the management, to avoid catastrophe on one or two occasions—as when the dishwashers went on strike. But we knew nothing of this and our sincere thanks are due to the Canadian Pacific Hotel management, for the comfort and luxury that were ours. The catering was excellent, the accommodation most comfortable.

The programme went very smoothly. For this, especial credit is due to the Programme Committee, to those who led the Round Table discussions, and the Sectional Meetings; all did their work very well, and showed evidence of careful preparation, and smooth team-work. Perhaps a special word should be said in thanks to a group of Committees, which were concerned with the duty of seeing that the machinery ran smoothly. First among these Sons of Martha was the Committee on Housing, which did a tremendous job, and did it very well indeed, but which had to take all the blame for allotments which they did not make, and yet kept their tempers, and went on working. The Committee on Signs and Badges, the Committee on Commercial Exhibits, the Committee which had to do with securing rooms for meetings, on little or no notice, and so on. It would be invidious, perhaps, to mention names—but these Committees especially formed a group which had all the unpleasant and hard jobs given them, and we feel that they deserve our thanks. The other Committees did their work well, and the months of careful rehearsing and preparation were amply repaid by the results.

Our President, Dr. Wallace Wilson, may well be proud of his meeting. It was a completely successful and a great meeting. (And to his able and always kindly leadership more than to any one factor, is due the great success of the Convention.) To his gracious helpmate, Mrs. Wilson, is due an especial meed of thanks. One stands amazed at the amount of work done by her and her Committee, in preparing the Entertainment Programme for the ladies visiting the Meeting. There was endless variety, and something for everybody. To these two delightful people, we owe special gratitude.

To record the highlights of the Meeting would be an endless task, but some few may be mentioned. The presentation to Dr. T. C. Routley, our invaluable General Secretary, signalising his 25th year completed in this office, was one such highlight, and he well deserved this recognition. He must have felt a great satisfaction, as well as pride, as he looked around at the monument to his work, the present Canadian Medical Association, which in his time, and largely through his guidance, has become a national asset, a body trusted and consulted by the Government of Canada, so that they asked it to nominate a man to represent Canada in New York in the Health Division of the United Nations' Conference. This is a unique honour, but it shows the place to which the C.M.A. has risen in accomplishment as a national organization. It was only fitting that Dr. Routley should be chosen.

Then, the appointment for the first time in Medical history, of a woman to the presidency of a provincial medical association—when Dr. Ethlyn Trapp of Vancouver, was chosen to be the president of the B.C. Division of the Canadian Medical Association. Dr. Trapp well deserves this honour, and we are fortunate in the choice of her as president.

To one group of men we would pay a sincere tribute—the hard working exhibitors, who, in the face of a great many discouragements and all sorts of frustrations, where these should not have existed, put on a really excellent show. We owe a great deal to these men—without them we could hardly have financed the meeting—and we should like to pay our compliments to them, not because of this consideration, but because, in spite of a great many handicaps and drawbacks, they retained always their cheerful, friendly attitude, and gave us much that will be helpful in days to come.

To the boys of the Press, too, we say "thank you". They are as keen and alive a bunch as we ever saw, and they played the game throughout. The confidence we reposed in them, was amply justified, and they worked with us from the start.

Well, we can't say it all. But speaking as one might who was well into the middle of it, we can honestly say that we enjoyed every minute of it, and were sorry to go. Winnipeg next! And may they have as good a crowd of fellows to work with and to work for, as we had at Banff.

We take pleasure in subjoining a letter from Mrs. Wallace Wilson, wife of our President, Dr. Wilson. She expresses admirably her gratitude to her co-workers, and they deserve it. But they had a good leader in their work.

* * * *

From the woman's point of view, our Convention at Banff, which is just over, was remarkable in that a larger number of visiting doctor's wives than usual were registered and welcomed by a smaller number of doctors' wives than usual. This was, of course, owing to the circumstances which made Banff our meeting place, instead of our own city. But so well and charmingly did the members of our Women's Commitee perform their duty and pleasure, that the general feeling of friendliness and welcome could not, I think, have been surpassed.

I want to thank in particular the Vice-Chairman and Hon. Secretary—Mrs. H. A. DesBrisay, Mrs. A. M. Agnew, and Mrs. J. Moscovich, who shared with me the months of planning and changing of plans, giving constant support and kindness that I value deeply, and carrying peronal responsibility, to the last day. I also want to thank the five Honorary Advisory members for their welcome counsel and their very practical help during the week of the Convention.

The Registration Committee, always a heavy one, with which was associated the Reception Committee ready to welcome friends and strangers, owed its success not only to the pleasant easy efficiency of its members, but to the outstandingly good planning beforehand of Mrs. Caverhill and her Co-convenors. The same success was seen in each of our Committees—Social, Reception, Golf, Signs and Badges, Publicity—whether the duties were great or small. Certainly all the woman golfers testified to the good time they had on their Competition Day!

Each Convenor and each member fulfilled her own responsibilities, and also went "the second mile." It is not invidious to mention the continuous work of Mrs. G. O. Matthews. She went her "second mile" daily. The task of Mrs. Matthews and her Co-convenor proved to be far more onerous than I had anticipated, and I am so very grateful to them both for what they did.

And may we also thank Dr. Milburn, Chairman of the Finance Committee, and Dr. Hatfield, Chairman of the Entertainment Committee, who never failed us throughout their own busy time. I turned to Dr. Hatfield again and again for assistance of one kind or another, which he offered us, and gave us, from first to last. This was a great help to the success of our Women's Programme, and a very great support to me personally.

I have received a large number of letters from "visiting wives." A typical note says 'Please thank the ladies of the Committee for flowers, parties, and kindnesses too numerous to mention", and so I wish to pass on this thanks, with my own, to the best Committee that the Women's Section of a C.M.A. Convention could possibly have.

I remain,

Yours very sincerely,

(Signed) ETHEL WILSON.

Chairman Women's Executive Committee,
British Columbia Division, Canadian Medical Association.

* * * *

## MEDICAL TREATMENT OF VETERANS BY THE DOCTORS OF THEIR CHOICE

It is the desire of the Department of Veterans Affairs to extend to veterans medical care by the doctor of their choice.

Doctors treating veterans are asked to adhere to the following procedure.

1. No authority is required for emergency procedures but payment will of course be dependent on the subsequent establishing of the man's entitlement to treatment by the Department.
2. Veterans suffering from certain Orthopædic, Plastic, Neurological, etc., disabling conditions previously treated for these conditions by the Armed Services during active service and referred to the Department on Discharge for treatment by the special services operated by the Department in Dpartmental Hospitals will ordinarily be referred to those special services for continuing treatment by the Hospital staff.
3. Veterans suffering from pensionable disabling conditions requiring other than ordinary investigation and/or treatment for those pensionable conditions will ordinarily be referred to Departmental Hospitals under the care of the hospital staff.
4. Veterans suffering from conditions referred to in Paras. 2 and 3 above may be treated in other than Departmental Hospitals only on authority of the Medical Advisor to the District Administrator. The doctor consulted should do everything necessary for the immediate handling of the case.
5. Change of doctors may not be made by a veteran during the treatment of a condition, unless he is away from home and is returning there, or for other good reason, without authority from the Medical Advisor to the District Administrator.
6. The Department, may, at its discretion, require, a veteran to report to a Departmental Special Treatment Centre for investigation and/or treatment of any case.
7. The Department assumes no responsibility for the payment of doctors' and hospital accounts or treatment allowances to the veteran for elective surgery performed without authority from the Medical Advisor to the District Administrator. The Department will pay for such elective surgical procedures after such authorization has been issued.
8. Physiotherapy, Mechanotherapy and Electrotherapy, outside Departmental Hospitals, require the special authorization of the Medical Advisor to the District Administrator.
9. The Department pays the dispensing agent for drugs and supplies according to a Departmental scale of charges. Drugs listed in the Physicians' Formulary of the Canadian Medical Association will ordinarily be dispensed; otherwise, sufficient reason will be given. Incidental drugs and dressings will be provided by the doctor

treating the case. When the doctor treating the case is the dispensing agent, a copy of the prescription will be submitted and the charges entered on Form 525 (see Para. 11). The Department encourages the principle of the dispensing of drugs to veterans by qualified pharmacists.

10. When previous clinical information is required for treatment purposes, such should be applied for to the Medical Advisor to the District Administrator, stating the exact information required.

11. A brief and comprehensive clinical report shall be forwarded to the Medical Advisor to the District Administrator by the attending physician or surgeon on Form 525—"Clinical Report and Account"—either at the beginning of, during or at the conclusion of treatment, as instructed on the reverse side of the form. In any case the form will be in the hands of the Medical Advisor to the District Administrator by the tenth of the month following that in which treatment is provided. Forms may be obtained from the Medical Advisor to the District Administrator, Shaughnessy Hospital, Vancouver.

12. In the case of veterans hospitalized, a copy of Form 100—"Hospital Case History Sheet"—will be attached to the first form 525 which is forwarded after the patient has been discharged from hospital. X-Ray, Laboratory, etc., forms will be attached to Form 525 when necessary. The doctor treating the case is responsible for the completion of Form 100.

While it is the primary responsibility of the attending doctor to treat the patient and it is the responsibility of the veteran to establish eligibility for treatment and other benefits, the Department expects that doctors will not only provide professional services, as such, but will also assist veterans in their rehabilitation and in keeping them rehabilitated and in obtaining the benefits to which they are entitled and act as their family physicians and counsellors on health in the broadest sense of the terms.

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## FRASER VALLEY MEDICAL ASSOCIATION ANNUAL MEETING

The Fraser Valley Medical Association held its Annual Meeting following dinner at the Westminster Club, New Westminster, on May 30th, 1946.

A social hour preceded the dinner and the traditional hospitality of the Royal City was fully evidenced. The meeting was well attended, and featured by the large number of returned men present, some new to the district, others having returned to their former practices on discharge from the Armed Forces.

The speaker of the evening was the Reverend Burton Thomas, who gave a searching and soul-stirring talk on, "Some Principles of Democracy."

Elections placed the following in office for the coming year:

President: Dr. J. G. Robertson.

Vice-President: Dr. E. K. Hough.

Secretary-Treasurer: Dr. J. F. Sparling.

The name of the Association was changed to the Westminster Medical Association.

Features of the evening were presentations made to Dr. Omar Van Etter on the occasion of his retirement from practice, and a variety of songs—words, music and voice supplied by Dr. J. T. Lawson.

**Royal Jubilee Hospital, Victoria, B. C., invites applications from medical men for position of Superintendent. Administrative education, experience required, salary open. Address full particulars, marked "Executive" to Secretary, Royal Jubilee Hospital, before September 30th.**

# British Columbia Medical Association

(Canadian Medical Association, Britsih Columbia Division)

| | |
|---|---|
| President | Dr. Ethlyn Trapp, Vancouver |
| First Vice-President | Dr. E. J. Lyon, Prince George |
| Second Vice-President | Dr. L. H. Leeson, Vancouver |
| Honorary Secretary-Treasurer | Dr. J. C. Thomas, Vancouver |
| Executive Secretary | Dr. M. R. Caverhill, Vancouver |

## ANNUAL MEETING

The Annual Business Meeting of the British Columbia Medical Association was held on Tuesday afternoon, June 11th, in the Fairholme Room of the Banff Springs Hotel.

Dr. A. H. Meneely presided.

The financial report was presented by the Honorary Secretary-Treasurer, Dr. L. H. Leeson. On motion this report was approved.

The reports of Chairmen of Standing Committees covering the year's transactions, were presented. The Chairman of the Divisional Advisory Committee pointed out that the duties of this committee were now finished, and moved that the work of this committee be terminated and its membership dissolved. This was seconded and carried.

In conjunction with Dr. K. D. Panton's report of the Committee on Medical Education, Dr. G. F. Strong presented a report of the study he had just completed relating to certain aspects of the proposed new Medical School, and presented a resolution urging that immediate steps be taken by the University authorities to ensure the opening of the Medical School in 1947. This resolution on motion was carried.

The report of the Nominating Committee was presented to the meeting by Dr. F. M. Bryant, the Chariman. On motion, nominations were closed. The President instructed the Honorary Secretary to cast a ballot for those placed in nomination, and in turn declared them elected.

President: Dr. Ethlyn Trapp, Vancouver.

First Vice-President: Dr. E. J. Lyon, Prince George.

Second Vice-President: Dr. L. H. Leeson, Vancouver.

Honorary Secretary-Treasurer: Dr. J. C. Thomas, Vancouver.

Five Directors-at-large: Dr. G. O. Matthews, Vancouver; Dr. S. G. Kenning, Victoria; Dr. L. A. C. Panton, Kelowna; Dr. W. Laishley, Nelson; Dr. W. A. Clarke, New Westminster.

Dr. Meneely conducted Dr. Ethlyn Trapp to the chair, and emphasized the uniqueness of the occasion, in that Dr. Trapp was the first woman to be elected to such high office in organized Medicine in Canada. Dr. Trapp in accepting the office of President expressed her deep appreciation of the honour, and stated that she would do her best to live up to the trust placed in her.

Dr. A. J. MacLachlan was re-appointed auditor.

It was decided that the 1947 Annual Meeting of the Association would be held in Vancouver.

Dr. Leeson introduced a resolution endorsing the proposed Academy of Medicine Building to house the Library of the Vancouver Medical Association and the offices of the College of Physicians and Surgeons, the British Columbia Medical Association and the Vancouver Medical Association, and authorizing the Board of Directors, in conjunction with the College and the Vancouver Medical Association, to proceed with the setting up of a company to organize the construction and operation of such a building.

# REGISTRATION OF BRITISH COLUMBIA MEMBERS AT BANFF MEETING

Dr. A. M. Agnew ..... Vancouver
Dr. J. D. F. Alexander ..... Vancouver
Dr. G. F. Amyot ..... Victoria
Dr. A. R. Anthony ..... Vancouver
Dr. L. H. Appleby ..... Vancouver
Dr. J. W. Arbuckle, Jr. ..... Vancouver
Dr. A. W. Bagnall ..... Vancouver
Dr. Gerald R. Baker ..... Quesnel
Dr. S. W. Baker ..... Ladysmith
Dr. Murray Baird ..... Vancouver
Dr. H. P. Barr ..... Penticton
Dr. M. R. Basted ..... Trail
Dr. Murray Blair ..... Vancouver
Dr. E. W. Boak ..... Victoria
Dr. H. H. Boucher ..... Vancouver
Dr. A. W. Bowles ..... New Westminster
Dr. T. A. Briggs ..... Courtenay
Dr. C. E. Brown ..... Vancouver
Dr. Harold Brown ..... Vancouver
Dr. F. M. Bryant ..... Victoria
Dr. F. W. Brydone-Jack ..... Vancouver
Dr. F. J. Buller ..... Vancouver
Dr. D. F. Busteed ..... Vancouver
Dr. U. P. Bryne ..... New Westminster
Dr. E. A. Campbell ..... Vancouver
Dr. H. Campbell-Brown ..... Vernon
Dr. H. H. Caple ..... Vancouver
Dr. M. R. Caverhill ..... Vancouver
Dr. G. A. Cheeseman ..... Field
Dr. H. H. Cheney ..... Vancouver
Dr. W. A. Clarke ..... New Westminster
Dr. G. H. Clement ..... Vancouver
Dr. D. E. H. Cleveland ..... Vancouver
Dr. W. A. Coghlin ..... Trail
Dr. N. C. Cook ..... Victoria
Dr. G. N. Cormack ..... Fort St. John
Dr. P. A. C. Cousland ..... Victoria
Dr. F. E. Coy ..... Invermere
Dr. G. A. Davidson ..... Vancouver
Dr. C. E. Davies ..... Vancouver
Dr. J. R. Davies ..... Vancouver
Dr. E. E. Day ..... Vancouver
Dr. H. A. DesBrisay ..... Vancouver
Dr. Sparling East ..... Fernie
Dr. E. H. W. Elkington ..... Victoria
Dr. R. J. Elvin ..... Vancouver
Dr. E. D. Emery ..... Nanaimo
Dr. B. M. Fahrni ..... Vancouver
Dr. H. K. Fidler ..... Vancouver
Dr. Christina A. Fraser ..... Vancouver
Dr. A. C. Frost ..... Vancouver
Dr. A. M. Gee ..... New Westminster
Dr. R. A. Gilchrist ..... Vancouver
Dr. H. F. P. Grafton ..... Kamloops
Dr. J. H. B. Grant ..... Vancouver
Dr. F. W. Green ..... Cranbrook
Dr. W. O. Green ..... Cranbrook
Dr. A. B. Greenberg ..... Vancouver
Dr. J. C. Grimson ..... Vancouver
Dr. W. R. S. Groves ..... Vancouver
Dr. C. H. Gundry ..... Vancouver
Dr. K. J. Haig ..... Vancouver
Dr. Margaret Hardie ..... Vancouver
Dr. B. J. Harrison ..... Vancouver
Dr. Elliott Harrison ..... Vancouver
Dr. J. E. Harrison ..... Vancouver
Dr. W. H. Hatfield ..... Vancouver
Dr. G. B. Helem ..... Port Alberni
Dr. A. T. Henry ..... Vancouver
Dr. F. S. Hobbs ..... Vancouver
Dr. G. L. Hodgins ..... Vancouver
Dr. A. W. Hunter ..... Vancouver
Dr. R. A. Hunter ..... Victoria
Dr. R. W. Irving ..... Kamloops
Dr. Paul P. Jackson ..... Vancouver
Dr. A. L. Jones ..... Revelstoke
Dr. B. Kanee ..... Vancouver
Dr. W. M. Kemp ..... Vancouver
Dr. G. C. Kenning ..... Victoria
Dr. S. G. Kenning ..... Victoria
Dr. G. E. Kidd ..... Vancouver
Dr. G. F. Kincade ..... Vancouver
Dr. R. P. Kinsman ..... Vancouver
Dr. O. E. Kirby ..... Vancouver
Dr. W. J. Knox ..... Kelowna
Dr. W. Laishley ..... Nelson
Dr. G. A. Lamont ..... Vancouver
Dr. G. E. Langley ..... Vancouver
Dr. R. G. Langston ..... Vancouver
Dr. G. C. Large ..... Vancouver
Dr. G. H. Lee ..... Vancouver
Dr. L. H. Leeson ..... Vancouver
Dr. T. H. Lennie ..... Vancouver
Dr. W. T. Lockhart ..... Salt Spring Island
Dr. A. L. Lynch ..... Vancouver
Dr. E. J. Lyon ..... Prince George
Dr. R. V. McCarley ..... North Vancouver
Dr. W. McK. McCallum ..... Vancouver
Dr. J. H. MacDermot ..... Vancouver
Dr. W. A. McElmoyle ..... Victoria
Dr. H. B. MacEwen ..... Vancouver
Dr. S. A. McFetridge ..... Vancouver
Dr. H. B. McGregor ..... Penticton
Dr. H. A. MacKechnie ..... Vancouver
Dr. A. J. MacLachlan ..... Vancouver
Dr. G. A. McLaughlin ..... North Vancouver
Dr. J. A. McLean ..... Vancouver
Dr. Keith MacLean ..... Vancouver
Dr. Daniel McLellan ..... Vancouver
Dr. E. C. McLeod ..... Vancouver
Dr. R. A. McLeod ..... New Westminster
Dr. T. S. G. McMurtry ..... Vancouver
Dr. A. Y. McNair ..... Vancouver
Dr. C. G. McNeill ..... Vancouver
Dr. Thomas McPherson ..... Victoria
Dr. M. McRitchie ..... Fernie
Dr. W. D. Marshall ..... Montreal
Dr. G. O. Matthews ..... Vancouver
Dr. A. H. Meneely ..... Nanaimo
Dr. A. M. Menzies ..... Vancouver
Dr. H. H. Milburn ..... Vancouver
Dr. George More ..... Duncan
Dr. MacK. Morrison ..... Vancouver
Dr. J. C. Moscovich ..... Vancouver
Dr. Fraser Murray ..... Vancouver
Dr. Roy Mustard ..... Vancouver
Dr. J. R. Naden ..... Vancouver
Dr. A. B. Nash ..... Victoria

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|---|---|
| Dr. John Nay | Vancouver |
| Dr. J. R. Neilson | Vancouver |
| Dr. R. O'Callaghan | Kimberley |
| Dr. Thomas O'Hagan | Jasper |
| Dr. Claire Onhauser | Hollyburn |
| Dr. R. A. Palmer | Vancouver |
| Dr. K. D. Panton | Vancouver |
| Dr. L. A. C. Panton | Kelowna |
| Dr. W. M. Paton | Vancouver |
| Dr. K. A. Peacock | West Vancouver |
| Dr. Florence Perry | Vancouver |
| Dr. S. C. Peterson | Vancouver |
| Dr. C. W. Prowd | Vancouver |
| Dr. L. E. Ranta | Vancouver |
| Dr. H. M. Robertson | Victoria |
| Dr. H. R. Robertson | Vancouver |
| Dr. Ross Robertson | Vancouver |
| Dr. R. B. Robertson | Victoria |
| Surg. Cmdr. H. Ruttan | Victoria |
| Dr. D. B. Ryall | McBride |
| Dr. C. A. Ryan | Vancouver |
| Dr. Olive M. Sadler | Vancouver |
| Dr. T. R. Sargeant | Vancouver |
| Dr. W. G. Saunders | North Vancouver |
| Dr. A. B. Schinbein | Vancouver |
| Dr. H. Scott | Vancouver |
| Dr. R. Scott-Moncrieff | Victoria |
| Dr. G. E. Seldon | Vancouver |
| Dr. P. Semenchuk | Calgary |
| Dr. W. W. Simpson | Vancouver |
| Dr. J. A. Smith | Vancouver |
| Dr. Howard Spohn | Vancouver |
| Dr. H. S. Stalker | Tranquille |
| Dr. D. E. Starr | Vancouver |
| Dr. P. L. Straith | Courtenay |
| Dr. G. F. Strong | Vancouver |
| Dr. T. W. Sutherland | Revelstoke |
| Dr. R. Miller Tait | Vancouver |
| Dr. J. C. Thomas | Vancouver |
| Dr. Ethlyn Trapp | Vancouver |
| Dr. A. J. Tripp | Invermere |
| Dr. A. E. Trites | Vancouver |
| Dr. Andrew Turnbull | Vancouver |
| Dr. Frank Turnbull | Vancouver |
| Dr. G. A. Upham | Vancouver |
| Dr. A. S. Underhill | Kelowna |
| Dr. C. H. Vrooman | Vancouver |
| Dr. J. T. Wall | Vancouver |
| Dr. L. H. Webster | Vancouver |
| Dr. W. A. Whitelaw | Vancouver |
| Dr. C. J. M. Willoughby | Kamloops |
| Dr. A. R. Wilson | Chilliwack |
| Dr. Wallace Wilson | Vancouver |
| Dr. L. G. Wood | Vancouver |

# The Committee on Medical Economics

## of British Columbia

JOINT COMMITTEE OF

Committee on Economics of the Council of the College of Physicians and Surgeons of British Columbia and the British Columbia Medical Association

Canadian Medical Association (*British Columbia Division*)

The Sub-Committee on Revision of Fees working under the Chairmanship of Dr. Roy Mustard, has completed a draft of a revised schedule of fees applicable to the General Practitioner. This proposed schedule has been passed to all District Associations for further study and opinion. It is anticipated that the revised schedule will be completed and ready for publication in August.

Members of the Profession are reminded that the Department of Veterans Affairs "Doctor-of-Choice" plan is in operation. In order to receive payment for services rendered to the veteran under the plan medical men must make sure that the veteran is eligible for treatment. Information as to eligibility can be obtained from the nearest D.V.A. office.

Fees paid under this plan are based on the 1943 D.V.A. Schedule. It is expected that this schedule will shortly be superseded by a new D.V.A. schedule agreed upon between the Department and the Canadian Medical Association at the Banff Meeting. Providing this new schedule is approved by the Treasury Board, it is expected that a copy of the schedule, together with complete regulations covering the operation of the Plan, will be in the hands of all doctors shortly.

During June the Grimmett Commission, which has been investigating the activities of the multitude of "Mutual Benefit Health and Accident Associations", registered under the Societies Act, that have sprung up in B.C., held sessions to hear the final summing-up of the situation by the Commission's counsel, Mr. D. J. McAlpine. Mr. McAlpine grouped these associations into six groups as follows:—

(a) Fraternal and Lodge Associations.

(b) Industrial Group Associations—B.C. Telephone, etc.

(c) Community Plans.

(d) Non-profit Hospitalization Plans.

(e) M-S-A and Blue Cross.

(f) The "Profit Associations".

Mr. McAlpine stated there was no evidence of need for interference in the first five groups.

Of the sixth group—the so-called "Profit Associations" the following recommendations were made in order or priority.

1. Their complete abolition.
2. Failing (1) they should be placed under rigid and strict control with supervision of their management, contracts, funds, etc. This control to be given if necessary by a special controller appointed for the purpose.
3. Failing (1) and (2) they should be placed under the provisions of the Insurance Act.

It is hoped that when the final Report of the Grimmett Commission is made that the Government will see fit to take steps such as outlined above to protect the public and the doctor from the abuses liable to appear in the operations of such associations under such little supervision and control as exerted by the Societies Act.

The Canadian National Railway Employees' Medical Aid Association of B.C. have now prepared a medical service plan modelled on the B.C. Teacher Federation Medical Plan. Their organizing committee have placed copies of their proposed constitution and by-laws with this Committee, and these have been distributed to all Sub-Committees on Medical Economics throughout the Province for study and opinion of the profession in the various districts. It would appear from a preliminary study that the plan as presented would be definitely more advantageous to the profession in general than the old C.N.R. Medical Service Plan, which expired on May 31st last. A further report on this plan should be available at an early date.

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**NOTICE**

**Please note that the evening hours in the library will be discontinued during the summer months but will be resumed in the fall.**

# A STUDY OF CERTAIN PROBLEMS RELATING TO THE ESTABLISHMENT OF A NEW MEDICAL SCHOOL AT THE UNIVERSITY OF BRITISH COLUMBIA

* * * *

G. F. STRONG, M.D.

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*Introduction*

This study was undertaken at the request of the Committee on Medical Education and the Board of Directors of the British Columbia Medical Association, and is concerned with certain problems relating to the establishment of a new medical school at the University of British Columbia, with particular reference to those questions regarding which there was difference of opinion. In addition, this study was to include an investigation sufficient to warrant critical comments on the survey of medical education authorized by the University of British Columbia, conducted by Dr. C. E. Dolman, and reported under date of May 3rd, 1946. The present report consists of a summary of the opinions derived from personal correspondence and interviews with a large number of well qualified individuals over the past six months. Those whose opinions have been sought include many Deans of Medical Schools, professors, associate and assistant professors of both pre-clinical and clinical departments, and in addition, individuals having knowledge of and interest in the overall picture of the problems of medical education, though not themselves attached to any one medical school. Examples of the latter are the Secretary of the Council on Medical Education and Hospitals of the American Medical Association and the Secretary of the Association of American Medical Colleges.

This study was directed particularly to those questions about which there has developed local difference of opinion and to those questions that must be settled if medical education in this Province is to be, as we all want it, of the highest quality. The present report deals with the following subjects relevant to the new medical school:

I. Location

II. Budget

III. Hospital requirements

IV. Research

V. Clinical Staff

It is natural that in the course of this investgiation many other subjects were discussed which will have bearing on later developments.

It is to be remembered that the starting point of this study was a plan, submitted by Dr. Dolman, calling for a split school, with the pre-clinical departments on the university campus and the clinical departments seven miles away near the Vancouver General Hospital. This original plan also included a budget of two hundred thousand, only fifty thousand of which was allocated to the clinical departments. It is gratifying to note that in the recent reports of his survey, Dr. Dolman has abandoned the split school and has increased the amount of suggested budget.

## 1. LOCATION OF MEDICAL SCHOOL

At first consideration and in theory, a Medical School as one faculty of a University should be located on the campus. Since close proximity to adequate clinical facilities is essential or present day medical teaching, this means that a large University Hospital should adjoin or be connected with the Medical School building. Such theoretical plan must receive the most careful study.

1. Of the large number of well-qualified individuals interrogated on the question of the location of our new school, a small majority of the total favored a location near the Vancouver General Hospital, the next larger group said location was immaterial as long as the whole school was close to adequate clinical facilities, and the remainder were in favor of the location on the university campus. (Many of the latter admitted an entire lack of knowledge of local conditions, but others who knew the local scene still favored a campus site.) There was almost complete unanimity in opposition to a split school. All agreed that the pre-clinical and clinical departments must be together and adjoin, or be connected with adequate clinical facilities.

2. The inference, therefore, that to have a first class medical school it must be located on the university campus is not justified. A recent survey (1) showed that only 23 of 66 medical schools in the United States were so located. A few of those *not* on a campus may be mentioned to indicate that location of medical school buildings is not essential to the success of the school.

Johns Hopkins University School of Medicine,
Harvard Medical School,
Cornell University Medical College,
Columbia University College of Physicians & Surgeons,
Northwestern University Medical School
University of Illinois College of Medicine
University of California Medical School
Stanford University School of Medicine,
University of Oregon Medical School,
and in Canada
University of Western Ontario Medical School
University of Manitoba Faculty of Medicine

3. There are far more important factors influencing the quality of the medical school than the location of the buildings. Given good students and an adequate staff made up of good teachers imbued with interest in research and with sufficient clinical facilities, *good medicine* can be taught *anywhere.*

4. Since medical education is the most expensive form of higher education and since the resources of this Province are *not* unlimited, the desirability of a campus location necessitating the construction of a University Hospital must be given more consideration.

5. The whole of the cost of construction and maintenance of the University Hospital, must be borne by the Provincial Government. While there is need for more hospital beds in this area, the need is for convalescent or chronic case care and not for acute beds. The construction and maintenance costs for convalescent and chronic beds is much less than for a University Hospital.

6. There are ample clinical facilities available in this community. These facilities are located at the Vancouver General Hospital, St. Paul's Hospital, Shaughnessy Hospital, and Grace Hospital. With these available facilities for medical teaching, it is extremely doubtful that there is justification for the large expenditure necessary for a University Hospital. (See below under Hospitals).

7. In the course of this study it has become apparent that for a medical school of 50 students per year a single building would suffice. There are numerous examples

of schools of similar size in which one building houses the whole medical faculty, one of the best of these is to be found at Syracuse University College of Medicine, in which on one floor of one wing the Public Health Laboratories are installed. (In Dr. Dolman's original plan three buildings were required, two on the campus and one at the General Hospital.)

8. The land area required for such a medical school building need not be great. Five acres is more than adequate. If land cost is to be avoided, the area can be reduced by increasing the height of the building. Such area is readily available at a central location near the Vancouver General Hospital.

9. To create or attempt to create a Health Centre *de novo* on the university campus would be extremely expensive and it would certainly not offer central location for such facilities. While it is true that patients would undoubtedly go to that site if free services were available, why transport so many individuals such a distance when central facilities exist.

10. In his recent study of the local situation regarding the proposed new Children's Hospital, one of Canada's most distinguished medical authorities, Dr. Alan Brown, Professor of Pediatrics, University of Toronto, had an opportunity to consider the whole question of location of facilities. He is unequivocally of the opinion that the new Children's Hospital as well as the whole Medical School should be located in the area of and as near as possible to the Vancouver General Hospital.

11. The suggestion that research would be impeded unless the school is on the campus is not valid. One excellent example that can be cited to refute such an argument is the outstanding work with the radio-active substances given clinical application at the University of California Hospital, San Francisco, but *produced* by the cyclotron located in Berkeley.

12. If the General Hospital site is chosen, the school must be *close* to the Hospital, not one, two or more blocks away. The proper site is on the Hospital grounds so that the medical school building can be connected with the Hospital.

13. The arguments advanced in the recent Survey (pages 21-27) in favor of campus location may now be answered seriatim:—

(a) *Administration.* It is admitted and generally agreed that the administration of a medical school should be left to the Dean. Proximity to the central administration is *not* essential. (Even if on the campus his office might be some distance from the central offices.)

(b) *Economy.*— The cost of the building would be no different regardless of location. The cost of the necessary land at the Hospital would have to be balanced against the cost of construction and maintenance of a 400 bed University Hospital on the campus. Structural alterations of the affiliated hospitals used for teaching would not be a significant factor. The land required for medical school buildings at the General Hospital would be 5 acres rather than 25-50 acres.

(c) *Prestige and prosperity.* The best answer is to be found in paragraph 2 above. There is no evidence that university morale is affected by location of medical school buildings. Regardless of site the clinical facilities of the Hospitals in downtown Vancouver will be used in any case.

(d) *Trends in Medical Curriculum.* The *trends* are all toward close integration of clinical and pre-clinical departments. The student is introduced to clinical medicine at an earlier stage. It is admitted that even a 400 bed University Hospital will *not* furnish all the clinical facilities required, therefore it is better to locate the school near more ample facilities which are themselves centrally located as regards other hospitals in the community. Clinical-pathological conferences, clinical-physiological conferences and "anatomical clinics" will, it is hoped, be a regular part of the teaching program regardless of location. The preventive outlook will likewise receive necessary

consideration. An *undivided school* located near ample clinical facilities is therefore imperative.

(e) *Premedical Education.* The curriculum for the required subjects in the 3 year premedical course must be the subject of careful study and constant revision, but it has no bearing on the location of the medical school buildings.

(f) *Co-operative Research.* Granted that there is dependence on physics and chemistry, there is even greater need for proximity when it comes to clinical facilities. The seven mile separation should not prevent co-operative research where the basic science departments are concerned, but it would prove a grat handicap to every student and faculty member in the clinical departments. (See also No. 2 above.)

(g) *Contribution to other University Departments.* These contribution can be made regardless of the fact that the medical school buildings are not on the campus. The Arts students who want to take subjects in the Department of Medicine could, if such a plan was deemed advisable, take such courses regardless of the location of the buildings.

This section of the survey report to be completed might have listed some equally eminent authorities just as certain that the best location was near our present hospital facilities.

14. *Long term planning.*

Politics can develop in a University Hospital as well as anywhere else, and there is no reason to believe that such politics would be any less "trammelling" than those found in any public service institution. The idea that the location away from the campus would produce an inferior grade of medical practioner is too ridiculous to consider. The statement (page 13) regarding the advantages of full time clinicians in the economic saving to the community is, of course, the well worn argument in favor of *state medicine.*

15. One further argument often advanced in favor of the campus location is that if the medical school is located elsewhere the medical student loses the cultural advantages of campus activity. From experience and from interviews with both faculty and students, it is obvious that good medical students have little time for extra-curricular activity.

16. It is to be pointed out again that medical education is post-graduate training. The medical students will have had at least three years of campus life and should when they enter medical school be prepared to settle down to intensive work. While every effort should and will be made to maintain their health, such measures cannot interfere with their medical studies.

17. There is one argument in favor of campus location that cannot be refuted. The advantage to the Student Health Service would be considerable. However, this single argument is not sufficient to offset the other arguments against such location of the medical school. The Student Health Service should be given adequate accommodation on the campus and the medical services should be supplied by the Faculty of Medicine.

18. As a part of the present study, a Dean of a Medical School was asked to visit Vancouver and study the local situation. Dr. David W. E. Baird, Dean of the University of Oregon Medical School, made a three day study in March, when he visited the campus, the Vancouver General Hospital, St. Paul's Hospital, Shaughnessy Hospital, and Grace Hospital. It was his opinion after his investigation that the logical site for the medical school was at the Vancouver General Hospital.

## II. BUDGET

There is general agreement that two hundred thousand is too low. Those interviewed felt that four hundred thousand was more nearly correct, and this amount, including the student fees should be requested if we are to do a satisfactory job of medical teaching. It is obvious of course that this full amount will not be required

until the full four years course is in operation. There can be no doubt that the question of an adequate *budget* is far more important than *location* when it comes to the results of medical education. Our aim in British Columbia should be to provide a first class Grade A school to train general practioners. To some it has seemed desirable that we should establish another Johns Hopkins. This is not only impossible but undesirable.

## III. HOSPITAL REQUIREMENTS

1. While a University Hospital may be ideal, it should be emphasized again and again that this ideal can only be attained at a tremendous cost both for initial construction and annual maintenance. Incidentally, it should be pointed out that if there is a University Hospital the budget of that Hospital must be kept separate from the Medical School. If this is not done, the deficit of the Hospital soon means that the Medical School is actually engaged in caring for the sick rather than educating medical students. To suggest that a teaching hospital can be self-sustaining or even anywhere near self-sustaining is to indicate a complete ignorance of hospital affairs. In no instance was there found any teaching hospital—or any hospital that cares for the indigent sick—that is anywhere near self-sustaining. Public funds must provide the maintenance costs and in teaching hospitals the per diem cost is universally one quarter to one third higher than in non-teaching institutions. The Provincial Government should therefore give a good deal of thought to the matter of a 400 bed University Hospital.

2. An illustration may help to make this point. In one state, the University Hospital of 400 bed capacity had an annual budget of one million dollars and a deficit of four hundred thousand dollars even though the funds it *did* receive came almost entirely from other sources of public monies. The distribution of patients was as follows:—

Indigents 80%
Part Pay 15%
Full Pay 5%

3. There are examples of good schools that derive their clinical facilities from affiliated but non-University Hospitals. In addition at many medical schools the University Hospital itself is small and furnishes only a small part of the clinical facilities which must then be obtained from affiliated hospitals. The important thing is that there be affiliation, that sufficient beds be available for adequate teaching, and that the medical school have control of the teaching staff. On all these points there can be and has been no disagreement.

4. Arrangements with affiliated hospitals are made on the basis of a written contract (one of the best of these is said to be that between the Medical School of the University of Rochester and the City Hospital of Rochester, N.Y.) or an oral agreement. There is an impression that such affiliation is more apt to be satisfactory when made with a private rather than with a public institution. The arrangements must include provision that the teaching staff be nominated by the Dean or a faculty committee of the medical school, and hold their hospital appointments as a result of selection by the Board of Directors of the Hospital concerned.

5. The teaching staff and the Hospital must be prepared to encourage research. No medical school can be worthy of the name today in which research does not play a prominent and an increasingly prominent part. This must of course apply to the pre-clinical as well as the clinical departments.

6. *Bed Requirements*

(a) To provide adequate clinical facilities the medical school should have available in the community a minimum of 10 beds per student in the third and fourth years (2). (Example 10x100=1000) while several hospitals participate in clinical teaching, one hospital usually carries the major responsibility and that institution should provide

a minimum of 8 beds per student in any one year. (Example 8x50=400). These beds should be distributed as follows:—

| | | |
|---|---|---|
| Medicine | 2 beds per student | 100 beds |
| Surgery | 2 beds per student | 100 beds |
| Pediatrics | 2 beds per student | 100 beds |
| Obstetrics | 1 bed per student | 50 beds |
| Others | 1 bed per student | 50 beds |
| | | 400 beds |

These, of course, are *minimum* requirements. The junior, or third year of the medical course is usually spent serving a clinical clerkship in Hospital, and these beds are required for such clerkships.

(b) The senior or fourth year should be spent serving clerkships in the Outpatient Department. The minimum requirements for such a department for a class of 50 students is 100 consultations per day. There is increasing emphasis on the value of outpatient department training. This is given under instruction of members of the clinical departments.

It is to be noted that didactic lectures have practically disappeared from the curriculum for the third and fourth year medical students. Hospital facilities are essential for these years.

7. It is obvious, therefore, that even if a 400 bed University Hospital should be built the clinical facilities of the Vancouver General, St. Paul's and Shaughnessy would still be required. In other words, the *construction* of a University Hospital will not obviate the necessity to adapt local hospitals for clinical teaching, but will be an extra out-of-pocket expense for which there would seem little if any justification. One of the leading professors of Medicine on this continent and a man of great experience and widely travelled is convinced that our new school should be located near the General Hospital, and is equally positive that if and when our Provincial Government has funds available for a University Hospital that Hospital should also be located in the same area.

8. There is widespread acceptance of the merits of a medical or health centre. To serve the greatest usefulness such a centre should be truly central in location and should bring together as many as possible of the varied health needs of the community. The Vancouver General Hospital is in itself already a health centre, including as it does all the services of a general hospital, plus the Infectious Disease Department, an active emergency service, and a large outpatient department. There is adjoining, the Vancouver unit of the Tuberculosis Control Department of the Provincial Board of Health. Most realistically minded individuals aware of the local situation felt that this Province would have to be wealthy indeed to attempt to create *another* new Health Centre at a far less central location. If to this present centre is added the *Medical School Building*, which, it is to be hoped, would include the Provincial Laboratories and in addition the new Children's Hospital, a real medical and health centre would be established. If and when the Provincial Government can afford to build and maintain a University Hospital, it might well be located in the same area. The comments from Dr. Alan Brown in paragraph No. 10 above are pertinent.

9. This report would be incomplete if reference were not made at this point to the situation as regards the local hospitals.

The Committee on Medical Education of the British Columbia Medical Association asked each of the local hospitals to make their clinical facilities available for medical teaching. All of the hospitals acceded to that request. The original plan for the medical school drafted by Dr. Dolman located the clinical years at the General Hospital. It is now being made to appear that local hospitals—and the General is usually indicated as chief culprit—are trying to "control" the medical school. Nothing could be further from the truth. Even though the matter of location is not settled it is

quite in order for the local hospitals to study the situation in order to ascertain what steps may be necessary to enable them to participate effectively in the teaching programme. If our local hospitals are used it will be because all of them recognize the obligation that public service institutions bear to the community at large and to the training of medical students in particular. Since all our hospitals have been engaged in interne training it is but a logical step to include training for third and fourth year medical students.

10. The Vancouver General Hospital (1085 beds) has all the services of a large general hospital, including the Infectious Disease Hospital operated by the General for the City of Vancouver. There is in addition a very active emergency service and a large Outpatient Department.

*Regarding the Vancouver General Hospital*

Since the recent survey chooses to make certain ill-founded and some false statements in reference to this institution, it would be well to set forth certain facts.

a. According to Dr. Dolman's first plan the two clinical years of the new medical school were to be located near the General Hospital. What more logical than that this Hospital should begin to study the whole situation regardless medical teaching as it would affect that institution.

b. Dr. Dolman repeatedly refers to the Vancouver General Hospital as a City Hospital. For the records it should be made clear that while doing the city work the General Hospital is a *private* institution operating under a provincial charter.

c. The Vancouver General Hospital is operated by a Board of Directors composed of 15 members made up as follows:—*eight* are chosen at the annual meeting of the governors of the corporation and are always men or women of the highest calibre giving generously of their time as a contribution toward communoty service, *three* are appointed by the Provincial Government and are likewise outstanding citizens interested in Hospital affairs, *three* are appointed from the city council, and one by the Medical Board of the Hospital. From the constitution of this board it will be clear that the Directors are free from any political control and actuated solely by requirements of the community and of the Hospital. If such a Board as that undertakes to make available the clinical facilities of the General Hospital for medical teaching the community and the University can rest assured that the relations with the Hospital can be just as cordial as those between many a Medical School and the governing board of its University Hospital.

d. When the Vancouver General Hospital was asked to make its facilities available (see Hospitals No. 9) a joint committee of the Board of Directors and Medical Board was established to study the whole problem. The preliminary discussions have indicated general agreement on the following points

1. A sufficient number and variety of active beds will be set aside for medical teaching.
2. These beds will be on closed wards.
3. The teaching staff will be appointed on a plan to be agreed upon by the Medical School and the Hospital. It is understood that the University through the Medical School is to have control of the teaching staff.

e. The Vancouver General Hospital is not an open Hospital. The indigent patients are admitted to closed wards. During the depression the number of such patients reached 65%, but during the recent inflation, has dropped to 20% of the total Hospital population. (This has been true all over this continent.) The Hospital at the present time conducts regular ward rounds in all major departments, a weekly clinical-pathological conference, and a monthly clinical staff meeting.

11. St. Paul's Hospital (600 beds) on Burrard St. is a general hospital operated by the Sisters of Charity of Providence, a Roman Catholic nursing order. It offers excellent clinical facilities and in view of the splendid contribution to medical teaching made by Catholic Hospitals elsewhere there is every reason to believe that these facilities will add much to the medical teaching programme.

12. Shaughnessy Hospital (approximately 1200 beds) operated by the Department of Veterans Affairs offers excellent opportunities for both undergraduate and post-graduate training.

13. Grace Hospital (55 beds) is a maternity hospital operated by the Salvation Army. Its services will be of great value in under-graduate training in obstetrics.

## 1V. RESEARCH

Little need be said in this report regarding research because there can be no difference of opinion as to the absolute necessity of including research in both the pre-clinical and clinical departments. Medicine can not be taught by merely reviewing our present day knowledge, it must be taught in an atmosphere which encourages constant advance in that knowledge. There is reason for discussing this subject at this point, however, to make it clear that *research* can be carried out regardless of the location of the medical school building, and can and is being carried out in non-university hospitals. The ultra scientific attitude can easily lead to the inference that research can be successful only on a university campus and clinical research only in a university hospital. If argument to controvert that viewpoint were needed, reference to the list of eminent medical schools *not* on a campus offers one. (See Location No. 2.)

That non-university hospitals can contribute to the advance of medical knowledge can also be proven by reference to current medical literature. Some medical school "ideally" located with adjoining University Hospitals have been notably sterile. The whole point is that the spirit of Research must be present and if it is, the location of the medical school building and hospital is of lesser moment.

## V. CLINICAL STAFF

In discussion of full time or part time personnel it must be clear that our arguments deal solely with the clinical departments. There can be no argument that clinical medicine can not be well taught today without some *full time members* of the major clinical departments, medicine, surgery, pediatrics, and obstetrics. These full time men do not need to be the heads of the departments and in fact there are good arguments against full time heads. The use of full time heads and staff in the clinical departments was advocated by Flexner at a time when medical training on this continent had reached a low ebb and proprietary schools flourished. There has been great change since then and the policy of full time heads for the clinical departments is by no means universally accepted at the present time. At Michigan in the past 30 years the system of full time heads has been tried twice and twice abandoned as unsatisfactory. The Dean of that school unhesitatingly avers that the full time plan is undesirable and does not produce the best results.

The disadvantage of the full time head of a clinical department is that he is in danger of developing an "ivory tower complex", and of becoming remote from the problems of medical practice for which he is training students. There is also a tendency for the full time head to "ride his hobby" and fill the beds on his service with only the cases in which he has the greatest interest.

The full time members in these departments should be fellows, and research assistants and assistant professors and associate professors if the budget permits. It is to be noted that the budget of any *one* clinical department with a full head and several full time men of professorial rank is more than Dr. Dolman apportioned to all clinical departments in his first plan.

Again and again it was emphasized that it is not the system that yields results. It is the man that is important. Some excellent work is being achieved in teaching and

research by departments directed by part time men and contrariwise some departments headed by a full time man suffer because the interest of those men is directed more toward their consulting work than the activities of their departments.

The full time younger men can look forward to advancement with increasing academic rank and increasing income when they transfer to part time positions. The designation clinical to indicate part time professors, associate or assistant professors is coming into widespread use and serves the helpful purpose of distinguishing the part time from the full time group.

In summary, therefore, the number and relative rank of full time and part time men should depend on the budget and on the capabilities of those available to fill the posts. It is not true that the heads of clinical departments *must* be full time men.

## SUMMARY

1. *Location*
   Because the very considerable *cost* of construction and maintenance of a University Hospital on the campus and the fact that the campus is far from a central location and from other available clinical facilities, the whole question of location of the new medical school should be the subject of further study.
2. *Budget*
   The Budget of the new medical school should be four hundred thousand dollars.
3. *Hospital Requirements*
   Steps should be taken to secure the necessary affiliation with local hospitals in order to require adequate clinical facilities.
4. *Research*
   Every effort should be made to encourage research activity in all departments of the new school.
5. *Clinical Staff*
   In organizing the clinical departments the best available men should be secured. Some full time men in the major clinical departments are essential.

## RECOMMENDATIONS

I. The next step in our study of the problems relating to the new medical school should be to secure a survey of the local situation by acknowledged experts in the field of medical education. For this purpose the following names are suggested. These men might be invited singly or as a group of two or three or more.
   1. Dr. Herman G. Weiskotten, Dean of Syracuse University College of Medicine, Syracuse, N.Y. Author of "Medical Education in United States 1934-39."
   2. Dr. Victor Johnson, Secretary of the Council on Medical Education and Hospital of the American Medical Association, 535 North Dearborn St., Chicago, Ill.
   3. Dr. Ernest W. Goodpasture, Dean of Vanderbilt University School of Medicine, Nashville, Tenn.
   4. Dr. Alan Gregg, Director, Division of Medical Sciences, Rockefeller Foundation, 49 E. 49th St., N. Y. City.
   5. Dr. Ray F. Farquharson, Assistant Professor of Medicine, University of Toronto, Faculty of Medicine, and President of the Royal College of Physicians and Surgeons of Canada.

   Other names can be suggested.

II. It is to be regretted that the first year of medicine cannot be started in 1946. If the school is to get under way in 1947 it is imperative that certain steps should be taken immediately:—
   1. A Dean should be selected.

2. Failing that, an acting Dean should be appointed.
3. If that is not feasible, a small committee should be selected to engage the *heads* of the pre-clinical departments of the new medical school at an early date in order that they may make necessary preparations.
4. An *anatomy act* should be passed in British Columbia as soon as possible.

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1. Medical Education in the United States 1934-39—Page 31.
2. Medical Education in the United States 1934-39—Page 100.

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# DR. COLIN W. GRAHAM (1881-1946)

## A TRIBUTE

Colin W. Graham was born in Montreal on November 27th, 1881, the second son of Mr. and Mrs. Isaac B. Graham. His father died when he was four years of age and on his mother fell the responsibility of bringing up the two sons and one daughter. At an early age the two boys—the elder, Stanley, is now Professor of Mining Engineering at Queen's University—had to fend for themselves to provide most of the funds for their education. In this they were successful and all Colin's preliminary schooling and university career was spent in Kingston, Ontario. He graduated B.A., M.D., C.M. from Queen's University in 1906.

His decision having then been made, he commenced his two year's post-graduate training in Manhattan Eye, Ear and Throat Hospital, New York City.

Completion of this training was followed by a year as a specialist in the Panama Canal Zone employed by the Isthmian Canal Commission of the United States Government.

He then made another important decision and in November, 1909, registered in the Province of British Columbia and commenced practice in the City of Vancouver, where he soon acquired a large and busy practice, and became one of the leading consultants in eye, ear, nose and throat in the Province, and was for many years a senior consultant on the staff of the Vancouver General Hospital. Except for travel, periods of study abroad and service overseas in the First Great War, his life from 1909 on was spent in British Columbia.

In 1913, before proceeding to Vienna for post-graduate study, in London, England, he married Kathleen, eldest daughter of the late Dr. D. H. and Mrs. Wilson and they had one son and one daughter.

In all the activities of his life, Colin Graham was a perfectionist. With his great intellectual gifts went a high degree of professional integrity, and his keen and enquiring mind permitted nothing less than complete thoroughness in all his work. If a new method of treatment or a new operation were reported he at once found out all he could about them, weighed and studied them and, if satisfied they were good, immediately set about mastering all details, even to the extent of frequently going away to another centre to perfect the details of the operation or the details of how and when to use a new method of treatment or a new drug.

Examples of his enthusiasm and drive were his early introduction to the Vancouver Medical Association of contact lenses and his organization of the first orthoptic clinic in Vancouver.

With his great ability went an uncommon degree of sound judgment, and with his great skill as an operator went a meticulous attention to all those minute details which he considered so necessary to the perfection of the operation and the attainment of the best results for the patient. The high calibre of his work won for him amongst those best qualified to judge, his patients and his professional associates, an unrivalled degree of confidence, respect and affectionate esteem.

In the community in which he spent his life, Colin Graham occupied an unique position as a friend. His capacity for friendship was great. He had no enemies, and his full and happy life was occupied by many interests outside his professional work. To him, the finer things of life were of great importance and interest. He delighted in good books, good music and fine paintings, and in later life and with the coming of more leisure, his garden gave him great delight. His was a fine example of the intelligent and civilized use of leisure, and to the employment of that leisure he brought to bear the same thoroughness shown in his professional work.

Was it paintings or music, then he must see, hear and study them; was it golf, then he was continually practising and trying to improve his game; was it fishing, how could he cast a better fly and how more skilfully land his fish; was it the garden, he must know all about his flowers and the soil.

In 1943, because of his health and the insupportable strain of a large practice, Colin moved to Victoria and there, able to control within limits the size of his practice, he spent three years of great happiness.

What a joy it was to see him in the surroundings of his new home; filled with a zest for life in the fullest sense and completely happy with his family around him, he would eagerly show you around the garden or, going indoors and surrounded by the books and painting he loved, he would enthusiastically converse on one or many of the multitude of things or persons in which he was interested.

Colin Graham's sudden death was a great loss to British Columbia and his place will not be filled.

To his wife and children go out the sympathy of his host of friends and devoted patients.

W.A.W.

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Issued April, 1946

# News and Notes

It is with the deepest regret that we record the passing of two members of the profession—Dr. Colin W. Graham of Victoria, and Dr. R. K. Brynildsen of Vancouver.

Congratulations are being received by Dr. and Mrs. John Piters of Vancouver on the birth of a son, and by Dr. and Mrs. H. O. Smith of Vancouver on the birth of a daughter.

Major Paul Phillips has returned to practice at Princeton following his discharge from the R.C.A.M.C.

Major R. R. M. Glasgow and Capt. J. G. MacKenzie have received their discharge from the R.C.A.M.C., and have gone to Michel to practise.

Dr. R. H. Gourlay and Dr. J. W. Arbuckle, Jr., have left Vancouver to take post-graduate courses in Montreal.

Major A. J. Stewart has received his discharge from the R.C.A.M.C., and is at the Vancouver General Hospital at the present time.

Colonel C. A. Watson and Lieut.-Colonel A. L. Cornish are with the Department of Veterans Affairs in Victoria, following their discharge from the Armed Forces.

Major A. L. Buell and Capt. C. G. McNeill have received their discharge from the R.C.A.M.C.

The following Medical Officers, who have been discharged from the Forces, are in practice in Vancouver:— Lieut.-Col. B. B. Moscovich, Major T. F. H. Armitage, Major W. E. Austin, Major Douglas Telford, Capt. D. M. King, Capt. R. A. Stanley.

Lieut.-Col. J. A. Wright and Major J. A. McNab received their discharge from the R.C.A.M.C. and are now at the Vancouver General Hospital.

The following Medical Officers have received their discharge and are in practice in Victoria:—Capt. O. C. Lucas, Capt. R. C. Newby and Major J. D. Stenstrom.

Capt. J. M. MacKinnon is at Shaughnessy Hospital following his discharge from the Army.

Capt. J. S. D. Burnes, who is stationed at Camp Borden Military Hospital, was home on furlough recently.

Lieut.-Colonel H. A. Bowker, who has recently been discharged from the R.A.M.C., after serving since 1938, has returned to Ladysmith where he is enjoying an extended holiday before re-entering the field of private practice.

Dr. W. M. G. Wilson, who has been associated with Doctors Garner and Jones at Port Alberni, has left for Toronto where he plans to spend two or three years doing post-graduate training in Ophthalmology.

Dr. M. R. Earle, who has been assisting Dr. George More at Duncan, is leaving for the East shortly to do post-graduate work.

The following British Columbia doctors were highly honoured in the last King's Birthday list by being made Officers of the British Empire, Civilian Division:—Dr. A. K. Haywood, Dr. G. L. Hodgins, Dr. W. J. Knox and Dr. A. B. Schinbein.

Dr. D. T. R. McColl has left Queen Charlotte City and is now at the Coqualeetza Indian Hospital at Sardis

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